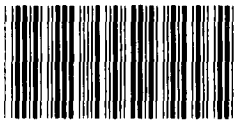
GAO

Briefing Report to the Chairman
Subcommittee on Social Security
Committee on Ways and Means
House of Representatives

December 1986

SOCIAL SECURITY DISABILITY

Implementation of the Medical Improvement Review Standard



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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-224648

December 16, 1986

The Honorable James R. Jones
Chairman, Subcommittee on
Social Security
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

In response to your request and later discussions with your office, we have been monitoring the Social Security Administration's (SSA's) and the state disability determination services' (DDSs') implementation of the medical improvement review standard. This standard resulted from the Social Security Disability Benefits Reform Act of 1984 (Public Law 98-460). Specifically, we were asked to provide information on SSA's effort with regard to resuming continuing disability reviews (CDRs), which have been under moratorium since 1984, and to discuss SSA's future plans for conducting CDRs.

To obtain feedback on the resumption of the CDR process, we sent a questionnaire to the DDSs, requesting information about their start-up effort, including agency staffing levels, training efforts, and caseload capabilities related to CDR resumption. We obtained the results of the CDR effort to date and discussed SSA's future plans for conducting CDRs and implementing the medical improvement review standard. We visited the DDSs in Arkansas, Missouri, New York, Oklahoma, and Texas to discuss their start-up of the CDR operation. We did not visit the DDSs to verify their responses to the questionnaire, nor did we verify the statistical information reported by SSA.

The situation can be summarized as follows:

-- SSA took more than a year to develop final regulations and procedures to implement the medical improvement review standard.

-- DDSs were not able to handle the volume of cases SSA's initial CDR resumption plan called for, and adjustments to the caseload plan were necessary to provide workload relief for the DDSs.

-- The primary impediment to conducting CDRs was the lack of DDS resources because they were working on a backlog of about 230,000 initial mental impairment cases.

-- The CDR effort to date has achieved limited results compared to initial plans. SSA had completed, as of September 26, 1986, 46,509 CDR cases, compared to the 347,000 projected cases in its original plan for fiscal year 1986.

-- At the end of fiscal year 1986, SSA estimated a backlog of 270,000 medical improvement expected cases. Also, there are somewhere between 500,000 and 1 million medical improvement possible cases that were required to be reviewed under the Social Security Disability Amendments of 1980 but had not been as of September 30, 1986. Based on progress as of September 1986 in processing CDR cases, SSA's original projection of becoming current during the first 24 to 36 months of operation will not be met.

-- SSA projects that 223,000 CDR cases will be processed in fiscal year 1987 with medical improvement expected cases being given priority. This projection is based on a national production per work year goal of 195 cases, which exceeds the actual production of 47 of the 53 DDSs for which data were available in fiscal year 1986 through September 26, 1986. Nearly all the DDSs, however, have shown an upward trend in production rates in the first three quarters of fiscal year 1986. (See app. IV.)

We discussed the matters contained in this document with SSA officials and incorporated their comments where appropriate. Also, we expressed our concern over the CDR case mix in an October 22, 1986, report to the Commissioner of SSA. (See app. V.)

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this briefing report until 30 days from its issue date. At that time, we will send copies to the Secretary of Health and Human Services and will make copies available to others on request.

Should you need additional information on the contents of this document, please call me on 275-6193.

Sincerely yours,

Joseph F. Delfico
Senior Associate Director

Contents

ABBREVIATIONS

CDR	continuing disability review
DDS	Disability Determination Service
HHS	Department of Health and Human Services
MIRS	Medical Improvement Review Standard
PPWY	production per work year
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income

SOCIAL SECURITY DISABILITY:

IMPLEMENTATION OF THE MEDICAL

IMPROVEMENT REVIEW STANDARD

INTRODUCTION

The Social Security Administration (SSA) administers the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. SSDI, authorized under title II of the Social Security Act, provides benefits to insured disabled workers and their families in amounts determined by the workers' wage history. SSI, authorized under title XVI of the act, provides assistance to needy aged, blind, and disabled persons, many of whom lack recent work experiences. Over the years, the two programs have paid substantial benefit payments; in 1986, the programs' payments will be about $20 billion.

Substantial increases in the SSDI disability rolls and increased costs of the program during the 1970's heightened congressional interest in the program's administration. (See figs. 1 and 2.) Concern centered on the lack of adequate follow-up on beneficiaries' conditions after they were placed on the benefit rolls. An SSA study completed in 1979 showed many beneficiaries were receiving benefits that they were no longer eligible for.

In an attempt to constrain program growth, provide more control over the size of the beneficiary caseload, and improve incentives for rehabilitation and return to work, the Congress enacted the Social Security Disability Amendments of 1980 (Public Law 96-265). A significant administrative measure in the amendments was a provision requiring the Secretary of Health and Human Services (HHS) to review all beneficiaries for eligibility through "continuing disability reviews" (CDRs). Before this time, SSA had reviewed only a small percentage of disability cases for continuing eligibility. Frequency of reviews for the "permanently" disabled was left to the Secretary's discretion; other beneficiaries were required to be reviewed at least every 3 years, beginning in January 1982. Under a provision enacted in 1983 (Public Law 97-455), the Secretary is authorized to waive this 3-year review on a state-by-state basis, depending on each state's backlog of pending cases, the projected number of applications for insurance benefits, and current and projected staffing levels of the state agency.

Figure 1:

Total SSDI Disability Beneficiaries and Disabled Workers (1970-85)

