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REPORT BY THE

Comptroller General

OF THE UNITED STATES

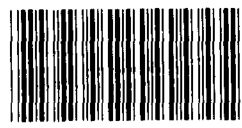
Controls Over Medical Examinations Necessary For The Social Security Administration To Better Determine Disability

In 1978 the Federal disability insurance program and the Supplemental Security Insurance program paid about $72 million for independent medical examinations of persons claiming disability. The need for and quality of the medical information purchased is not well documented.

Program officials do not know how often State agencies have paid for independent medical examinations which were too comprehensive or were inadequate for determining disability without further information.

Meaningful program evaluation is limited further because: time and accuracy goals for processing claims do not consider the effect of one on the other; not all systems for measuring achievement provides reliable data; and the Social Security Administration has no means of measuring program efficiency.

This report responds to a request from the Chairman, Subcommittee on Social Security, House Committee on Ways and Means.



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HRD-79-119

OCTOBER 9, 1979

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(4)

The Honorable J. J. Pickle
Chairman, Subcommittee on
Social Security
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

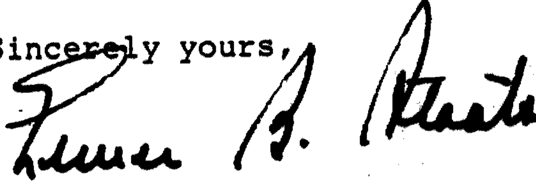
In response to the Subcommittee's letter of March 2, 1978, we reviewed the consultative examination system and identified its role in the initial disability decision process. In addition, we evaluated the Social Security Administration's attempts to measure the amount of consultative examination expenditures needed for meeting program requirements and its efforts to measure overall program performance.

We identified weaknesses which precluded the Social Security Administration from achieving meaningful program measurement and evaluation. Because of these and other uncorrected weaknesses, the disability determination process provides no assurance that a reasonable degree of uniformity and efficiency can be achieved in the programs.

As requested by your office, we did not take the additional time to obtain written comments from the Department of Health, Education, and Welfare. The matters covered in the report, however, were discussed with Social Security Administration personnel. Their comments are incorporated, where appropriate.

As arranged with your office, we are sending copies of this report to the House Committee on Government Operations, the Senate Committee on Governmental Affairs, the House and Senate Committees on Appropriations, the Director of the Office of Management and Budget, and the Secretary of Health, Education, and Welfare. Copies will be made available to other interested parties who request them.

Sincerely yours,



Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY HOUSE COMMITTEE ON WAYS AND MEANS

CONTROLS OVER MEDICAL EXAMINATIONS ARE NECESSARY FOR THE SOCIAL SECURITY ADMINISTRATION TO BETTER DETERMINE DISABILITY

D I G E S T

Persons applying for disability benefits under the Social Security Act, as amended, should receive objective and uniform consideration of their claims. The key to the claim consideration process is the determination of whether a claimant is disabled.

However, the way disability decisions are reached differs considerably among the 54 State agencies under contract with the Department of Health, Education, and Welfare which process disability claims. Because of this and the inherent subjectivity of decisionmaking, total uniformity of decisions may never be achieved.

Consultative examinations play a critical role in the disability determination process, and State agencies have been spending more and more for such examinations. Social Security Administration budget officials have attempted to control the increase in the number of examinations by limiting budget increases until program officials could justify them. These officials have been attempting to provide this justification for almost 3 years, but they have generally been unsuccessful. (See p. 5.)

Two of the most important factors in determining what the consultative examination purchase rate should be and the number of examinations being purchased unnecessarily are

--program documentation standards and

--State agency case development practices.

State agencies and Social Security Administration regional offices have disagreed with the central office about the level of documentation needed in disability cases. This, coupled with the Social Security Administration's inability to measure State agency performance and evaluate key issues affecting consultative examination purchases, has made the question of how many examinations are needed difficult to answer. (See p. 8.)

GAO believes that consultative examinations are essential to the disability decision, when medical evidence from other sources is inadequate or unavailable. Funds should be available when such examinations are needed. It is foolish to save about $107 in consultative examination funds if this results in incorrectly paying about $29,000 in benefits. At the same time, there is a need for greater fiscal responsibility and better management control over the examination's use. (See p. 13.)

Social Security Administration program officials have not analyzed how frequently State agencies have paid for consultative examinations which were more comprehensive than needed or which were incomplete or inadequate. However, some Social Security Administration studies show that some of the examinations have been so inadequate that a disability decision could not be made without further information. (See pp. 11 and 12.)

Differences between Social Security Administration program and budget officials over the consultative examination budget highlights the need for an improved measurement system, but the inability to measure State agency performance is not limited to managing the consultative examination process. This problem is also shown in the way the Social Security Administration shifts emphasis on improving processing time, achieving accuracy, and minimizing consultative examination expenditures. Rather than using these criteria

simultaneously to comprehensively evaluate State agency performance, the Social Security Administration emphasizes them separately. This encourages State agencies to adopt short-run expedients to achieve results in the area being emphasized--sometimes at the expense of the overall program objective. (See p. 14.)

Meaningful program measurement and evaluation are limited further because

--time and accuracy goals for claim processing were set arbitrarily without considering the effect of one on the other,

--not all systems for measuring goal achievement provide valid or reliable data, and

--the Social Security Administration has no way to measure how efficiently the program is operating. (See p. 19.)

