UNITED STATES GENERAL ACCOUNTING OFFICE
Washington, D.C.

FOR EXPECTED RELEASE
Wednesday, August 18, 1982

STATEMENT OF

EDWARD A. DENSMORE, DEPUTY DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ON

SOCIAL SECURITY ADMINISTRATION'S PROGRAM FOR REVIEWING THE CONTINUING ELIGIBILITY OF DISABLED PERSONS

SUMMARY OF GAO STATEMENT SUBMITTED TO THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ON SOCIAL SECURITY ADMINISTRATION'S PROGRAM
FOR REVIEWING THE CONTINUING ELIGIBILITY
OF DISABLED PERSONS
AUGUST 18, 1982

--Based on a nationwide sample case review conducted in 1979, Social Security estimated that as many as 20 percent of the persons on the disability rolls were not disabled. Social Security conducted a follow-up study in 1980 and 1981, and found that about 26 percent of the beneficiaries were ineligible at a cost of about $4 billion annually to the Trust Fund.

--Congress enacted Section 311 of Public Law 96-265, which required Social Security, beginning in January 1982, to review the status of the disabled whose disability has not been determined to be permanent at least once every three years.

--Social Security accelerated its efforts and began reexamining the disability rolls in March 1981. About 451,400 cases were selected for investigation between March 1, 1981, and May 31, 1982. The States made decisions on about 240,000 cases resulting in the termination of benefits in about 106,800 or 44 percent of the cases reviewed.

--Many of the terminated cases, however, have appealed to the administrative law judges. The reversal rate, or those whose benefits were reinstated, was 67 percent according to one study and 61 percent according to another.

--GAO's case review found certain administrative problems in Social Security's decisional process--(1) attending physician data is often not useful to the examiners, and (2) decisions are too frequently based solely on current evidence-- often no more than 2 to 3 months old, and often on "one-shot" consultative medical examinations.

--The most significant contributing factor in the high termination rate is due to the major changes in the criteria and guidance used in the decisional process. The criteria have become more explicit in certain areas, and in some areas more stringent.

--Beneficiaries who were awarded benefits several years ago under a more liberal, less objective evaluation process, are subjected to the newer, more objective, more stringently interpreted set of evaluation guidelines. As a result, many persons are being terminated from the rolls whose medical conditions have not changed or may have become worse.

--GAO believes that the Congress should clarify its intent on whether persons already on the rolls should be subjected to a "new determination", that is, evaluated solely under current criteria, or whether the prior decision should be taken into account and some medical improvement criteria followed.

Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss the Social Security Administration's (SSA's) recent efforts in reexamining the continued eligibility of persons on the disability rolls. These reexaminations, begun in March 1981, are commonly referred to as Continuing Disability Investigations or CDIs.

Because of the concerns expressed to us by several Members of the Congress over the medical conditions of the large number of beneficiaries being terminated from the rolls as part of the CDI effort, in January 1982 we began to review SSA's policies and practices for conducting these investigations. CDIs are performed by the various State Disability Determination Services (DDSs) following guidelines and instructions provided them by SSA. We have met with State officials and examiners in California, New York, Pennsylvania, and Ohio and examined approximately 100 case folders. In addition, we met with several administrative law judges and SSA officials.

We completed our case reviews in May 1982 and provided testimony on May 25, 1982, to the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs. We identified areas that warrant more detailed work and scheduled several assignments to start this year that will probe these selected areas of the CDI program further.

Because audit work has not been performed subsequent to our previous testimony, I will reiterate, with some updated and additional information, our previous testimony.

We have identified a number of issues and problems with the current CDI process that deserve attention by the Congress and SSA. First I would like to explain briefly the evolution of events which brings us to today's conditions; secondly, present some of our observations to date about the CDI process; and also provide some suggestions for improving the process.

BACKGROUND

In the past, SSA's primary means of identifying beneficiaries who may have medically recovered or regained the ability to work, and assessing their continuing eligibility for disability benefits, was through the "medical reexamination diary process". This process involved establishing a future medical reexamination date (diary) for beneficiaries with certain medical conditions that were believed to have a high potential for medical improvement. When the diary date matured, State agencies were to reevaluate the beneficiaries' medical condition. Investigations were also to be done when it was learned that a beneficiary had returned to work.