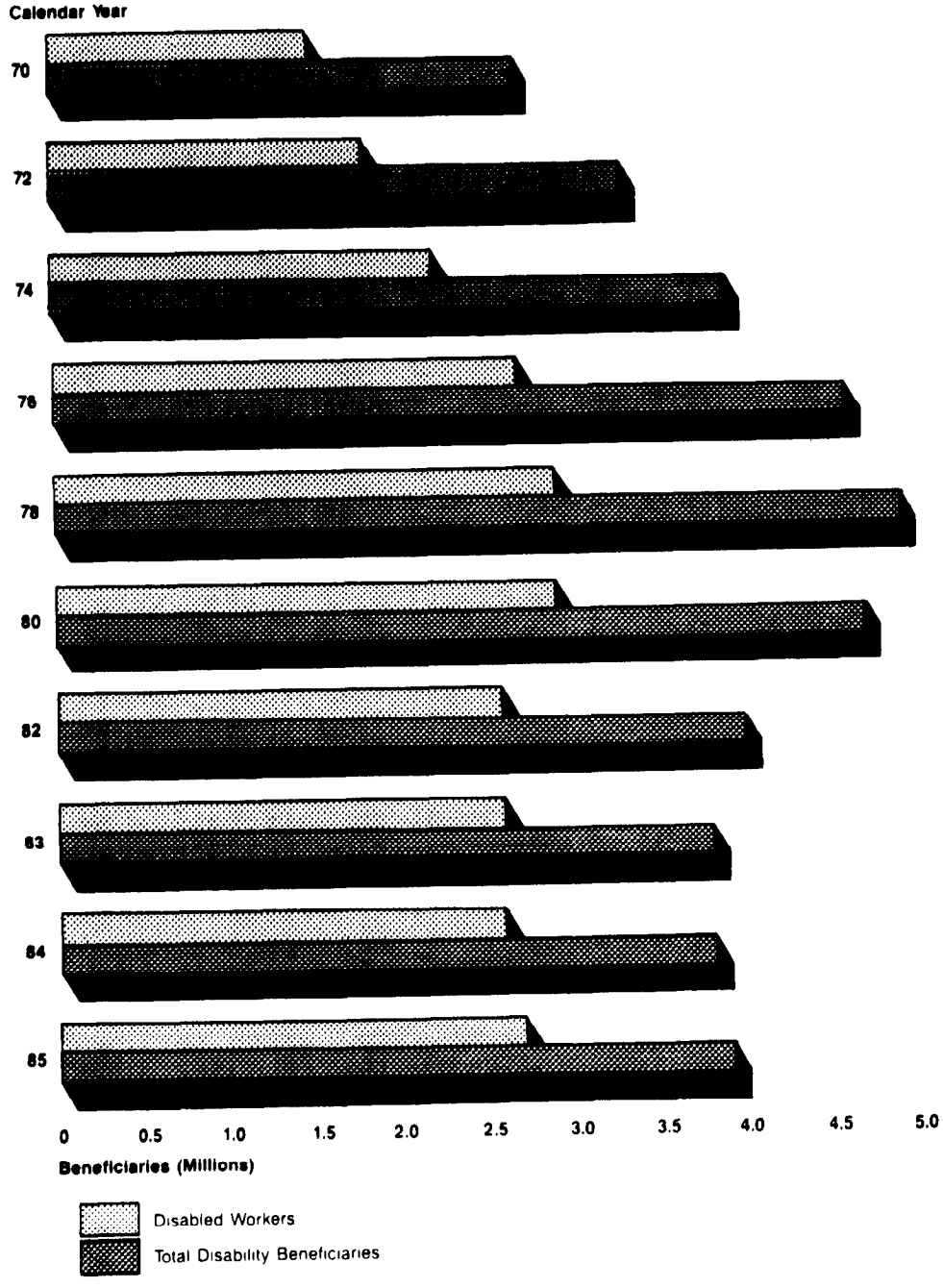
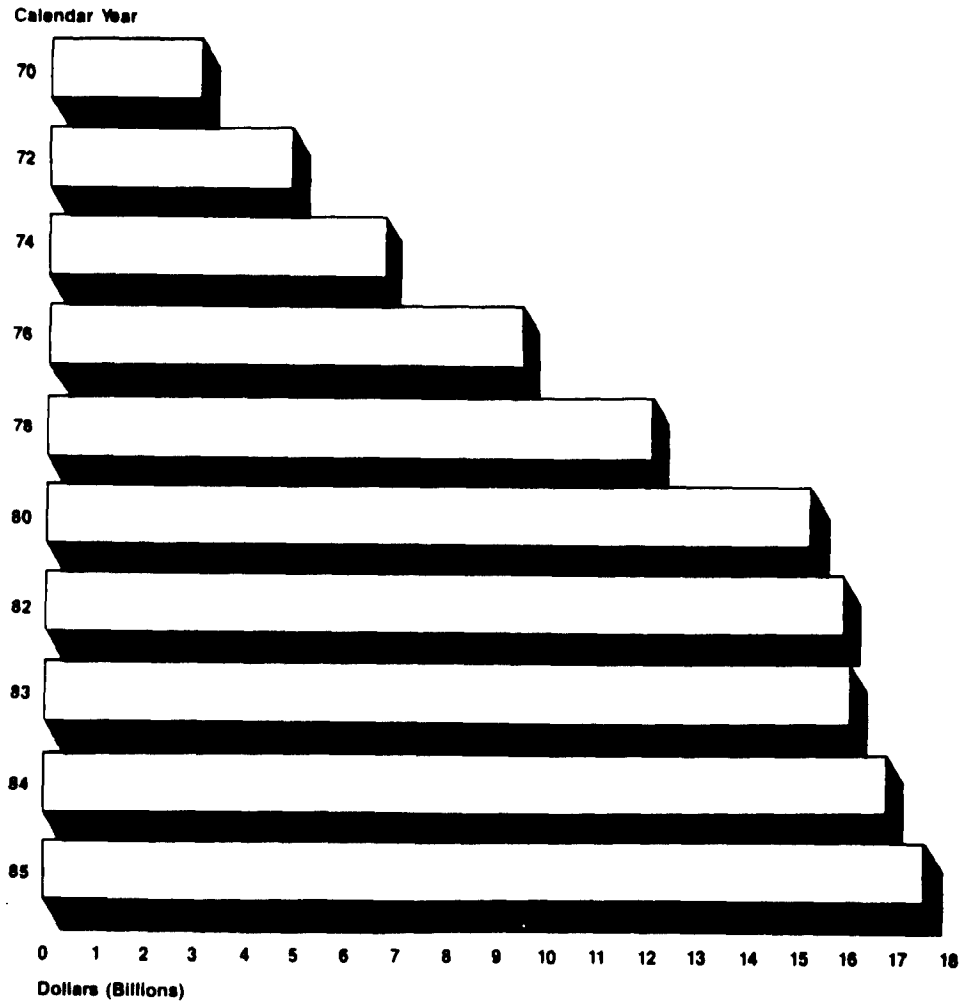


Figure 2:

Total SSDI Disability Benefit Payments
(1970-85)



Disability decisions are made by 54 "state" agencies--one in each state (except South Carolina which has a separate agency for the blind), the District of Columbia, Guam, and Puerto Rico--known as disability determination services (DDSs). These agencies are regulated by SSA, which develops program policy, regulations, adjudicative criteria, and instructions.

SSA and the DDSs began the CDR process in March 1981. The criteria used were the same as those used for initial applications. According to SSA, DDSs had reviewed 1,203,066 cases for continuing eligibility through September 1984 and found 495,802 (or 41.2 percent) ineligible for continuing benefits.

Since the inception of the CDRs in 1981, this reexamination process has been controversial. Much of the controversy has been centered on whether medical improvement should be demonstrated before anyone is terminated from the disability rolls. Before the implementation of the Medical Improvement Review Standard (MIRS), all that had to be shown was that a person was able to engage in substantial gainful activity. In 1983, this controversy was heightened when 18 DDSs were ordered by their governors or federal courts to provide evidence of medical improvement before terminating disability benefits. Eight more DDSs were ordered by their governors to discontinue processing benefit terminations. As the year progressed, this situation worsened, and on December 7, 1983, SSA advised all DDSs to temporarily stop processing benefit terminations.

On January 24, 1984, the CDR process was to resume, with each DDS following one of three possible procedures appropriate to its circumstance. DDSs could (1) resume processing and notification of disability terminations in accordance with court-imposed standards, (2) resume such processing and notification in accordance with SSA instructions, or (3) continue to hold all medical cessations pending further consideration of unsettled medical-improvement litigation in the circuit court covering the state. In April 1984, the Secretary of HHS placed a national moratorium on CDRs.[1]

Concerned about the erosion of public faith and confidence in the disability program, the Congress, in October 1984, passed the Social Security Disability Benefits Reform Act of 1984 (Public Law 98-460). The act prescribed a standard of review, including a medical improvement provision for determining whether disability should continue. The act required the Secretary to prescribe regulations to implement the standard within 180 days after enactment.

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[1]According to SSA, a limited number of cases were not placed under the moratorium until October 1984.

SSA drafted the initial regulations on MIRS and on April 30, 1985, published them for review and comment. Interested parties were given until June 14, 1985, to submit comments, which were received from 106 sources. Based on the comments, SSA revised the regulations and submitted them to the Secretary for final review on August 13, 1985. On September 13, 1985, the regulations were sent to the Office of Management and Budget for review and approval.

Final regulations for MIRS were issued on December 6, 1985. These regulations define medical improvement as any decrease in the medical severity of the individual's impairment(s) since the most recent favorable medical determination, based on changes in the symptoms, signs, or laboratory findings associated with the impairment(s). If medical improvement has occurred, a decision must also be made on whether the improvement affects the individual's ability to work. This second decision is based on the comparison of functional capacity (ability to do basic work activities) to determine if it has increased since the most recent favorable medical determination.

MIRS contains several exceptions that allow benefits to be terminated even when the beneficiary's medical condition has not improved (if the beneficiary is performing substantial gainful activity, medical or vocational therapy techniques allow the person to work despite his unchanged condition, the prior decision was in error or was fraudulently obtained, or new or improved diagnostic techniques or evaluations reveal that the impairment is less disabling than originally thought). According to SSA regulations, to insure the program's integrity, it is important that the exception provisions are carefully applied and that determinations made in accordance with the provisions are fully documented, accurate, and consistent with findings.