Although GAO has three times previously addressed weaknesses in administering the disability program, (see footnote, p. 4) corrective action since the August 1976 recommendation is still incomplete. Until these and other weaknesses are corrected, there is no assurance that a reasonable degree of uniformity and efficiency will be achieved in these ever-growing, very expensive programs.

Accordingly, the Secretary of Health, Education, and Welfare should direct the Commissioner of Social Security to:

--Develop and implement, in close cooperation with the State agencies, clear, concise, and attainable documentation guidelines and standards necessary for making an acceptable disability decision. These standards should be formulated by giving full consideration to their effect on timeliness, accuracy, and cost.

--Conduct a national elapsed time study to

(1) determine realistically how long it takes to make a sound disability determination and

(2) identify the best development practices used by State agencies.

--Redefine required developmental practices based on

(1) practices identified during the elapsed time study, management reviews, and regional action plans and

(2) the desired level of time, accuracy, and cost to be achieved by the State agencies.

--Improve the system used to measure State agency performance by

(1) setting goals that are realistic, comprehensive, and compatible--State agencies should participate in setting these goals to increase their understanding and acceptance of the goals;

(2) making the necessary changes to the systems used to measure accuracy and processing time;

(3) developing a capability to evaluate State agency efforts to obtain the medical evidence of records, and the appropriateness and quality of consultative examinations in an ongoing basis; and

(4) providing feedback to State agencies based on overall performance, rather than considering the performance standards individually.

--Assist State agencies in correcting problems limiting the achievement of the program objective. (See p. 29.)

GAO did not take the additional time to obtain written comments from the Department of Health, Education, and Welfare; however, major findings were discussed with Social Security Administration personnel, and their views are reflected in the report where applicable.

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ABBREVIATIONS

DI	Social Security Disability Insurance program
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SPAR	special postadjudicative review
SSA	Social Security Administration
SSI	Supplemental Security Income

CHAPTER 1

INTRODUCTION

The Social Security Administration (SSA) administers two benefit programs for disabled persons. The SSA Disability Insurance (DI) program was established in 1954 under Title II of the Social Security Act to prevent the erosion of retirement benefits of wage earners who become disabled and are prevented from continuing payments into their social security account. In 1956 the program was expanded to authorize cash benefit payments to the disabled.

To be eligible for DI benefits, a worker must be fully insured for social security retirement purposes and generally have at least 20 quarters of coverage during the 40-quarter period ending with the quarter in which the disability began.

The Congress established a separate Disability Insurance Trust Fund to specifically identify the costs of the DI program. All disability insurance benefit payments and associated administrative costs are disbursed from this fund.

Title XVI of the Social Security Act established the Supplemental Security Income (SSI) program to provide cash assistance to needy aged, blind, and disabled persons. Effective January 1, 1974, the program replaced the former federally assisted, State-administered programs of Old-Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled.

Eligibility under this title is limited by income and resources. The limits vary by marital status and living arrangements. The SSI program is financed from Federal general revenues and is intended to provide a minimum income for eligible recipients. States can supplement Federal SSI benefits with their own funds.

The statutory definition of disability under the DI and SSI programs is substantially the same. Disability is defined as the inability to engage in any substantial gainful activity because of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. Substantial gainful activity is any level of work performed for remuneration or profit that involves significant physical or mental duties, or a combination of both. Work may be considered substantial even if it is performed part time and is less demanding, responsible, or pays less than the individual's former work.

A claimant can apply for disability benefits at any Federal SSA district or branch office. Applications are processed by claims representatives, who interview the applicant and prepare disability and vocational reports for use by State agencies.

The determination of an applicant's disability is made by one of 54 State agencies, whose primary function is to develop medical, vocational, and other necessary evidence, to evaluate the evidence, and make a decision. The State agency uses the disability and vocational report prepared by the SSA district or branch office to determine what additional information must be obtained to fully develop a claim so that a decision can be made.

The criteria used for making the disability determination and the guidelines for developing and processing claims are furnished to the State agency by SSA.

Before 1972, SSA reviewed all State agency actions before the decision was finalized and the claimant was informed. Questioned allowances and denials were returned to the State agency for change or further development. In mid-1972 SSA abandoned the 100-percent review and replaced it with a preadjudicative sample review, and in 1974 SSA changed from a preadjudicative sample review to a postadjudicative sample review. Finally, in 1977 SSA began the Special Postadjudicative Review--also a sample review. Under this system SSA began returning cases that contained documentation deficiencies in addition to those with decision errors.

The State agencies carry out the disability determination process under agreements with the Department of Health, Education, and Welfare (HEW). The costs incurred in making disability determinations are borne by the Federal Goverment.