We reported to the Congress in March 1981 1/ that SSA had not adequately followed up on disability insurance beneficiaries to verify that they remain disabled. SSA had limited its investigations to a small percentage of beneficiaries, and even beneficiaries who met the criteria for reexamination had not always been investigated. Only about one of every five persons awarded disability was targeted for reexamination. The remainder, about 2.3 million persons, were never reexamined and would very likely

---

1/ "More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries," HRD-81-48, March 3, 1981.

remain on the rolls unless they returned to work, reached age 65 and converted over to the retirement program, or died.

Based on a nationwide sample case review conducted in 1979, SSA estimated that as many as 20 percent of the persons on the disability rolls did not meet the disability criteria. SSA collected current medical evidence on about 3,000 cases and in some instances visited and interviewed beneficiaries in their homes. Using this evidence, SSA examiners and physicians determined whether or not the individuals were currently disabled. Based upon this sample, we estimated that as many as 584,000 persons were not eligible for benefits costing the Disability Trust Fund over $2 billion annually.

SSA conducted a follow-up study in 1980 and 1981 and reviewed 2,817 randomly selected cases from the 2.8 million beneficiaries that were on the rolls during July, August, or September 1980. In this study nearly all of the cases included one or more consultative examinations. 1/ The findings from this study were consistent with that of the 1979 study, and showed that about 26 percent of the beneficiaries on the rolls during the July/September 1980 period were not disabled. SSA estimated from this study that erroneous disability payments amount to about $4.0 billion annually.

Congressional concern over the high degree of selectivity in designating cases for medical reexamination and other inadequacies in the review procedure led to the enactment of Section 311 of

1/ In the 1979 study only about one-half of the cases reviewed included consultative examinations. A consultative examination is the purchase of medical evidence in the form of a medical examination or laboratory test.

Public Law 96-265, known as the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review the status of disabled beneficiaries whose disability has not been determined to be permanent at least once every three years. SSA officials estimated that this legislative mandate would require them to perform investigations on approximately 3 million cases over a 3-year period.

Due largely to an increased emphasis on cost-saving measures and to prepare for the massive workload anticipated in 1982, SSA began several projects aimed at improving the continuing disability process. SSA conducted several studies to help profile those beneficiaries with the highest likelihood of being found ineligible for disability benefits. Using these profiles, SSA began reexamining beneficiaries in March 1981 under an accelerated CDI review. 1/

CDI CASE SELECTION AND WORKLOAD

SSA selected about 451,400 cases for investigation between March 1, 1981, and May 31, 1982. The States have completed investigations and made decisions on about 240,000 cases, 2/ resulting in the termination of benefits in about 106,800 or 44 percent of the cases reviewed. This is in addition to the regular

1/ Beginning January 1, 1982, the review was referred to as the "Periodic Review" because of the legislative mandate.

2/ Another 35,000 cases have been reviewed by the States, but are considered "no decision cases" due to various reasons such as (1) being returned to the SSA district offices for further development of work related issues, (2) being sent to the wrong DDS, (3) individuals are deceased, and/or (4) having had an investigation already done in the last 12 months.

investigations of about 155,000 diaried cases per year that were determined to be subject to medical improvement.

Many of those individuals terminated at the DDS level, however, will appeal and have their benefits reinstated by administrative law judges (ALJs). While there is only a paucity of data to indicate the reversal experience to date, SSA has developed some information. The Office of Hearings and Appeals (OHA) has been tracking CDI cases through the process. OHA's data showed that for the period February through May 1982 the ALJ's adjudicated 16,200 CDI cases and reversed 9,882 cases or 61 percent. Another SSA study showed that of 6,683 CDI cases terminated at the DDS level in 1980 and 1981, about 3,360 or 50 percent of the cases had been appealed to the ALJ level. As of March 1982, the ALJs had made decisions on 2,451 cases and reinstated benefits in 1,647 or 67 percent of them.

During March and April of 1981, cases selected by SSA for investigation involved younger beneficiaries (under age 50) who were initially adjudicated in 1973, 1974, and 1975--years when the quality of decisions was believed to be at its lowest.

A different selection methodology was used beginning in May 1981. Cases were selected each month based on specific profiles using such characteristics as current age, total benefit payments, date of entitlement, numbers and kinds of auxiliary beneficiaries, and age at filing. SSA believed the profile selection technique would result in a more cost-effective use of resources than reviewing random groups of cases.