SSA set January 6, 1986, as the start date for resuming the CDR process.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Chairman, Subcommittee on Social Security, House Committee on Ways and Means, asked us to monitor the implementation of MIRS. Through later contacts with the Chairman's office, we were asked to provide information on SSA's and the DDSs' experiences in CDR start-up, document their progress to date, and determine what their future plans are. Our fieldwork was conducted between December and June 1986 at SSA headquarters and its Region VI office in Dallas as well as DDSs in Arkansas, Missouri, New York, Oklahoma, and Texas. We selected the DDSs for their relatively diverse caseloads and resources and their geographic differences.

To obtain feedback on the start-up of the CDR process, we sent a questionnaire to 53 DDSs[2] (see app. I) asking for information as of January 31, 1986. We designed the questionnaire to obtain information on the DDSs' readiness to resume CDRs and to obtain their comments (both positive and negative) on implementation of MIRS and its effects on their operations. We did not visit the DDSs to verify their responses. We pretested the questionnaire at one DDS location before mailing it to the DDSs. We followed up with telephone calls to some of the DDSs and obtained additional data through these calls. We did not verify the statistical information reported by SSA regarding the CDR process.

We reviewed disability workload plans and production reports and interviewed SSA officials to assess CDR resumption progress. We discussed with SSA officials their plans and projections for processing CDR cases. Except as noted above, our work was conducted in accordance with generally accepted government auditing standards. We discussed the matters in this document with SSA officials and incorporated their comments where appropriate.

PREPARING FOR CDR RESUMPTION

In preparing to resume the CDR process, SSA developed a CDR resumption plan that included an early information system to assure accurate decisions, training procedures, and a case workload plan.

Assuring Accurate Decisions

To help assure that CDR case decisions are correct and that the new medical improvement review regulations are clearly carried out, SSA implemented an early information system consisting of a case bank and a sample review of "live" cases. In addition, SSA gave a "second look" to all cessations during the early phase of CDR resumption.

The case bank was developed to (1) measure how well the adjudicative and review components within SSA's regional offices and DDSs understood and applied the standard and (2) identify the need for additional training before the CDR process moved into full operation. Consisting of 17 cases covering the major body systems, the case bank provided an opportunity to apply the medical improvement concepts to case examples for which answers were already available. Solutions to each case were available so that review results could be analyzed and decisions made as to the need for additional training.

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[2]We did not send questionnaires to the South Carolina state agency for the blind, and we did not receive a response from Guam.

The sample review of live cases was established to assess the effectiveness of program instructions, procedures, and training on the implementation of the new criteria. The system was designed so that feedback--including additional training, policy clarification, and questions and answers--could be provided before DDSs are given authority to discontinue a claimant's benefit (cessation decision).

The live case sample review provides for the DDSs to submit a specified number of completed cessation cases to SSA for review. The number of cases varies depending on the DDS's size. SSA reported that as of October 15, 1986, 47 DDSs are continuing to operate under the early information requirements of sending all cessations for SSA regional review. As of that date, SSA reported that 558 cessations were pending regional review, 2,051 cessations were approved for releasing notices to the beneficiary, and 218 disagreements were returned to the DDSs for additional work.

According to SSA, the "second look" includes a review of CDR cessations by the regions over a specified period. It also includes a review of all decision review category cessations. Additionally, SSA has provided for a special central office policy staff review of selected cessation cases involving the use of exception categories under MIRS. This special review will continue until SSA is certain that the MIRS principles are being correctly applied.

Training CDR Examiners

To prepare CDR examiners and review personnel for evaluating claims under MIRS, SSA prepared various training packages covering such areas as MIRS terms, concepts, evaluation process, exceptions, and rationale writing for decisions on both continuances and cessations. "Train the trainer" sessions were held for CDR examiners in Baltimore. These persons then returned to their offices to train the examiner/physician staffs. One of these training packages was prepared to help new examiners learn to make continuing disability decisions as efficiently as possible while becoming proficient in following policies and procedures contained in SSA's Program Operations Manual System. As part of the CDR resumption, SSA instructed the DDSs to complete SSA's prescribed training for MIRS and other specific case training packages before processing any CDR cases.

We asked the DDSs in our questionnaire to rate the adequacy of the SSA training for the CDR resumption. Table 1 shows the prescribed training components and summarizes the DDSs' responses.

Table 1:

Rating of SSA Initial CDR Training

Training components	More than adequate	About adequate	Less than adequate
	----------(percent)[a]----------		
CDR examiner training program	10	67	23
MIRS	12	60	29
Medical improvement not expected	17	67	17
DDS role in processing CDR court cases	2	62	37
Rational writing for CDR cases	10	71	20

[a]Due to rounding, totals may not add to 100 percent.

Thirty-nine of the DDSs said that they supplemented some part of prescribed training.

CDR Resumption Case Workload Plan

In July 1985, SSA released its case workload plan for resuming the CDR program. The plan projected the anticipated volumes of CDRs to be processed during the first 24 to 36 months of operations. The plan placed 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 cessation decisions were made, but which will need review under the new MIRS. 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.

Medical improvement possible--cases in which improvement in medical condition is possible but a specific time period for improvement was not predicted. Nevertheless, the

3-year review requirement of the law[3] 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.

SSA's initial plan was to release 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. The national monthly workload figures in the plan for fiscal year 1986 (assuming a January CDR resumption) are shown in table 2.

Table 2:

CDR Initial Release Plan

Case category	Cases per month		Total for months 1 to 9
	Months 1 to 6	Months 7 to 9	
Decision review	5,685	6,541	53,733
Medical improvement expected	11,517	18,676	125,130
Medical improvement possible	12,967	9,572	106,518
Medical improvement not expected	25,305	4,778	166,164
Total	55,474	39,567	451,545

According to November 19, 1985, guidance, SSA's central office is responsible for ensuring that (1) CDR cases are released monthly in accordance with budgeted workloads and (2) the CDR workload plan is adjusted for any unique situations or unanticipated factors in the field offices and DDSs. The SSA regional offices and DDSs are responsible for providing input and perspective on workload/resource situations and making recommendations for adjusting the workload and/or volume.

[3]The 1980 amendments required CDRs for all beneficiaries on the disability rolls except those determined by the Secretary to have permanent impairments whose frequency of review was left to the Secretary's discretion.

STATES NOT FULLY PREPARED FOR CDR RESUMPTION

Although DDS administrators requested SSA to delay resumption of the CDR program because of an existing mental case backlog, SSA released to the DDSs the first volume of cases for CDR resumption in January 1986. SSA records show that 46,155 cases had been released as of January 31, 1986. These cases began flowing to DDSs in December 1985, with instructions for no actual beneficiary contact before January 6, 1986, or until training was completed if later. However, DDSs were not fully prepared to resume processing the CDR cases, and for the most part, few CDR cases were processed. By the end of June 1986, 6 months after SSA released the first group of cases, only 13 DDSs had completed cases equal to the number of their initial month's release.

The Council of State Administrators of Vocational Rehabilitation, representing 37 DDS administrators, wrote the associate commissioner for disability on November 1, 1985, expressing concern over a backlog of mental impairment cases resulting from the new disability mental impairment criteria. The letter requested that no CDR cases be sent to the DDSs until the mental impairment case backlog was reduced. (The Disability Benefits Reform Act of 1984 required revised mental regulations and included a provision that mental claims filed and denied between the law's enactment date and the date of the regulations--August 28, 1985--be re-reviewed under the new regulations.) The backlog in December 1985 was estimated at about 230,000 cases. The governor of one state, Pennsylvania, did not lift his moratorium on performing CDRs until February 10, 1986.