Over the past several years, the number of beneficiaries, the amount of benefits paid, and the administrative costs in terms of dollars and staff have increased significantly for both programs. Between fiscal years 1972 and 1978 beneficiaries increased from 3.1 million to 7.1 million and benefits paid increased from $4.0 billion to $15.4 billion. During this same period the cost of program administration by State agencies increased from $68.2 million to $280 million and the number of employees from 4,400 to 9,600:

Disability Programs

Fiscal year	Beneficiaries (end of year) Titles II and XVI	Benefits paid during year: DI Trust Fund	Benefits paid during year: SSI General Revenue	Benefits paid during year: Total	Program administration by State agencies: Cost	Program administration by State agencies: Employees
	(millions)	(billions)			(millions)	(thousands)
1972	3.1	$ 4.0	$ -	$ 4.0	$ 68.2	4.4
1973	3.4	5.2	-	5.2	80.4	6.3
1974 (note a)	5.2	6.2	0.8	7.0	146.8	10.3
1975	6.0	7.6	2.3	9.9	206.8	10.1
1976	6.5	9.2	2.6	11.8	228.3	9.3
1977	6.7	11.1	2.9	14.0	254.2	9.4
1978	7.1	12.2	3.2	15.4	280.0	9.6

a/Payment of SSI benefits started in January 1974.

Program administration for State agencies includes the cost for personnel, indirect costs, and medical costs. Medical costs include expenditures for medical evidence of record (such as physician reports and hospital records in SSI cases) and (in both programs) for independent medical (consultative) examinations if adequate medical evidence of record is not available for a decision.

SSA budget officials are concerned with the increasing cost of State agency program administration, especially with medical costs. Nationally, expenditures for medical costs accounted for $75.8 million of the $280 million program administration costs in fiscal year 1978. Expenditures for consultative examinations represent about 95 percent ($72.1 million) of the total medical costs.

PROPOSALS TO STRENGTHEN THE INITIAL DISABILITY DECISION PROCESS

Recent studies of the SSA disability determination process have concluded that the process is not structured as it should be and that any major system reform depends on strengthening the initial stage of determining disability. There have been proposals within HEW and the Congress to improve the disability decision process during the past year. These proposals range from incremental changes to maintaining the present process--from putting specially trained claims representatives in district offices to handle disability cases and establishing Federal review of sample cases before the decision is finalized to federalizing the disability determination process.

OBJECTIVES AND SCOPE OF REVIEW

By letter dated March 2, 1978, the Chairman of the Subcommittee on Social Security, House Committee on Ways and Means, requested that we evaluate the consultative examination system and recommend how the system can be improved.

The consultative examination system is just one part of the initial disability determination process. We addressed the disability decision process in three previous reports, 1/ and cited problems caused by weaknesses in SSA's program administration and the limitations of the Federal-State relationship. Many of these weaknesses (e.g., inadequate criteria and guidelines, poor quality input from SSA district offices, and varying case processing procedures) also affect the consultative examination system. Accordingly, rather than repeat issues from past records we agreed with the chairman's office to limit the scope of our review to identifying the proper role of consultative examinations in the initial disability decision process and evaluating SSA's attempts to measure the level of consultative examination expenditures needed to meet program requirements. This report also addresses SSA's efforts to measure overall program performance.

Our review was conducted at SSA Headquarters in Baltimore; SSA regional offices in Atlanta, Boston, Chicago, and San Francisco; and State disability determination units in Alabama, Arkansas, California, Connecticut, Indiana, Kansas, Ohio, and Oregon.

1/"The Social Security Administration Should Provide More Management and Leadership in Determining Who Is Eligible for Disability Benefits," (HRD-76-105, Aug. 17, 1976).

"The Social Security Administration Needs to Improve Its Disability Claim Process," (HRD-78-40, Feb. 16, 1978).

"A Plan For Improving the Disability Determination Process By Bringing It Under Complete Federal Management Should Be Developed," (HRD-78-146, Aug. 31, 1978).

CHAPTER 2

SSA IS UNABLE TO DETERMINE THE NUMBER OF CONSULTATIVE EXAMINATIONS NEEDED IN ITS DISABILITY PROGRAMS

Consultative examinations play an important role in the disability determination process. State agencies are purchasing more examinations, and the expenditures for them have been steadily increasing during the past 5 years. There is some disagreement between SSA program and SSA budget officials as to whether the increase is warranted.

SSA budget officials, concerned about rising administration costs, have attempted to control the consultative examination purchase rate by limiting budget increases until program officials could justify the increases. Program officials have been attempting to provide this justification for almost 3 years, but have been generally unsuccessful. Their arguments supporting why consultative examinations must be bought when needed are sound. However, because of an inability to measure State agency performance and to evaluate key issues affecting consultative examination purchases, the question of the number of examinations needed is still not adequately answered.

THE ROLE OF CONSULTATIVE EXAMINATIONS IN THE DISABILITY DETERMINATION PROCESS

Medical evidence is a key factor in the disability decision. The Social Security Act requires that the physical or mental impairment causing disability be demonstrated by "medically acceptable clinical and laboratory diagnostic techniques."

When possible, all medical evidence should be obtained from existing sources (such as treating physicians or institutions). SSA will pay for such information in SSI claims through the State agencies. Claimants for DI benefits are responsible for providing, at their own expense, information from treating sources that will demonstrate the existence of a medically determinable impairment. SSA assists claimants with obtaining existing medical evidence.

Often, treating sources cannot or do not provide sufficient evidence for a disability decision. The State agency must then purchase the necessary medical evidence

in the form of a medical examination or laboratory test. Such purchases are called consultative examinations, and may be needed to

--clarify the clinical findings and diagnosis,

--obtain necessary data not otherwise available,

--resolve a material conflict or an inconsistency in the evidence obtained, or

--resolve the issue of medical improvement in continuing disability cases.