PERIODIC REVIEW TERMINATIONS--
WHY THEY ARE HAPPENING

As indicated by our March 1981 report, SSA was paying disability benefits to many persons who were not eligible for the program. This has been confirmed by the periodic review efforts to date. While we cannot quantify them, the CDI/Periodic Review is identifying beneficiaries who

--should never have been placed on the rolls initially, or

--have medically improved, or

--have died or returned to work, and otherwise would have gone undiscovered.

However, many of those losing their disability benefits have been on the SSA rolls several years, still have what we would all consider to be severe impairments, and have experienced little or no medical improvement. This raises questions about how and why these people are being terminated, and the fairness of SSA's decisions.

We will address these questions by looking at some of the factors causing these terminations (also referred to as cessations) including:

--State agency medical development practices, and

--the changed adjudication process and climate.

State Agency Medical
Development Practices

Much of the criticism brought to our attention about the periodic review effort has been directed toward the State agencies, and their procedures for medically developing CDI cases. Specifically, concern has been expressed that State agencies are

--terminating benefits without giving individuals adequate time to present medical evidence,

--not obtaining or considering relevant information from treating physicians, and

--overrelying on purchased consultative examinations which are sometimes too brief and possibly biased.

We did find some instances of poor medical development practices, as well as some decisions that were not adequately supported. We also question the State agencies' usual practice of gathering and evaluating only evidence that is from the most recent three months. We believe, however, that medical development issues are not unique to the CDI effort and are not the primary cause of the high number of cases being terminated.

Results of case review

To address the issue raised about State agency medical development practices, we reviewed 98 CDI cases in the 4 States we visited. Most of the cases were selected--either directly by us, or by State agency personnel monitored by us--as the State agency quality assurance units completed tneir technical review. This total also contained some cases (6) that had received a hearing before an administrative law judge. Our purpose in reviewing these cases was to look at the mechanics and timing of the medical development.

Forty-two of the 98 cases we reviewed, or about 43 percent, had resulted in cessations. Because of the small size of our sample, and the timing of our selection, we cannot project the results of our sample to what has happened in the CDI/Periodic Review effort since March 1981. The table below presents some of the statistical information about the cases we reviewed.

	Cessations	Continuances	Total
Number of cases	42	56	98
Average age of beneficiary	43	45	44
Average years on disability	7	9	8
Average case processing time 1/ (in days)	127	83	102
Percent of cases where claimants' physicians were contacted	69	74	71
Percent of contacts responding to DDS	90	81	85
Percent of cases with consultative exam ordered	86	54	67

1/ We counted from the date beneficiary was first contacted concerning the review (either by mail or phone) to the date the DDS physician signed the notice of decision.

The 42 cessations we reviewed averaged nearly 127 days from the time the beneficiary was first contacted about the review to the date of the DDS decision. This includes the 10 or more days allowed a beneficiary after being notified of the decision to submit any additional evidence. The shortest processing time we found for a terminated case was 34 days, the longest was 368. We found no instances where beneficiaries were terminated without being given time to develop and present their medical evidence.

We found that attending physician data is usually requested unless it is not relevant to the impairment, too old, or from a source known to be uncooperative. We found only a few instances where examiners did not request evidence from what we felt was a relevant source. While most sources did respond, we found a

significant variation in quality, quantity, and objectivity in their responses.

It is difficult to evaluate the extent to which attending physician data is considered in the States' decisions. Examiners complain that much of the information received from treating sources is too old to satisfy SSA's requirements, too subjective, too opinionated, and too sketchy to satisfy evidentiary requirements. Also, treating physicians often don't perform the kinds of tests required by the medical listings. Therefore, while it is clear that some portion of attending physicians' reports are not fully considered, we cannot determine the extent of this nor what impact this has on the final decision. We did see instances where attending physicians said their patients were totally disabled, yet the States discontinued benefits. However, these were invariably cases where the physicians submitted little objective evidence to support their conclusions.

There has also been much concern expressed about the use--or overuse--of consultative examinatons in connection with the CDI effort. The 1981 consultative examination purchase rate in CDI cases varied in the four States visited. We estimate it was 62 percent in Pennsylvania, 59 percent in Ohio, 58 percent in California, and 39 percent in New York.

Examiners say CDI's generally require consultative examinations more often than other claims because many long-term disabled people haven't been to physicians recently. Ohio, for example, ordered examinations for only 30 percent of its entire caseload, but nearly 60 percent for CDI's. During this limited study, we did not

attempt to evaluate the appropriateness of the consultative exam purchase rate, or the quality of the exams purchased. We do, however, plan to look at tnese and other issues pertaining to consultative examinations in the near future.