In responding to our questionnaire, 10 DDSs reported that they had not assigned CDR cases to examiners during the first month of CDR resumption. Forty-two DDSs reported that 11,488 CDR cases had been assigned to examiners for development and decision as of January 31, 1986. Forty-five DDSs responded that after the first month of CDR resumption (Jan. 31, 1986), some or all of their disability examiners had completed the SSA prescribed training for resumption of CDRs. Seven DDSs reported that none of their disability examiners had completed the prescribed training. However, based on responses to our questionnaire, all of the CDR examiners were to have completed the training by September 1986.

In responding to our questionnaire, the DDSs estimated that they could process only about 151,000 CDR cases by September 30, 1986. SSA had estimated that 347,000 CDR cases would be processed by that date.

ADJUSTMENTS TO THE CDR WORKLOAD PLAN

Because most DDSs were unable to process the first distribution of CDR cases according to SSA's plan, SSA drastically reduced its second release of cases. According to SSA, after receiving feedback from the DDSs on their ability to accommodate additional cases, it released only 10,151 CDR cases (compared to 55,474 cases as originally planned). The 10,151 cases, which went to 27 states and the District of Columbia, included 2,200 decision reviews, 1,584 medical improvement expected, 1,775 medical improvement possible, and 4,592 medical improvement not expected cases. During this release, SSA did not release any CDR cases to 26 DDSs and released only decision review cases to 13 DDSs. Table 3 shows the second distribution of cases by states.

In February 1986, SSA reassessed the workload plan in relation to resources available for the individual DDSs and determined that the third distribution would include 21,869 cases. However, after receiving additional feedback from DDSs on their capacity and resource availability, SSA decided not to make a third distribution and to reassess its workload mix and case distribution for the remainder of the fiscal year.

CDR WORKLOAD PLAN FOR REMAINDER OF FISCAL YEAR 1986

In May 1986, SSA gave us data on revisions it made to the mix of cases that would be processed by the DDSs and the number of CDR cases to be distributed for the remainder of the fiscal year. These revisions were more in line with views we expressed to SSA before CDR resumption (see p. 20). SSA revised the case mix, giving top priority to processing decision review cases, and projected that all of the decision review cases (60,400) would be distributed by the end of fiscal year 1986.

SSA's original plan called for decision review cases to be completed over a 12- to 18-month period. SSA officials said the switch, making decision review cases top priority, was brought about because of the DDSs' limited remaining funds available to purchase medical examinations for the remainder of fiscal year 1986 and concern by the courts that remanded court cases were not being done as a result of the slower CDR start-up. According to SSA officials, the decision review cases would require fewer consultative medical examinations than either medical improvement possible or medical improvement expected cases. Most of the decision review cases require reviewing the prior denial decision and applying the medical improvement standard to that decision.

Table 3:

Second Distribution of CDR Cases
By Case Category and Location

State	Number of cases by category: Decision review	Medical improvement expected	Medical improvement possible	Medical improvement not expected	Total
New Jersey	102	0	0	250	352
New York	502	0	0	825	1,327
Delaware	12	0	0	0	12
District of Columbia	5	0	0	0	5
Maryland	31	0	0	0	31
Alabama	120	267	289	565	1,241
Mississippi	44	219	218	425	906
South Carolina	52	219	237	463	971
Illinois	101	110	121	263	595
Indiana	54	113	140	277	584
Michigan	82	219	253	493	1,047
Minnesota	33	61	70	136	300
Wisconsin	44	196	227	443	910
Iowa	94	0	0	0	94
Kansas	45	0	0	0	45
Missouri	290	0	0	0	290
Nebraska	45	0	0	0	45
Colorado	266	0	0	0	266
Montana	16	0	0	0	16
North Dakota	7	0	0	0	7
South Dakota	20	0	0	20	40
Utah	17	0	0	0	17
Wyoming	2	4	4	10	20
Arizona	65	128	156	304	653
Nevada	16	30	41	81	168
Idaho	13	18	19	37	87
Oregon	59	0	0	0	59
Washington	63	0	0	0	63
Total	2,200	1,584	1,775	4,592	10,151

According to SSA the following numbers represent the maximum number of CDRs that could be completed, considering total system capacity and given the $25 million increase[4] in funding for fiscal year 1986. On May 1, 1986, $10 million was made available for DDS budgets for the third quarter of fiscal

[4]This $25 million was a part of an SSA request for reapportionment of funding for DDSs.

year 1986, and an additional $15 million was made available for the fourth quarter. SSA's CDR workload mix plan and actual results are shown in table 4.

Table 4:

CDR Planned and Actual Workload for Fiscal Year 1986

Case category	Planned releases through 9/30/86	Actual releases through 9/26/86	Planned dispositions in FY 1986	Actual dispositions through 9/26/86
Decision review	60,400	20,612	34,277	7,325
Medical improvement expected	30,000	21,904	13,000	8,628
Medical improvement possible	20,100	15,287	11,600	[a]
Medical improvement not expected	39,500	37,985	31,000	30,556
Other cases	133	2,255	133	-
Total	150,133	98,043	90,010	46,509

[a]Combined with medical improvement not expected total.

The 90,010 planned total case dispositions (cases processed) for fiscal year 1986 compares to 347,000 dispositions projected under the original plan.

SSA INITIATIVE TO ASSIST STATES IN REVIEWING CDRs

SSA is providing assistance to selected DDSs in completing CDRs. This assistance, described in the following sections, comes from federal resources in SSA's central and regional offices.

SSA Regional Offices

The regional offices either provide direct assistance in CDR processing or assist in processing mental impairment cases, which in turn increases DDS capacity for CDR processing. The assistance depends on the examiner staffing in disability quality branches or physicians (especially psychiatrists) on the regional medical staffs. The following are SSA's regional projects.

Region I (Boston)--Using disability quality branch examiners in Rhode Island, Massachusetts, and New Hampshire to assist in processing mental impairment cases.

Region II (New York)--Temporarily assigning claims representatives to New York and New Jersey to aid in beneficiary contacts on medical improvement not expected cases. A disability quality branch review of 1,300 mental impairment cases for West Virginia.

Region V (Chicago)--Temporarily assigning physicians and examiners to Ohio and Michigan to assist in processing mental impairment cases.

Region VI (Dallas)--Using disability quality branch examiners and regional physicians in Arkansas, Louisiana, and Texas to assist in processing mental impairment cases.

Region IX (San Francisco)--Sending disability quality branch examiners and a physician to Hawaii to review mental impairment cases.

Office of Medical Evaluation

SSA's central office physician staff in its Office of Medical Evaluation would have begun receiving CDR "preeffectuation" review cases[5] and CDR quality assurance cases requiring physician review as early as April 1986. Because these workloads did not materialize, a plan was developed to use Office of Medical Evaluation psychiatrists to provide assistance in completing the psychiatric review technique form[6] for mental impairment cases. According to SSA, using Office of Medical Evaluation resources in this manner increases the DDSs' capacity for CDR workloads.

SSA's Office of Disability Operations and Program Service Centers

SSA's Office of Disability Operations and Program Service Center examiners had been expected to begin processing CDR preeffectuation cases about April 1986; however, without this workload, they were available for other work. According to SSA, this group represents its largest potential capacity to assist DDSs. SSA decided, based on workload priorities and workload mix, that this capacity could best be used in processing decision review cases.

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[5]Public Law 96-265 requires that, for all years after 1982, 65 percent of all disability allowances be reviewed before the decision is effected.

[6]This form documents psychiatrists' evaluations of mental impairment cases.

The decision review process, as described in SSA's Programs Operations Manual System, is a three-step procedure for the majority of cases.

Step 1: The case is sent to the DDS for file screening, telephone contact with the beneficiary, and completion of a district office guidance form. (In about 10 to 15 percent of the cases, the guidance form is not necessary, as the file includes all pertinent information and a favorable decision is obvious. These cases are completed with step 1.)

Step 2: The case is sent to the district office for a face-to-face interview with the beneficiary, as specifically tailored by the instructions in the district office guidance form.