Expenditures for medical evidence represent a significant share of the SSA disability programs' administrative costs. Medical costs have increased from $51.6 million in fiscal year 1975 to $75.8 million in fiscal year 1978. The percentage of cases in which consultative examinations are purchased has also increased from 19.7 percent in fiscal year 1975 to 30.2 percent in fiscal year 1978.

Disagreement over consultative examinations needed

Beginning with fiscal year 1977 budget negotiations, SSA program officials have been seeking additional funds to allow an increase in consultative examination purchases. They have supported their requests with the following arguments:

1. Medical evidence is a legal requirement for claims adjudication and should not be subjected to arbitrary budget constraints.

2. Recent increases in consultative examination purchase rates and requests for further increases are the logical result of recent efforts to improve case documentation and the quality of disability decisions.

3. Historical data indicate that the denial rate goes up as the consultative examination rate goes up. Therefore, it would be cost beneficial in terms of program costs to spend more for consultative examinations and pay out less in benefits. (Latest estimates show that an average consultative examination costs $107, whereas an average DI allowance will result in payment of $29,000 in benefits and an average SSI disability allowance will result in payment of $37,000 in benefits.)

Budget officials, concerned about rising medical costs, refused to accept these arguments as conclusive, and have limited funding increases below requested levels. The officials also intend to continue restricting medical fund increases until program officials demonstrate that higher levels of consultative examinations are needed and that available funds are being used properly.

PROGRAM OFFICIALS ARE UNABLE TO DETERMINE THE NECESSARY CONSULTATIVE EXAMINATION PURCHASE RATE

Program officials have been unable to successfully show the need for more consultative examinations--early attempts were inconclusive or unsuccessful. Recent efforts, although more elaborate, have not addressed the key issues that are necessary for determining how many consultative examinations are needed and for assuring that funds are properly controlled.

In February 1977 program officials requested each SSA regional office to review consultative examination purchase practices in each State agency to assure that resources were being "properly managed." Although results varied among the regions, the review indicated that evidence from treating sources was not pursued adequately, consultative examinations were purchased unnecessarily, and consultative examination reports were often inadequate for State agency use.

Although this inquiry to the State agencies indicated serious problems with managing the consultative examination process, no indepth analysis was made on an overall basis to further identify the source of the problems or to indicate the appropriate remedial action.

In August 1977 program officials studied the relationship between consultative examinations and the quality of disability decisions. The study indicated that the quality or correctness of the disability decision is the same in cases with and without consultative examinations. It also indicated that cases with consultative examinations were only slightly better documented than cases without them.

Although these efforts provided less than decisive support for their contention, program officials maintained their position that more consultative examinations were necessary. To demonstrate this, they conducted another study in 10 States during the period January to May 1978. In December 1978 program officials consolidated the results

of this study and others in a report entitled "Cost Effectiveness of the Consultative Examination Process." The report states that consultative examination needs vary among States. Overall, examinations are needed for meeting program documentation requirements in about 40 percent of all claims during initial development. In addressing whether available funds are being used properly, the report states that consultative examinations were purchased unnecessarily in only 3 percent of the cases.

Two of the most important factors in determining what the consultative examination purchase rate should be and the number of examinations being purchased unnecessarily are (1) program documentation standards and (2) State agency case developmental practices. Because of disagreements between State agencies and SSA regional and central offices over the amount of documentation needed in disability cases and SSA's failure to adequately evaluate State agency case development practices, we question the validity of the study conclusions.

Documentation standards should be better defined

In an August 1976 report, 1/ we demonstrated substantial disagreement among States on the adequacy of documentation in selected cases. In August 1978 2/ we reported that State agencies, SSA regional offices, and the SSA central office differed on the level of documentation they required for supporting a disability decision and that the level required varied (depending on whether SSA emphasized cost, timeliness, or accuracy at any given time).

In addition, two recent HEW studies note the lack of uniform documentation requirements and recommend that SSA develop more specific standards for the documentation necessary to support a disability decision.

1/"The Social Security Administration Should Provide More Management and Leadership in Determining Who Is Eligible For Disability Benefits" (HRD-76-105, Aug. 17, 1976).

2/"A Plan For Improving The Disability Determination Process By Bringing It Under Complete Federal Management Should Be Developed" (HRD-78-146, Aug. 31, 1978).

In SSA's 1978 consultative examination study, program officials attempted to determine the number of consultative examinations needed to achieve an adequate documentation. However, there is little consensus in the State agencies and the SSA central and regional offices on what constitutes adequate documentation.

The results of the 1978 consultative examination study indicate that interpretation of documentation standards is still a problem. For example, in the 2,013 study cases the initial Federal reviewer and the State agency examiner disagreed on the need for a consultative examination in about 18 percent (360) of the cases. When these 360 cases were given to a second Federal reviewer, the two Federal reviewers disagreed in about 40 percent of the cases.