CDI cases need special development

One aspect of State agency medical development that we believe needs to be changed is the practice of developing these CDI cases as if they were new claims. SSA has issued no specific development guidance for these cases, but rather has instructed the State agencies to adjudicate these claims in generally the same manner as initial claims. As a result, State agencies are gathering only current evidence--generally no more than 2 or 3 months old--and using this evidence to determine if the beneficiary currently meets SSA's criteria for disability. This practice can result in incomplete information and is one of the major reasons treating sources are not contacted or their information is not considered in the decision. It also helps explain the high consultative examination purchase rate.

While the need for current evidence is obvious, we also believe there is a need for a historical medical perspective in these CDI cases. Many of these individuals coming under review have been receiving benefits for several years. To base a decision on only the recent examinaton--often a purchased consultative examination--could give a false reading of that person's condition. This is especially true for those impairments subject to

fluctuation or periodic remission, such as mental impairments. For example:

> A 49 year old beneficiary in Pennsylvania was awarded disability insurance benefits in 1966 for schizophrenia. As part of the CDI/Periodic Review, the State agency tentatively determined in March 1982 that his disability had ceased. This decision was based soley on a consultative examination report that found him "fairly alert and responsive with schizophrenia controlled by medication". Following a due process procedure, however, the State agency reversed its decision in April 1982 because of information submitted by the beneficiary's treating physician. This report showed a history of repeated hospitalizations since 1950, emotional swings, and withdrawn and anti-social behavior.

Another tie between the initial claims process and the CDI efforts that might need change is the processing time goal. One measure of examiner performance in both initial claims and CDI cases is the percent of cases pending over 70 calendar days. While some examiners in the 4 states visited said they felt no undue pressure to move CDI cases, others said they are constantly aware of the time goal pressures. They felt it was unrealistic to be expected to develop these CDI cases in 70 days. CDI cases are often more difficult to develop than initial claims, and are more time consuming since they generally require more use of consultative exams.

We plan to evaluate this issue further to determine if it is causing examiners to rush their decisions.

The Adjudication Process and Climate

A more significant factor in explaining the number of CDI/Periodic Review terminations is the way the medical evidence is evaluated to determine if eligibility for disability benefits

continues. State agencies use the "sequential evaluation" process to determine if a beneficiary remains eligible. This process is a series of decisions based on medical and vocational evidence. Essentially, the State agency must determine if the beneficiary is working; if the alleged impairment is severe; if the impairment meets or equals the medical listings 1/; or, when the impairment is severe, but does not meet or equal the listings, if it prevents the beneficiary from doing his/her past work or any other work.

Changes in the Evaluation Process

SSA--after almost a decade of prompting from the Congress, GAO, and others--has made major changes in the criteria and guidance used in the disability determination process. The criteria have become more explicit in certain areas, and in some areas they have become more stringent.

During the early and mid-1970s, those close to the disability program, especially State DDS administrators, voiced the need for revised medical listings. For example, in response to a March 1976 letter from the Chairman of the Subcommittee on Social Security, House Ways and Means Committee, one State administrator wrote, "The listings are outdated, and desperately need revision." Another said:

> "...the listings are about 10 years out of date . . . for example listing 404, on myocardial infarction, is considered in error. A large majority of persons who have myrocardial infarctions, and survive, do return to work. Therefore, we may be allowing claims in which return to work is more than reasonable, in light of current medical practice..."

1/Medical evidence by itself is sufficient to establish that a person is disabled where it establishes the presence of an impairment included in the "Listing of Impairments" or an impairment(s) medically equivalent to a listed impairment(s).

The medical listings were finally revised in 1979.

There were similar complaints about the need for improved, formal guidelines on evaluating vocational factors in the sequential evaluation process. In a 1978 Subcommittee report, Members of the Subcommittee on Social Security stated that they had

> "...for years urged the promulgation of more definite regulatory guidelines which would promote uniformity in decisionmaking and provide for enhanced administrative control of the program in this area. These proposed regulations spell out through a grid mechanism the weights to be given to the nonmedical factors..."

The vocational grid became effective in 1979.

During the mid-1970s, SSA also began to get more explicit about what it meant by a "severe" impairment. This was conveyed in written and oral policy instructions, training programs, and case returns to State agencies from SSA's quality assurance system. The result was an increase in the number of denials for "slight impairments".