Step 3: The case is returned to the DDS for necessary medical development and final decision making.

SSA identified 14 DDSs to assist in processing their decision review case workload. The SSA examiners complete step 1 of the three-step decision review case process. According to SSA, using these examiners to complete step 1 of the decision review process has the advantage of putting the cases in process without using DDS resources until step 3 of the process. Table 5 shows the DDSs that SSA is assisting.

Table 5:

Federal Assistance in Processing Decision Review Cases as of September 1986

State	Step 1 by SSA examiners	Step 1 by DDS examiners	Total decision reviews
New York	4,803	0	4,803
Pennsylvania	5,042	1,161	6,203
Tennessee	1,332	99	1,431
Ohio	3,815	1,762	5,577
Arkansas	1,593	118	1,711
Louisiana	580	87	667
Oklahoma	147	24	171
Texas	628	182	810
Montana	321	0	321
Arizona	578	0	578
California	7,053	243	7,296
Iowa	750	0	750
Hawaii	195	6	201
Oregon	384	0	384

FUTURE OUTLOOK FOR CDR PROCESSING

At various times before the resumption of the CDR effort, we met with SSA's task force members responsible for developing the CDR resumption plan and other high-level SSA officials. We expressed our concern that claimants with a high probability of medically improving were not given priority in SSA's CDR workload mix. Also, for court-remanded cases and other re-reviews pursuant to the law, we believed equity required that SSA resolve the eligibility status as promptly as possible to relieve any uncertainty on behalf of the 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 CDR categories to test the new CDR procedures and project the decision outcomes for each of the case categories under MIRS. 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. If only medical improvement expected cessation cases are considered, the cessation rate would rise to 76 percent.

SSA's original CDR workload plan contained a disproportionately large number of medical improvement not expected cases in relation to the other case categories (decision review and medical improvement expected cases). For example, the plan called for a release of 151,830 medical improvement not expected cases--over 40 percent of the total cases planned for release during the first 6 months of operations. SSA classifies the medical improvement not expected cases (permanently disabled beneficiaries) as those whose medical impairment is not expected to improve. This category includes such impairments as paraplegia, mental retardation, and cerebral palsy. The medical improvement expected cases involve beneficiaries whose impairments are expected to improve within a 6- to 18-month period. This category includes such impairments as certain infectious diseases, recovery period following surgery, etc. The decision review cases are those pending court-ordered review under MIRS.

We agree with SSA's change in case emphasis for fiscal years 1986 and 1987. As stated on page 15, SSA revised its workload mix for the remainder of fiscal year 1986 shortly after making its second distribution of cases. According to the associate commissioner for disability, SSA made decision review cases its top priority for the remainder of the fiscal year and expected to have all these cases distributed by September 30 and completed by December 30, 1986. However, as shown in table 4, page 17, as of September 26, SSA had released only about

one-third of the planned decision review cases and completed about one-fifth of its planned dispositions of decision review cases.

At the end of fiscal year 1986, there were significant backlogs of medical improvement expected and medical improvement possible cases. SSA estimated a backlog of 270,000 medical improvement expected cases. SSA does not consider medical improvement possible cases as backlogged, because the Secretary is authorized to waive the 3-year review on a state-by-state basis depending on each state's backlog of pending cases. There are, however, between 500,000 and 1 million medical improvement possible cases required to be reviewed under the 1980 amendments that have not been done.

The medical improvement expected cases are expected to be the top priority in fiscal year 1987. SSA is developing a plan keying on the medical improvement expected workload. The intent of this effort is to screen the medical improvement expected case backlog to determine which cases should be processed early under a special selection process. The selections would start with the type of impairments that were scheduled for a reexamination based on high improvement rates, such as fractures or expected postoperation improvement.

In preparing the CDR resumption plan, SSA grouped CDR cases into four major categories that make up the workload of cases to be processed (see pp. 12 and 13). Included in the medical improvement possible category are about 40,000 "rescinded cessation decisions" cases that were previously reviewed and had a cessation decision made at the DDS, but were not effectuated because of the moratorium placed on CDRs by the Secretary of HHS. The medical improvement expected category includes 18,000 "benefit continuation" cases. These cases involve cessation determinations with pending appeals; according to SSA, most of these are still in benefit status. We believe that a high probability exists that many of these 58,000 beneficiaries will have medically improved. Delay in re-reviewing these cases results in the trust fund paying excessive benefits. (See app. V.) In commenting on a draft of this report, SSA officials said that these subgroups of cases will be included in SSA's fiscal year 1987 priority workload.

We wrote to SSA on April 30, 1986, to obtain its future CDR plans. In a response dated May 14, 1986, SSA said that for fiscal years 1987 and 1988, CDR case dispositions are expected to be about 478,000 and 590,000, respectively. However, during a national DDS meeting in June 1986, SSA announced a revision to its fiscal year 1987 projections to 322,000 CDR cases. In commenting on a draft of this report, SSA officials said they had further reduced the fiscal year 1987 projection to 223,000 CDR cases. The projected dispositions include decision review, 26,000; medical improvement expected, 143,000; and medical

improvement possible and medical improvement not expected, 54,000. Based on fiscal year 1986 dispositions and current estimates for future dispositions, SSA will not meet its original projection of becoming current in medical improvement expected cases within 24 to 36 months.

SSA's revision was based on a national production per work year (all cases processed nationally divided by total DDS staff) goal of 195 cases for each DDS. Achieving the revised SSA projected national production per work year goal of 195 cases for fiscal year 1987 will require significant improvement by several states. For example, SSA's cumulative performance statistics through September 26, 1986, show that national production is 167 cases per work year and only six DDSs have achieved a production per work year of 195 or more. (See fig. 3.) The individual quarterly DDS production per work year for the first three quarters, as reported by SSA, is shown in appendix IV.

Figure 3:

States' Production Per Work Year (PPWY)
Fiscal Year 1986 (Through September 26, 1986)