SSA guidelines for State agencies list impairments considered to be disabling. These impairments are described in terms of specific clinical and laboratory findings. Although perhaps desirable, these specific clinical findings are not always required for making the disability decision. SSA's minimal documentation standards, as applied in quality assurance review at both State and Federal levels, require only that the documentation be sufficient for assuring that reversal of the disability decision is improbable. Such a subjective standard affects not only the decision to purchase a consultative examination, but also leads to an inconsistent evaluation of State agency performance. (See ch. 3.)

In addition, some SSA and State agency officials have expressed concern that the documentation level required may be too high. They think that SSA's documentation requirements may result in the purchase of many consultative examinations which do not add measurably to program accuracy. We think the consultative examination study demonstrates the need to evaluate this issue.

In one group of study cases, State agency examiners purchased consultative examinations to supplement evidence obtained from treating sources. SSA reviewers were asked to make a preliminary decision to allow or deny these claims based only on the evidence from treating sources. After considering the additional information in the consultative examination, the SSA reviewers altered their preliminary decision in only one out of every four cases.

In another group of study cases, SSA reviewers determined that State agency decisions had been made without

sufficient evidence. The State agency was requested to purchase the additional evidence needed. The State agency changed its initial decision in only 3 percent of the cases where additional evidence was purchased.

The analyses presented above do not demonstrate that any of the consultative examinations were unnecessary. The analyses addressed only the effect of the consultative examinations on the decision to allow or deny. They do not consider the legal requirement for objective data or the administrative need to be confident in the final decision. Nevertheless, study data demonstrate the need for determining if the level of documentation required by SSA or the level actually being obtained by State agencies is excessive for program needs.

In view of the above, we think program officials' conclusions about the number of consultative examinations needed are unacceptable. Since consultative examinations are appropriate only when sufficient evidence cannot be obtained from treating sources, standards for sufficient evidence must be carefully evaluated and clearly defined before determining the need for consultative examinations.

How good are State agency case development practices?

The adequacy of State agency efforts to obtain medical evidence from treating sources is another factor that must be considered when evaluating the need for and appropriateness of consultative examinations. The 1978 consultative examination study was designed to measure compliance with SSA medical development guidelines. However, program officials did not properly analyze the data collected on the adequacy of claim development and processing by the State agencies, and they did not address this issue in the study results.

State agencies may purchase consultative examinations only after every consideration has been given to obtaining existing medical evidence from treating sources. Specifically, SSA guidelines instruct State agencies to

--contact relevant sources of medical evidence,

--make followup contacts when the sources do not respond to initial contact, and

--make followup contacts when information provided by the source does not meet State agency needs.

When analyzing the study results, program officials considered a consultative examination necessary if the medical evidence in the file was insufficient after attempting to contact relevant sources. They did not properly consider the adequacy of attempts to contact these sources, nor did they consider failure to make followup contacts with unresponsive sources or sources providing incomplete evidence. A more complete analysis of the information collected and State agency developmental practices could affect the study's conclusions.

The results of SSA's February 1977 preliminary consultative examination study, although not conclusive, indicate that State agencies are not following proper procedures for adequate development of medical information on claims. A memorandum from the SSA Financial Management Branch dated July 26, 1977, on the current status of funding for purchase of consultative examinations states:

> "* * * Unfortunately the conclusion from the survey was that many States are not following proper procedures which results in the purchase of many unnecessary CEs [consultative examinations] * * *."

The review in one State concluded:

> "The results of the study indicate a gross inadequacy among the examiners/supervisors in distinguishing when a consultative examination is necessary as the next developmental step or when other sources within the folder should be tapped or expanded. * * * if annualized, the total amount of money spent unnecessarily would be $447,332."

Results of recent studies performed by various SSA regional offices and State agencies, as well as discussions with officials at those offices we visited, indicate that these problems still exist.

In addition, neither the 1978 SSA study nor the December 1978 report on consultative examinations addresses the quality of the information purchased. Program officials did not analyze how frequently State agencies paid for consultative examinations which were more comprehensive or extensive than

needed or which were incomplete or inadequate. The results of some recent SSA and State agency studies indicate that funds have been wasted on unnecessary, incomplete, or inadequate evidence. For example, the results from five of a State agency's studies indicated that inadequate consultative examination reports were obtained about 68 percent of the time. Many of these reports were so inadequate that a disability decision could not be made without further information.

SSA's accuracy statistics also raise a question about the quality of consultative examinations. From February 1977 to October 1978, 9.2 percent of the cases reviewed in which consultative examinations were purchased contained deficiencies, the majority of which were documentation deficiencies. This does not imply that the consultative examinations were deficient in all such cases, but it does point out the need to address the issue.

We believe program officials have not adequately evaluated their consultative examination needs because they have failed to properly address the adequacy of State agency claim development and the quality of the information being purchased. In addition, since SSA's ongoing quality assurance review does not measure compliance with medical development guidelines, program officials are without the information needed to manage the consultative examination process. This matter will be discussed further in chapter 3.

HAS FUNDING FOR CONSULTATIVE EXAMINATIONS BEEN UNDULY RESTRICTED?

Since fiscal year 1977 there have been spot shortages of consultative examination funds at the end of the fiscal year. Some States delayed processing cases and carried them over to the next fiscal year. Others, faced with an allocation perceived to be inadequate, eased their documentation requirements in order to reduce consultative examination expenditures.