All of these changes had a definite impact on tightening up the "adjudicative climate". In response to a 1978 survey by the Subcommittee on Social Security, one State administrator said,

> "...I believe the primary reason for the recent conservative approach to disability evaluation is a direct result of the activities of the Subcommittee on Social Security, the General Accounting Office, and others involved in evaluating the effectiveness of the program. The Administration has apparently carefully considered all of the comments, inquiries, opinions, etc., and concluded tnat a 'tightening up' is desired. This view may be somewhat of an over simplification; but in the real world it is quite likely the root cause of the recent trends. In summary, I believe the 'adjudicative climate' has changed."

Impact of Changes on
the CDI Beneficiaries

The changes to the sequential evaluation process and the adjudicative climate were evolutionary and were not developed to address specifically the CDI/Periodic Review program. Because of the changes, however, many beneficiaries are being terminated. The changes in the medical listings in 1979 have affected some beneficiaries who previously qualified under the old listings, but do not meet the criteria of the revised listings. For example:

> A 51 year old beneficiary in New York was awarded disability benefits in 1975 following a myocaridial infarction (heart attack). At that time, the medical listings only required evidence showing that the infarction occurred, and that the claimant had chest discomfort. The revised medical listings for heart impairments now require specific exercise test results or specific readings from a resting electrocardiogram (EKG). While the beneficiary's resting EKG readings in both 1974 and 1982 show similar abnormalities and he continues to suffer from angina (chest pain), his benefits were terminated because the EKG readings do not meet the requirements of the new listings.

Similarily, beneficiaries put on disability because their condition "equaled" the listings are now being terminated because of a more narrow application of this concept. In 1975, 44 percent of all awards were based on equaling the medical listings--instances where the impairment was not specifically described in the listings, but was considered equal in severity; or the combination of impairments was medically equal to any that were listed. In 1981, only about 9 percent of all awards were based on equaling the listings. Examiners have told us that beneficiaries allowed in the past with multiple impairments are now being

terminated under the CDI effort because their impairments are being evaluated independently rather than looking at the total effect of the impairments. For example:

> A 50 year old beneficiary in Ohio suffered from hypertension, diabetes, and depression. Although none of these impairments met the specific listing, the claimant was awarded benefits in 1971 when their combined effect was considered. As part of the CDI review, the State agency obtained evidence that contained essentially the same findings as that from 1971. However, the State agency now considered the impairments individually and terminated benefits because none met the specific listings.

The formalized vocational grid, now part of the regulations is also a factor in many terminations. In the mid-1970s many individuals whose impairments did not meet or equal the listings were allowed because of vocational factors (age, education, prior work experience)--even though there was little or no guidance available at that time on how to evaluate those factors. When re-evaluating beneficiaries previously allowed for vocational factors, State agencies now terminate benefits in many of these cases because of the vocational grid. For example, beneficiaries 49 years old or younger with severe impairments that do not meet or equal the listings cannot be found to be disabled unless they are illiterate or unable to communicate in English. Most of the beneficiaries being terminated under this review effort are age 49 or younger.

A New Decision

In summary, through the CDI/Periodic Review process, SSA is reviewing a group of beneficiaries who were awarded benefits several years ago under a more liberal, less objective evaluation

process. These are generally people who were led to believe that they were being granted a lifetime disability pension. Now, with no advanced explanation from SSA about the purpose, process, or possible outcome of the Periodic Review--they are subjected to a new decision, much the same as if they were applying for disability benefits for the first time. There is no presumptive effect given to the prior findings of disability, nor to the years that these individuals have been entitled to payments.

The new decisions are made using a newer, more objective, more stringently interpreted set of evaluation guidelines; and are made in a tougher "adjudicative climate." At the same time, these decisions are subject to the same inherent weaknesses that have always plagued the SSA disability determination process--subjectively, and medical development of questionable quality and completeness.

Subjecting everyone to a new decision has a major adverse impact on the group of beneficiaries who were placed on the rolls initially through the appeals process. Because of the historical differences in adjudicative criteria between the State and the administrative law judges (ALJs), many of these beneficiaries are now being taken off the rolls after reexamination by the same State agency that found them not disabled originally. Since the State's original decision was "not disabled," a new decision by the State would generally be expected to have the same conclusion, particularly in light of the tightened disability determination criteria and adjudicative climate. Many of these

individuals may be put back on the rolls after another appeal. 1/ We do not know how many cases are affected by this "merry-go-round" review, but the number could be quite large.