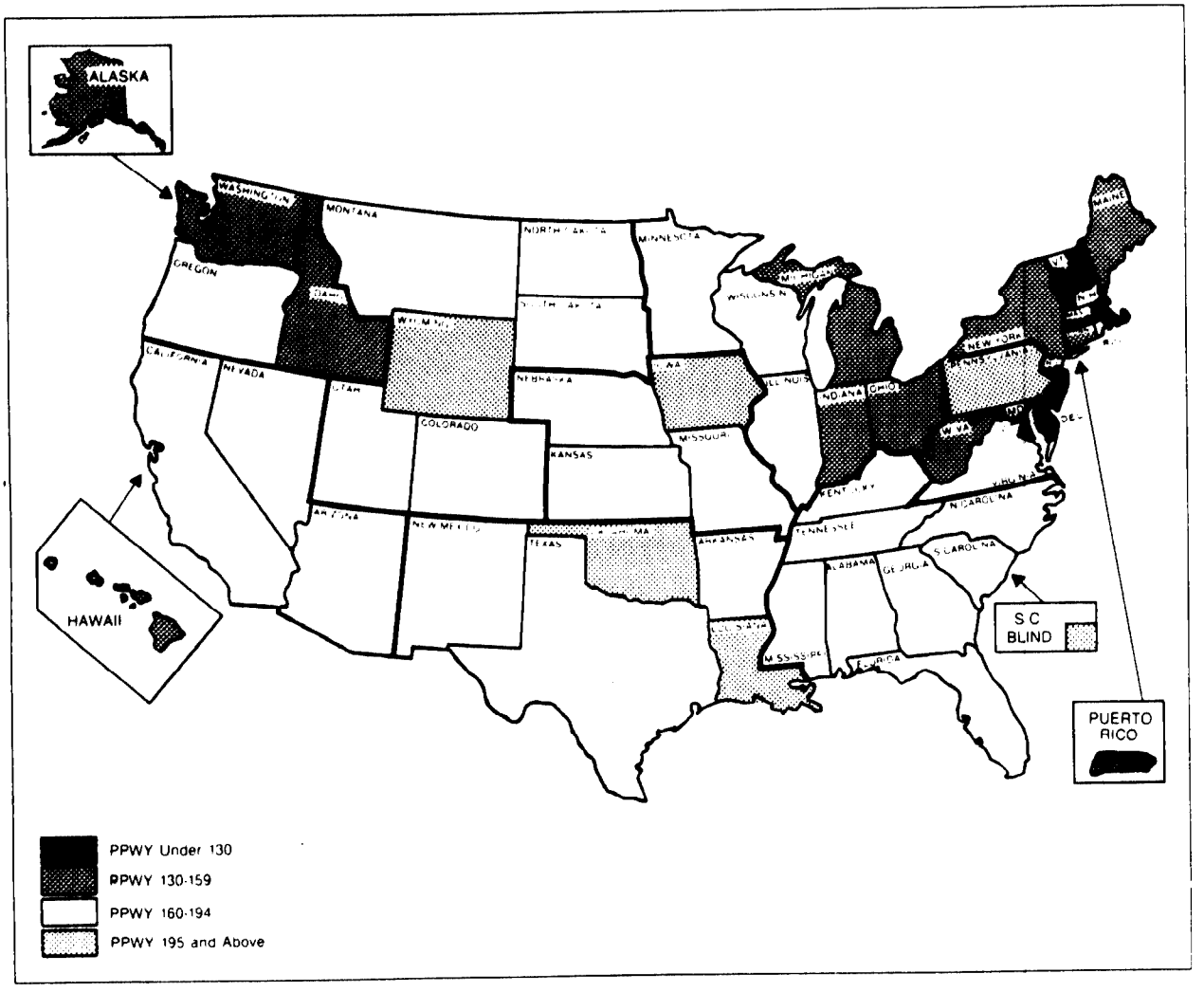
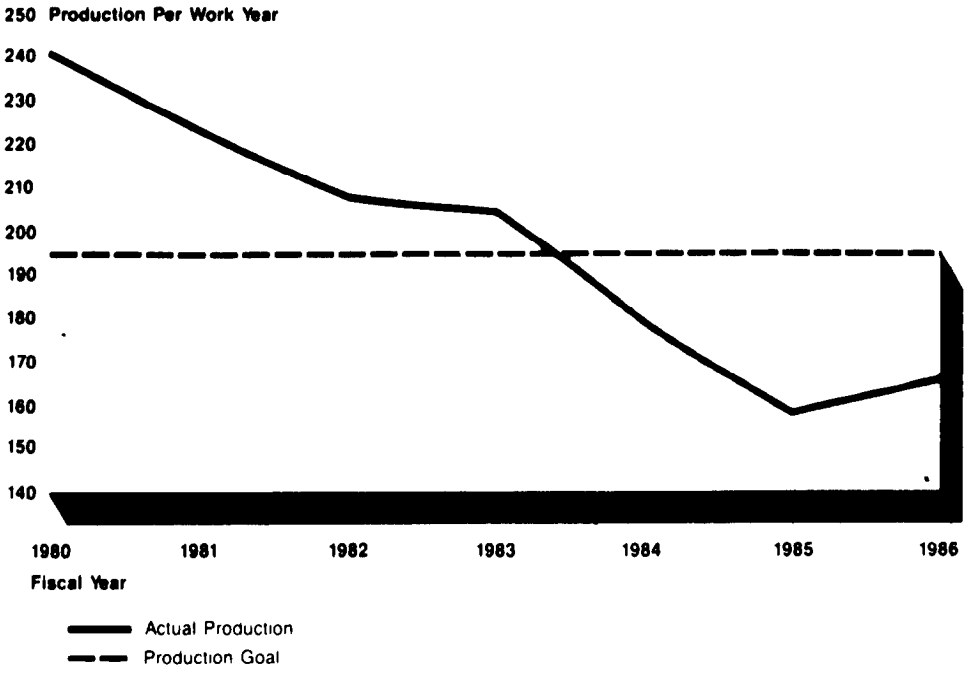


Figure 4 shows the trend in DDS production levels since fiscal year 1980. During this period, many events occurred that affected production levels, including the start-up of CDRs in 1981 and the moratorium on CDRs in 1984. Also, the disability program underwent several major revisions, which resulted in numerous requirements and rule changes for processing cases during this period.

Figure 4:

National Production Per Work Year Statistics
(FY 1980 Through September 26, 1986)



SSA officials stated that variances among the DDSs' operations could account for some of the differences in production levels. For example, SSA officials said that different length work weeks (32 vs. 40 hours), short-term production surges, and attrition rates are several reasons for possible state variances. While production levels are rising as shown by data in appendix IV, it is uncertain whether DDSs can meet the production goals.

SSA has an ambitious CDR production goal for fiscal years 1987 and 1988. Other workloads, such as initial disability claims, have a higher priority than the CDR workload. Therefore, the successful completion of the fiscal year 1987 CDR plan will depend on factors that cannot be fully anticipated at this point.

In commenting on a draft of this report, SSA officials agreed that with the uncertainty of the number of CDR cases that can be processed in a given year, DDSs should concentrate on CDR cases in which medical improvement is highly possible and claimants are expecting action on their cases. In an October 22, 1986, report to the SSA Commissioner, we stated our concerns over SSA's CDR case processing priorities and recommended that DDSs process such cases. (See app. V.)

EARLY CDR RESULTS

As of September 26, 1986, SSA reported that decisions had been made on 46,509 CDR cases under the medical improvement review standard. SSA data show that the continuance rate for all categories of CDR cases has been about 94.4 percent. Table 6 provides the number of CDR decisions by case category and continuance rate. It is too early to make conclusions about overall continuance rates due to the low number of CDRs and the types of cases completed to date. Also, there is a substantial time lag before a case can be completed because of SSA's early information procedures, which affect continuance rates.

Table 6:

CDR Cases Processed to a Decision as of September 26, 1986

Case category	Number of cases processed	Continuance rate (percent)
Decision review	7,325	93.6
Medical improvement expected	8,628	83.2
Medical improvement possible and medical improvement not expected	30,556	97.8
Total	46,509	94.4

Table 7 shows a state-by-state breakdown of cases released compared to cases processed.

Table 7:

Comparison of CDR Cases Released and Processed as of September 26, 1986

State	CDR cases released	CDR cases processed
Connecticut	812	420
Maine	424	266
Massachusetts	2,743	458
New Hampshire	224	83
Rhode Island	389	185
Vermont	177	52
New Jersey	2,698	1,158
New York	8,461	3,261
Puerto Rico	3,338	894
Delaware	248	83
District of Columbia	184	29
Maryland	1,223	428
Pennsylvania	5,085	542
Virginia	2,066	1,569
West Virginia	1,254	819
Alabama	3,593	1,488
Florida	5,336	2,965
Georgia	2,342	584
Kentucky	2,321	1,306
Mississippi	2,122	1,200
North Carolina	3,679	2,695
South Carolina-vocational rehabilitation	2,028	1,381
South Carolina-blind[a]	-	156
Tennessee	2,206	319
Illinois	5,489	3,303
Indiana	2,610	1,124
Michigan	6,312	3,211
Minnesota	1,090	535
Ohio	4,517	1,953
Wisconsin	2,256	1,165
Iowa	758	474
Kansas	478	338
Missouri	1,824	1,332
Nebraska	302	205
Arkansas	1,136	323
Louisiana	1,345	857
New Mexico	539	293
Oklahoma	1,007	333
Texas	3,723	1,616
Colorado	622	245
Montana	259	147
North Dakota	229	117
South Dakota	152	127

State	CDR cases released	CDR cases processed
Utah	213	140
Wyoming	116	70
Arizona	1,267	806
California	5,820	3,630
Hawaii	119	8
Nevada	423	196
Alaska	73	34
Idaho	432	236
Oregon	773	497
Washington	1,196	723
Total	98,043	46,509

[a]CDR cases released to South Carolina are not separated in SSA's CDR case release reports. CDR cases for South Carolina-blind are included in South Carolina-vocational rehabilitation case releases.