Shortages do not appear to be widespread. Of the State agency and SSA regional office personnel interviewed, about 73 percent thought that funds available for consultative examinations were sufficient. While the budget for consultative examinations may have been restricted more than program officials would have liked, expenditures for consultative examinations and the number of cases with consultative examinations have been rising. At the same time, the processed workload has shown an overall decline.

Fiscal year	Processed workload (SSI and DI)	Number of cases with consultative examinations	Percent of processed workload	Cost
				(millions)
1976	2,365,168	577,901	24.0	$56.1
1977	2,396,436	643,806	26.8	67.0
1978	2,213,752	669,806	30.3	72.1
1979 (estimated)	2,324,550	712,242	a/30.6	84.1

a/During the first half of the year the State agencies had been purchasing consultative examinations in about 34 percent of the claims processed.

In our opinion both budget and program officials must remember that the consultative examination budget does not exist in a vacuum. Program officials are justified in arguing the dangers of attempting to curb rising administrative costs by restricting consultative examination expenditures. Shortages in consultative examination funds could be harmful to the disability program if claims are delayed or adjudicated without sufficient evidence.

The attention focused on consultative examinations by budget officials, however, has demonstrated the need for program officials to better manage the funds available, better define program documentation standards, and better measure State agency performance. We believe budget officials are justified in believing that program officials cannot correct program problems merely by increasing consultative examination expenditures.

CONCLUSIONS

In summary, consultative examinations are essential to the disability decision in cases where medical evidence from others is inadequate or unavailable. Funds should be available when such examinations are needed. It makes little sense to save $107 in consultative examination funds if the savings result in incorrectly paying $29,000 in benefits. At the same time, there is a need for greater accountability for alloted funds and better management of the consultative examination process.

CHAPTER 3

BETTER MEASUREMENT OF STATE AGENCY PERFORMANCE--

AN IMPORTANT STEP IN IMPROVING THE DISABILITY PROGRAM

The failure to accurately and fully measure State agency performance is not limited to managing the consultative examination process, but is characteristic of SSA's management of the disability program as a whole.

The SSA disability program is to provide prompt, quality, uniform decisions to claimants at the least cost to the Government. Progress toward this objective can be measured in terms of the timeliness, accuracy, and cost of the disability decision--SSA can identify problem areas by examining these three factors together. However, SSA does not evaluate State agency performance by using all of these criteria simultaneously; instead, it emphasizes first one and then another.

For example, SSA's fluctuating emphasis between timeliness and accuracy goals encouraged State agencies to use short-run expedients to bring about immediate results--often at the expense of other goals and the overall program objective. This type of management is partly due to the way the goals were set, and partly due to weaknesses in the systems used to collect information on goal achievement.

STATE AGENCY PROCESSING TIME AND ACCURACY GOALS

In 1970 program and administrative staff from the SSA disability program received hundreds of thousands of black lung cases to adjudicate. The disability program was strained further with the introduction of the SSI program in 1974. With the disruption caused by increased workloads, SSA's emphasis was placed on case processing time and production. SSA established goals for the percent of cases to be adjudicated within a given number of days; these goals were expressed as the percent of cases pending. There was little concern about the effect of these goals on documentation requirements or on the quality of disability cases. One State agency supervisor said the States were pressured to get the cases out as quickly as possible by any means necessary. He said that quality was not a consideration and that medical documentation was poor or nonexistent.

In the past 2 years SSA's concern for the quality of disability cases has increased, and SSA officials now contend that the emphasis on processing time and accuracy is equal. In March 1977 SSA established national accuracy and processing time standards for State agencies for initial Title II and Title XVI cases:

Accuracy	Goal
Cases free of clear decisional errors	99 percent of cases in postadjudicative review
Cases without deficiencies	90 percent of cases in postadjudicative review
Processing time	
Mean processing time	38 days
Median processing time	33 days
Percent of cases pending 45 days	18 percent
Percent of cases pending 70 days	5 percent

In December 1977 the mean processing time was lowered from 38 to 36 days, and the cases pending goals were dropped from national statistics but continued as informal goals by SSA program officials.

SSA improperly uses program goals

Goals or standards are to allow management to compare how an organization or program functions to how it ought to function. The measurement of performance in terms of such goals increases the perception of the problems which limit achievement of overall program objectives. SSA has continued to emphasize these goals individually, while providing little analysis and feedback to the States about problems encountered and little assistance to help the States correct these problems and meet the goals.

Although SSA is in the best position in terms of both resources and management to provide uniform guidance to all State agencies, some State agency officials said that SSA gives them no guidance or assistance in meeting the established goals. A State agency director stated that, during a regional conference, one of his examiners asked for ways to meet the goals. An SSA regional official told the examiner that he would have to "use his own initiative." A supervisor from another State in the same region, who asked the same question, was told, "That's your problem." Another supervisor in that State said the SSA regional philosophy seems to be, "Here are the goals--go meet them."

There are, of course, regional variations. In April 1978 one of the SSA regional offices we visited met with representatives of the State agencies in the region. The purpose of the meeting was to share experiences and ideas that would help reduce case processing time. As a result, the regional office developed a model which specifies the average time for completing each major step in case processing and offers States alternatives to current organizational patterns and operating procedures.