MEDICAL IMPROVEMENT ISSUE NEEDS TO BE ADDRESSED

For the reasons discussed above, many beneficiaries whose conditions have not improved, or may even have worsened, are being told they are "no longer disabled," and are terminated from SSA's disability rolls. We believe the aspect of "no medical improvement" for a large percentage of the cessations during the last year accounts for much of the adverse publicity given the CDI/Periodic Review process. This is not a new issue, but perhaps has been exacerbated by the large number of "non-diaried" cases examined by SSA during the last year.

During our limited case review, we did not attempt to quantify the number of cessations where there was no apparent medical improvement. However, a recent SSA study may provide some insight into this question. The study evaluated over 21,000 disability cases, and discontinued benefits in about 7,000 (33 percent). These cases were reviewed by SSA examiners and physicians for changes in the severity of the individual's impairment. Of the 7,000 cases where benefits were terminated, only 51 percent were

---

1/ A recently completed study by SSA of over 3,600 decisions by ALJs highlighted clear differences in adjudicative criteria between the ALJs and the States as a major reason for the high number of decisions by ALJs to award benefits. For example, the ALJs awarded benefits in 64 percent of the 3,600 cases, whereas SSA's Office of Assessment, using State agency criteria, would have awarded benefits in only 13 percent. The study also highlighted the significant effect of a face-to-face meeting with the claimant.

determined to have medically improved. In 35 percent of the cases, benefits were ceased even though the severity of the impairments was judged to be the same as or worse than when benefits were initially awarded.

Under SSA's operating guides which have been followed by the States for approximately 4 years, disability is found to have ceased when current evidence shows that the individual does not meet the current definition of disability. SSA's policy states that it is not necessary to determine whether or how much the individuals' condition has medically improved since the prior favorable determination.

The possible need for legislation on the medical improvement issue was addressed by a 1976 staff report of the Subcommittee on Social Security, House Committee on Ways and Means, entitled "Disability Insurance--Legislative Issue Paper." SSA's policies since 1969 on CDI terminations had been that it was necessary to have documentation supporting an improved medical condition. The staff report pointed out that

> Revitalization of the CDI program can be carried out administratively, although if it is the subcommittee conclusion that the medical improvement requirement criteria should be altered, this may have to be done by legislation.

SSA dropped its former policy in May 1976 and until now there have been only a few court decisions on the issue. Those decisions have consistently argued for a return to some form of medical improvement.

The legislative history of the 1980 Amendments clearly indicates that the Congress was concerned about the individuals who

have medically improved and remained on the disability rolls. However, it is not clear what the Congress' view was toward those who have not medically improved. Whether the Congress intended that all beneficiaries would be subjected to a "new determination," or whether it is expected the earlier decisions to afford some presumptive weight, is an issue that we are still reviewing. Recent decisions in the U.S. Courts suggest that the Courts believe a degree of "administrative finality" or res judicata effect should prevail on these cases. Several class-action suits are pending which presumably will address this issue.

We believe the Congress should state whether cessations are appropriate for those already on the disability rolls who have not medically improved. There are other matters relating to the medical improvement issue that need to be considered also, such as how to deal with those on the rolls as a result of clear erroneous initial awards, and those that, despite no medical improvement, clearly come under a changed eligibility criteria or definition. We plan to work with this Committee and other Members of the Congress in developing these matters further.

- - - - -

We plan to continue reviewing several of the other issues discussed, and as this work progresses we will consider what actions SSA should take to improve the disability determination process and, specifically, the Periodic Review.

On July 14, 1982, we transmitted our previous testimony to the Secretary, Department of Health and Human Services, and

recommended that the Commissioner of Social Security take the following actions.

--Notify all disability beneficiaries and explain to them the purposes of the Periodic Review, and the importance of their providing complete and current medical evidence. If these reviews remain "new determinations" with little consideration given to the prior determination, this aspect should be fully explained to the beneficiaries.

--Issue policy guidance to the State agencies emphasizing the need for obtaining a full medical history in all Periodic Review cases. The medical history should cover the period from the initial disability determination and include medical information used in the initial determination.

--Establish a processing time goal for managing the Periodic Review caseload that is commensurate with thorough development of medical evidence.

- - - - -

That concludes our statement. We shall be pleased to respond to any questions you or other members of the Committee may have.