CONCLUSION

SSA's progress toward its CDR goals has been limited because DDS resources have been used primarily to process a backlog of mental impairment cases. There is a large backlog of CDR cases, and it is too early to predict when SSA will be able to eliminate the backlog and become current with respect to the CDR program.

Because of the large backlog of CDR cases, SSA needs to set priorities for its caseloads, concentrating on cases where medical improvement is highly possible and scheduled CDRs are past due. We recommended that SSA give high priority to such cases in a report to the Commissioner of SSA (see app. V).

APPENDIX I

U.S. GENERAL ACCOUNTING OFFICE

SURVEY OF STATE DISABILITY

DETERMINATION AGENCIES

/ / /

INTRODUCTION

The U.S. General Accounting Office, an agency of the Congress, is conducting a study of the implementation of the new Medical Improve- Review Standard for continuing disability reviews (CDRs). This questionnaire is designed to obtain information from each State disability determination agency about the volume of continuing disability review cases received from SSA, and about agency staffing levels, training and caseload capabilities related to CDR resumptions.

Please complete and return this questionnaire within 2 days of receipt. If it is more convenient, you may submit your answers by phone. Call Cam Zola or Jeff Bernstein on (301) 597-7932. They will be happy to accept your response. Thank you for your assistance.

A preaddressed business reply envelope is enclosed for your convenience. Should it be misplaced, return this questionnaire to:

Cam Zola
U.S. General Accounting Office
441 G Street, N.W. Room 6846
Washington, DC 20548

I. CDR RESUMPTION CASELOAD

1. As of January 31, 1986, how many CDR resumption cases had your agency received? (ENTER NUMBER. IF NONE ENTER "0".)

_____total CDR resumption cases received
-->(IF "0", SKIP TO QUESTION 6.)

2. Consider all CDR resumption cases that your agency has received. How many of these cases fit into each of the following categories? (ENTER NUMBER. IF NONE, ENTER "0".)

CATEGORY	NUMBER OF CASES
Decision reviews	_____
Medical improvement expected	_____
Medical improvement possible	_____
Medical improvement not expected	_____

APPENDIX I

3. As of January 31, 1986, how many of these cases had been assigned to an examiner for development and decision? (ENTER NUMBER. IF NONE, ENTER "0".)

_____ number of CDRs assigned

—>(IF "0", SKIP TO QUESTION 6.)

4. As of January 31, 1986, how many of these cases had cleared your agency (sent out with a decision or recommendation for cessation)? (ENTER NUMBER. IF NONE, ENTER "0".)

_____ number of CDRs cleared

—>(IF "0", SKIP TO QUESTION 6.)

5. Consider all CDR resumption cases that had cleared your agency as of January 31, 1986. How many of these cases were continuances? (ENTER NUMBER. IF NONE, ENTER "0".)

_____ number of cases that were continuances

6. What is the earliest date that your agency assigned, or anticipates assigning CDR resumption cases to examiners for development and decision? (ENTER MONTH, DAY, AND YEAR.)

/__/__/--/__/__/--/__/__/
mo. day yr.

II. CDR STAFF AND TRAINING

Questions in this section refer to examiners assigned to perform CDRs using the Medical Improvement Review Standard, and training in implementing this standard.

7. How many of your agency's examiners are assigned to perform CDRs? (ENTER NUMBER.)

_____ CDR examiners

8. How many of these examiners perform CDRs exclusively? (ENTER NUMBER. IF NONE, ENTER "0".)

_____ examiners performing CDRs exclusively

9. As of January 31, 1986, how many of your CDR examiners had completed the SSA-prescribed training related to implementing the Medical Improvement Review Standard? (ENTER NUMBER. IF NONE, ENTER "0".)

_____ examiners completed training

10. If some had not completed this training, by what date do you estimate that <u>all</u> your CDR examiners will have completed this training? (ENTER MONTH, DAY, AND YEAR.)

/__/__/--/__/__/--/__/__/
mo. day yr.

11. Listed below are the five components of SSA-prescribed training for CDR resumption cases. In your opinion, is each component more than adequate, about adequate, or less than adequate training material for that part of the CDR process it relates to? (CHECK ONE BOX FOR EACH ROW.)

	MORE THAN ADEQUATE	ABOUT ADEQUATE	LESS THAN ADEQUATE
	1	2	3
1. CDR Examiner Training Program			
2. Medical Improvement Review Standard Training			
3. Medical Improvement Not Expected			
4. DDS Role in Processing Court Case Decision Review Cases			
5. Rationale Writing for CDR Cases			

12. Has your agency supplemented the SSA-prescribed CDR training in any way? (CHECK ONE.)

1. [ ] Yes (BRIEFLY DESCRIBE.) _____

_____

_____

_____

2. [ ] No

APPENDIX I

III. AGENCY'S CASELOAD CAPABILITY

13. As a result of the SSA moratorium on processing mental impairment claims, how many cases, other than code "122" cases, did your agency hold for determination under the new mental impairment listings? (ENTER NUMBER.)

_____cases

14. As of January 31, 1986, how many of these cases had been cleared, how many were in the process of being developed by an examiner, and how many had not yet been assigned to an examiner? (ENTER NUMBER. IF NONE, ENTER "0".)

Cases cleared _____

Cases in process _____

Cases not yet assigned _____

15. As of January 31, 1986, how many "code 122" cases had your agency received from district offices for redevelopment and redetermination? (ENTER NUMBER. IF NONE, ENTER "0".)

_____cases

16. About how many "code 122" cases, in all, do you expect to receive from district offices for redevelopment and redetermination? (ENTER NUMBER. IF NONE, ENTER "0".)

_____cases

17. If your current staffing levels were to remain constant, given the non-CDR caseload your agency anticipates for FY 1986, approximately how many CDR cases do you estimates your agency could clear from January 1, through September 30, 1986? (ENTER NUMBER. IF NONE, ENTER "0".)

_____estimated number your agency could clear

IV. OTHER COMMENTS

18. Please note any comments, or observations you might have about the implementation of the Medical Improvement Review Standard or its effect on your agency's operation in the space below. We would like to know what your agency's experience with the new standard has been and what you anticipate it might be in the future. We would appreciate both positive and negative comments.

    Thank you for your help.

APPENDIX II

CDR CASES RELEASED

AS OF SEPTEMBER 26, 1986

State	Medical improvement possible	Medical improvement not expected	Medical improvement expected	Decision review	Other	Total CDR cases released
Connecticut	193	362	146	72	35	808
Maine	64	173	110	70	17	434
Massachusetts	349	821	356	1,035	182	2,743
New Hampshire	27	91	64	27	15	224
Rhode Island	114	167	64	25	19	389
Vermont	22	74	43	30	8	177
New Jersey	517	1,170	596	351	64	2,698
New York	1,793	3,654	1,445	1,374	195	8,461
Puerto Rico	701	966	344	1,318	9	3,338
Delaware	37	96	85	20	10	248
District of Columbia	32	66	74	9	3	184
Maryland	220	613	264	78	48	1,223
Pennsylvania	596	2,293	1,043	1,056	97	5,085
Virginia	294	898	501	343	30	2,066
West Virginia	222	446	306	265	15	1,254
Alabama	431	1,197	908	1,041	16	3,593
Florida	682	1,767	1,016	1,776	95	5,336
Georgia	400	1,000	500	395	47	2,342
Kentucky	454	784	694	362	27	2,321
Mississippi	254	828	760	243	37	2,122
North Carolina	370	1,276	714	1,229	90	3,679
South Carolina-vocational rehabilitation	282	750	691	274	31	2,028
South Carolina-blind[a]	-	-	-	-	-	-
Tennessee	332	1,054	438	345	37	2,206
Illinois	527	1,548	1,415	1,941	58	5,489
Indiana	705	986	480	381	58	2,610
Michigan	1,130	2,822	1,460	812	88	6,312
Minnesota	123	446	314	156	51	1,090
Ohio	570	1,674	748	1,389	136	4,517
Wisconsin	474	1,133	529	94	26	2,256
Iowa	98	272	191	156	41	758
Kansas	66	208	125	68	11	478
Missouri	276	579	410	512	47	1,824
Nebraska	47	109	82	62	2	302
Arkansas	158	394	259	298	27	1,136
Louisiana	191	577	383	159	35	1,345
New Mexico	98	188	152	96	5	539
Oklahoma	126	564	205	89	23	1,007