Generally, however, the actions proposed or encouraged by SSA regional officials demonstrate the narrow emphasis on achieving immediate statistical results rather than on meeting the overall program objectives. For example, regional offices were required to prepare "action plans" to assist State agencies with meeting program goals. One SSA region's July 25, 1978, action plan for a State agency notes, "Increased examiner production standards have been established * * *. Unpaid examiner overtime will be required of those not meeting standards." Similarly, another regional action plan proposed that one State agency reinstate overtime "to continue achievement of aged case goals and improve processing time." A third regional action plan proposed that a State agency select two adjudicators to review all initial claims and to select those which can be closed within 72 hours. These attempts to reduce processing time do little to identify or correct underlying problems which cause time delays and detract from the program's objectives.

An SSA headquarters official responsible for setting the goals said that the central office did not provide State agencies with any procedural or policy changes to assist in meeting the goals. He said performance improvement was left to regional office and State agency management initiative.

The SSA central office's prime effort in this area seems to be collecting and reporting time and quality statistics. The statistics are reported without identifying problems, analyzing the causes of the problems, or recommending corrective actions.

State agency officials view SSA's statistical reports with suspicion--one State agency examiner said the statistics are used by SSA to embarrass examiners. Other State agency personnel said management uses the statistical reports to pressure the examiners into meeting goals. The value of these statistics is further questioned since the measurement systems used by SSA are not always valid or reliable. Three of the four systems we studied produced questionable and inaccurate information. (See p. 21.)

Pressure to meet goals leads to expedient development practices

When faced with the continuous pressure to meet conflicting program standards with little or no guidance from SSA, State agencies adopt expedient claims development and processing practices. These practices are not in the best interest of the claimant or the Government. This can be seen in one State agency's March 31, 1977, memorandum to its staff:

> "For the last month and a half we have experienced an increase in receipts which has raised the pending workload beyond the capacity of our present staff to handle the workload efficiently. We can see no indication that receipts will drop off in the near future. Drastic action seems indicated to reduce the workload substantially to prevent the build up of a backlog that will clog all aspects of case processing. Aged claim figures are already rising.
>
> "We have just begun to show some hard won progress in quality after six months of effort. If we respond to the present caseload problem by asking all examiners to push out claims, it seems certain that we will not only lose these gains, but make it even harder to regain lost ground once the workload is brought in line. The present situation requires some hard choices. The following proposal is not a good solution,

but it is the least undesirable one we can think of. It involves selected groups of people who will consciously and knowingly put out poorly documented claims."

"A group of initial examiners, one from each unit and one backup from each unit, chosen for their ability to move claims and to hold and apply two levels of documentation simultaneously will work half days on claims, other than their own looking for claims that they can write up, on the basis of an informed guess; or assumption, that the decision is correct, without the documentation required by the program. The other half of the day they will work their own pendings, apply full program requirements. Their supervisors will be asked to reduce their assignments to the point where they can handle their own work in a half day."

This practice was discontinued by a memorandum dated December 19, 1977. However, on that same date the agency issued another policy memorandum:

"All of us are engaged in a constant effort to balance the competing demands for adequate documentation and short case processing time. In circumstances of short staff, heavy workload, or a build up of old cases, in any unit it may become necessary for the unit supervisor to make a management decision, independent of the rest of the agency, to apply expedients to cases that are not documented according to program standards. In these circumstances, the unit supervisor may * * * authorize determinations based on less than full documentation * * *."

A supervisor in this State agency said that in May 1978 the State agency made the commitment to improve its quality. He added, however, that, because of the ever-present pressure by the SSA regional office to reduce caseloads and meet processing time goals, the State agency still promotes--or at least condones--measures which adversely affect quality.

The administrator of another State agency, after receiving a letter from the SSA regional office emphasizing poor performance in meeting program goals, wrote a memorandum to his staff. The memorandum, dated August 11, 1978, concludes by saying:

"As you will surmise by reading this memo, the emphasis is placed on production but each of you must keep in mind the importance of quality and processing time. You are encouraged to utilize expedients outlined in DIL-II-47, dated March 21, 1974, which, if followed, should shorten processing time of many cases."

DIL-II-47 is an SSA disability insurance letter which supplements the Disability Insurance State Manual. It outlines temporary expedients to be used to help reduce the backlog of cases caused by the introduction of the SSI program. After this letter was sent out in 1974--prior to SSA's emphasis on quality--nine States felt that the directive had an adverse effect on the adjudication of claims or that it reduced quality. Personnel in one State agency felt that the effect was so adverse that it discontinued using such expedients.

As illustrated by the preceeding discussion, the pressure to meet processing time goals has been predominant. When faced with the choice between quality or quantity, quality was generally sacrified by State agencies. SSA's emphasis has fluctuated, however, and there were instances where States were asked to improve accuracy at any cost. For example, one State agency was told to get its accuracy up regardless of what happened to processing time or consultative examination expenditures.

OTHER WEAKNESSES IN SSA'S PERFORMANCE MEASUREMENT SYSTEM

In addition to the way the program performance goals are used, there are other weaknesses in SSA's measurement of State agency performance which preclude a meaningful, comprehensive evaluation of the disability program:

--The time and accuracy goals were set arbitrarily and without considering the effect of one on the other.

