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Report to the Commissioner, Social Security Administration
Department of Health and Human Services

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SOCIAL SECURITY

Adjusting Continuing Disability Review Priorities

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Ms. Dorcas R. Hardy
Commissioner, Social Security Administration
Department of Health and Human Services

Dear Ms. Hardy:

We have reviewed SSA's plans for resuming continuing disability reviews (CDRs) as part of our work for the Chairman, Subcommittee on Social Security, House Committee on Ways and Means, involving SSA's implementation of the medical improvement review standard. Throughout our review, we have been concerned that the limited CDR resources of the Disability Determination Services (DDSs) were not concentrated on the CDR cases that (1) would produce the most savings to the trust fund because medical improvement is highly possible and (2) involve claimants who have had actions pending on their cases for some time. We stated our concerns during several meetings with SSA officials, including the Associate Commissioner, Office of Disability.

SSA officials informed us of revisions to the planned mix of cases that SSA will send to the DDSs, bringing it closer in line with our suggestions. This letter reiterates our concerns about the CDR case mix and recommends that SSA give high priority to two specific groups of cases.

In preparing to resume the CDR process, SSA developed a national case workload plan for state DDSs. This plan, released in July 1985, placed all types of CDR cases into four categories to more clearly reflect the nature of the CDRs— decision review cases, medical improvement expected cases, medical improvement possible cases, and medical improvement not expected cases. These categories are defined as follows:

- Decision review—cases in which prior benefit cessation decisions were made, but which will need review under the new medical improvement standard. Included are remanded court cases that need review under the new medical improvement criteria and some reopened mental impairment cases that need review under the new mental impairment criteria and the medical improvement criteria.
- Medical improvement expected—cases in which medical improvement is expected and can be predicted at the time of the initial decision. These cases are usually scheduled for review within 6 to 18 months after the initial decision. This category includes such impairments as certain infectious diseases and the recovery period following surgery.

- Medical improvement possible—cases in which improvement in medical condition is possible but a specific time period for improvement was not predicted. Nevertheless, a 3-year review requirement of the law applies (i.e., the impairments were not classified as permanent).
- Medical improvement not expected—cases classified as permanent impairments in which medical improvement is not expected. They are reviewed at 5- to 7-year intervals. This category includes such impairments as paraplegia, mental retardation, and cerebral palsy.

SSA's initial plan was to provide 451,545 cases nationally to the DDSs for the first 9 months according to the following breakdown—53,733 decision review cases, 125,130 medical improvement expected cases, 106,518 medical improvement possible cases, and 166,164 medical improvement not expected cases.

At various times during our review and before the CDR effort resumed, we met with SSA's task force members responsible for developing the CDR plan and other high-level SSA officials. We questioned the appropriateness of having DDS resources committed to reviewing such a high proportion of medical improvement not expected cases. We expressed our concern that claimants with a high probability of medically improving were not given sufficient priority in SSA's CDR workload mix. Also, for court remand cases and other re-reviews pursuant to the law, we believed that equity required that SSA resolve the eligibility status as promptly as possible to relieve any uncertainty on behalf of these claimants.

SSA was aware that the medical improvement not expected cases would yield a lower rate of benefit cessations than the medical improvement expected and decision review cases. Before resuming the CDR program, SSA reviewed a sample of about 100 cases in each of the four CDR categories to test the new CDR procedures and project the decision outcomes for each category under the medical improvement review standard. This study indicated that the medical improvement not expected cases would have a cessation rate of only about 5 percent, whereas the decision review and medical improvement expected cases would have cessation rates of 72 and 35 percent, respectively.

In May 1986 SSA officials told us that the agency's case workload emphasis for the remainder of fiscal year 1986 and for fiscal year 1987 had been revised. SSA made decision review cases its top priority for the remainder of the fiscal year and expected to have all of these cases released to the DDSs by September 30, 1986, and completed by December

30, 1986. According to these officials, SSA plans to give the medical improvement expected cases top priority in fiscal year 1987 and to further screen these cases to give the earliest attention to cases with impairments having the highest likelihood of medical improvement.

As of August 29, 1986, SSA had released only 18,588 of the approximately 60,000 decision review cases and had completed 5,198 of them. By the end of fiscal year 1986, there will be a significant backlog of medical improvement expected and medical improvement possible cases needing review. SSA estimates that there is a backlog of 270,000 medical improvement expected cases and that there are somewhere between 500,000 and 1 million medical improvement possible cases that have not been reviewed as required by the 1980 amendments.

While this change in workload emphasis is in line with our earlier suggestions, there are two groups of CDR cases (a total of 58,000 cases) specifically identified by SSA that we believe also should receive high priority. Included in the medical improvement possible category are about 40,000 cases that were previously reviewed and benefit cessation decisions made at the DDS, but that were not effectuated because of a moratorium placed on CDRs by the Secretary of Health and Human Services. Also, under the medical improvement expected category, SSA identified about 18,000 cases involving prior cessation determinations with appeals pending. According to SSA officials, most of these beneficiaries are still in benefit status.

SSA's CDR workload plan as reported to us in May 1986 did not account for the 40,000 "rescinded cessation cases" and included the 18,000 prior cessation cases in the medical improvement expected category to be distributed in fiscal year 1987. We believe that there is a high probability that many of these 58,000 beneficiaries will have medically improved, as shown by SSA's test of the new CDR procedures and projection of decision outcomes which projected a 70-percent cessation rate for these cases. Delay in re-reviewing these cases results in the trust fund paying excessive benefits. For example, assuming that at least half of these 58,000 open cases would be ceased, the trust fund would lose at least $15 million each month that these individuals remain on the disability rolls.

In a September 17, 1986, meeting, SSA officials told us that they now plan to include all these cases (58,000) in their 1987 workload. However, since May 1986, SSA has revised its CDR workload plan for fiscal year 1987 several times. In addition, there is uncertainty as to the number of

CDR cases that can be processed in a given year. Therefore, we believe that your attention is needed to ensure that these cases receive high priority.

Recommendation

We recommend that you direct the Associate Commissioner, Office of Disability, to (1) process the 58,000 cases immediately after completing the decision review cases and (2) not process medical improvement not expected cases until DDSs become current with the decision review, medical improvement expected, and medical improvement possible cases.

Copies of this report are being sent to the Secretary of Health and Human Services and the Department's Office of Inspector General. We would appreciate being advised of the actions you plan to take on our recommendation.

Sincerely yours,

Joseph F. Delfico
Senior Associate Director

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