State	Medical improvement possible	Medical improvement not expected	Medical improvement expected	Decision review	Other	Total CDR cases released
Texas	418	1,892	918	398	97	3,723
Colorado	108	290	167	25	32	622
Montana	34	78	85	54	8	259
North Dakota	32	78	100	17	2	229
South Dakota	22	43	49	31	7	152
Utah	45	55	67	32	14	213
Wyoming	18	37	52	7	2	116
Arizona	238	457	344	191	37	1,267
California	952	2,011	1,389	1,229	239	5,820
Hawaii	14	42	40	20	3	119
Nevada	85	119	96	109	14	423
Alaska	6	18	23	22	4	73
Idaho	31	160	81	157	3	432
Oregon	118	273	213	153	16	773
Washington	191	386	365	216	38	1,196
Total	15,287	37,985	21,904	20,612	2,251	98,039

[a]CDR case releases to South Carolina are not separated in SSA's CDR case release reports. CDR cases for South Carolina-blind are included in South Carolina-vocational rehabilitation case releases.

CDR CASES PROCESSED

AS OF SEPTEMBER 26, 1986

State	Combined--medical improvement possible/ medical improvement not expected	Medical improvement expected	Decision review	Total CDR cases processed
Connecticut	347	31	42	420
Maine	183	54	29	266
Massachusetts	348	0	110	458
New Hampshire	69	12	2	83
Rhode Island	175	7	3	185
Vermont	32	13	7	52
New Jersey	970	148	40	1,158
New York	2,599	366	296	3,261
Puerto Rico	644	104	146	894
Delaware	65	13	5	83
District of Columbia	18	9	2	29
Maryland	347	77	4	428
Pennsylvania	346	0	196	542
Virginia	992	196	381	1,569
West Virginia	534	163	122	819
Alabama	1,001	321	166	1,488
Florida	1,940	465	560	2,965
Georgia	190	233	161	584
Kentucky	954	211	141	1,306
Mississippi	791	331	78	1,200
North Carolina	1,509	373	813	2,695
South Carolina-vocational rehabilitation	772	479	130	1,381
South Carolina-blind	149	7	0	156
Tennessee	239	3	77	319
Illinois	1,645	421	1,237	3,303
Indiana	857	159	108	1,124
Michigan	2,399	450	362	3,211
Minnesota	399	77	59	535
Ohio	1,087	368	498	1,953
Wisconsin	893	200	72	1,165
Iowa	260	142	72	474
Kansas	207	97	34	338
Missouri	773	360	199	1,332
Nebraska	132	56	17	205
Arkansas	137	2	184	323
Louisiana	554	236	67	857
New Mexico	170	88	39	297
Oklahoma	236	47	50	333
Texas	1,108	465	43	1,616

APPENDIX III

State	Combined--medical improvement possible/ medical improvement not expected	Medical improvement expected	Decision review	Total CDR cases processed
Colorado	186	33	26	245
Montana	96	41	10	147
North Dakota	66	45	6	117
South Dakota	67	40	20	127
Utah	79	52	9	140
Wyoming	45	24	1	70
Arizona	565	213	28	806
California	2,302	968	360	3,630
Hawaii	0	0	8	8
Nevada	126	42	28	196
Alaska	13	12	9	34
Idaho	133	54	49	236
Oregon	300	122	75	497
Washington	435	164	124	723
Total	30,484	8,594	7,305	46,383

APPENDIX IV

AVERAGE PRODUCTION PER WORK YEAR[a] BY DDS

THROUGH FY 1986 THIRD QUARTER

DDS	Quarter 1 PPWY	Quarter 2 PPWY	Quarter 3 PPWY	Cumulative PPWY through third quarter
National	132.5	167.4	182.3	160.0
Connecticut	93.9	129.6	164.9	131.7
Maine	105.9	157.8	159.2	140.8
Massachusetts	100.8	119.6	140.1	120.4
New Hampshire	100.2	123.0	141.6	117.7
Rhode Island	99.8	139.1	143.9	128.9
Vermont	67.7	116.2	135.0	108.5
New Jersey	98.2	132.2	134.5	121.6
New York	121.8	158.5	168.7	148.6
Puerto Rico	57.5	99.4	100.1	82.5
Delaware	93.4	95.9	110.2	99.8
District of Columbia	84.2	91.4	117.4	95.6
Maryland	95.3	124.4	132.6	117.3
Pennsylvania	158.9	180.3	229.7	187.8
Virginia	103.3	173.6	179.0	151.8
West Virginia	111.0	161.0	157.8	142.7
Alabama	141.1	166.9	188.3	165.6
Florida	124.5	179.5	199.3	165.3
Georgia	129.2	181.7	204.0	171.5
Kentucky	137.0	163.7	182.4	162.0
Mississippi	135.2	183.3	193.1	170.5
North Carolina	116.7	193.3	203.5	169.2
South Carolina-vocational rehabilitation	152.3	191.1	183.4	174.3
South Carolina-blind	282.5	632.5	417.5	425.0
Tennessee	152.0	179.9	189.1	172.4
Illinois	135.9	173.0	178.9	161.8
Indiana	122.8	146.8	164.5	142.0
Michigan	109.3	132.0	145.0	127.5
Minnesota	144.8	169.6	186.0	165.4
Ohio	125.1	138.4	162.5	140.7
Wisconsin	160.1	154.3	211.2	172.8
Arkansas	129.1	179.1	204.0	169.7
Louisiana	226.7	254.6	228.0	235.1
New Mexico	131.1	181.7	196.9	168.9
Oklahoma	185.2	206.2	214.1	199.5
Texas	134.7	179.0	193.9	168.3
Iowa	132.9	172.0	240.1	185.3
Kansas	129.0	192.9	188.7	171.7
Missouri	159.5	203.9	214.1	191.2

DDS	Quarter 1 PPWY	Quarter 2 PPWY	Quarter 3 PPWY	Cumulative PPWY through third quarter
Nebraska	160.1	172.4	198.3	178.3
Colorado	127.8	163.5	185.4	158.9
Montana	136.2	172.2	197.2	168.6
North Dakota	138.4	179.5	186.3	166.8
South Dakota	146.0	155.3	194.5	165.2
Utah	142.8	157.3	207.5	162.9
Wyoming	173.3	251.9	231.3	218.9
Arizona	153.3	179.8	224.9	184.9
California	168.9	195.0	200.2	188.5
Guam	-	-	59.0	-
Hawaii	106.2	143.2	167.9	138.1
Nevada	167.4	169.5	195.7	175.8
Alaska	107.6	144.8	136.0	125.6
Idaho	121.3	168.6	172.4	153.4
Oregon	131.5	187.3	207.4	177.3
Washington	96.3	142.2	172.4	135.4

[a]Production per work year is the number of cases processed divided by the workers or staffing used to complete them.

APPENDIX V

OCTOBER 22, 1986, REPORT TO SSA COMMISSIONER

REGARDING CDR PROCESSING PRIORITIES

United States General Accounting Office

GAO

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

October 1986

SOCIAL SECURITY

Adjusting Continuing Disability Review Priorities

GAO/HRD-87-4

APPENDIX V

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division
B-224648

October 22, 1986

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.

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- 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

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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

(105317)

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