--Not all systems for measuring goal achievement provide valid or reliable data.

--SSA has no means for measuring how efficiently the program is operating.

Performance goals were set arbitrarily

Although State agency managers are held accountable for meeting the goals, they were not given the opportunity to participate in setting them. Furthermore, SSA set the time and accuracy goals independently, without considering the effect of one on the other. As a result, achievement of one goal is at the expense of the other.

The processing time goal was set arbitrarily; it was based on the performance of about 25 percent of the State agencies at the time the goal was set. No analysis was made to see why these State agencies were achieving the lower processing times, nor was there any study to determine what the processing time should be under various circumstances. The accuracy goals were established in a similar manner, also without the benefit of analysis or study. One official said that each goal was considered when setting the other goal. However, this seems unlikely, based on the method described above and on the experience to date.

When the performance goals were set the State agencies focused their efforts on meeting the processing time goal, with little regard for accuracy. As a result, the national average processing time statistics for DI cases met or exceeded the time goal for several months. As SSA and, in turn, State agency officials began to emphasize the accuracy goals, processing time began to suffer. The last month in which the DI national average processing time statistics met the time goal was October 1977. SSA processing time reports for July 1978 show that only eight (15 percent) of the State agencies met the 36-day goal for DI cases. The national average was 41.7 days.

The 36-day goal for SSI cases was even more arbitrary. Because of imperfections in the system used to record SSI processing times, SSA had no valid data on State agency experience when the goal was set. SSA has also been unable to measure progress toward the goal. (See p. 23.)

Most State agency personnel interviewed felt that the processing time goals were too short and were unrealistic in light of program documentation and accuracy standards. SSA officials stated in August 1978 that they agree that the time goal is unrealistic and that they were considering raising it to 39 days. This proposed goal, like the earlier goals, is an arbitrary figure and not based on any study or analysis.

Data on goal achievement are not valid or reliable

Program goals are of little value if the systems used to measure performance in meeting those goals and to provide feedback on that performance are unreliable or invalid. Reliabity refers to the consistency or uniformity with which a defined measurement process yields the same or similar results when applied to the same event more than once. Validity concerns the meaningfulness of what is being measured.

State agency accuracy is measured through the Special Postadjudicative Review (SPAR) of DI and SSI cases. Processing time is measured by the SSI Initial Claims Processing Times Report for SSI cases. These systems, used by SSA to measure and also to report State agency performance, provide feedback which is neither reliable nor valid. There are apparently no major problems with the system used to measure DI processing time.

SPAR

The SPAR system was implemented nationally on a test basis on Januray 31, 1977. Under this system, SSA reviews a sample of cases adjudicated by the State agencies for decisional accuracy and adequacy of documentation. DI cases are reviewed at the central office; SSI cases are reviewed at the regional offices. According to SSA guidelines, cases should be returned to the State agency for corrective action if the SSA quality review indicates that an error was made in any of the 22 SPAR categories. Categories 1 through 16 cover instances in which the documentation is adequate but the decision to allow or deny is incorrect. Categories 17 through 22 are cases in which the documentation is so inadequate that a decision cannot be made. SSA also requires certain deficiencies to be reported to the State agencies for informational purposes only--for example, claims where there is sufficient information available to make a decision but less information than required by the criteria, or where an excessive or unnecessary amount of medical evidence has been gathered. In such instances, SSA sends a written explanation of the deficiency to the State agency but does not return the case.

SSA is using the SPAR system to measure State agency performance in meeting the accuracy goal and to provide the results to the State agencies on a quarterly basis. However, problems with the system limit SSA's ability to

measure State agency accuracy. For example, all decisional errors are not returned for corrective action. SSA guidelines cite at least four situations in which a decision is clearly wrong and no corrective action is required. These incorrect decisions are not changed, nor are they entered as deficiencies into the SPAR system, and therefore they are not reflected in the accuracy statistics. One SSA official said he believes that such incorrect decisions represent only a small percentage of all cases. Nevertheless, the problem still exists, and it should be corrected.

There is also some question about what constitutes a SPAR deficiency. SSA guidelines define a clear decisional error (categories one through six) as a decision which the reviewer can say is incontrovertably wrong. Apparently, however, not all decisions returned to State agencies for correction are so clearly wrong. State agencies often disagree with Federal reviewers. For the period January 1977 to June 1978, 31.5 percent of DI cases and 17.7 percent of SSI cases returned as clear decisional errors were not reversed by State agencies. These were cases where, after additional case development by the State agencies and in subsequent negotiative procedures, the State agencies' opinion prevailed and SSA withdrew its objections.

SPAR categories 17 through 22--the criteria for documentation deficiencies--are the most troublesome. There is a lack of uniformity among the regions and between the regional and central offices in the way these categories are interpreted and applied. One SSA official said that this problem was due in part to a differing philosophy on the purpose of the SPAR system. Some reviewers believe that returning cases is the reason for SPAR, and thus they record a large number of errors. Others concentrate on identifying trends and the broader underlying problems rather than on recording and reporting individual errors. This tends to cause a disparity in the number of SPAR deficiencies reported by the various regional offices.

It appears that part of the problem also stems from the nebulous guidelines that instruct reviewers when to return cases as SPAR documentation deficiencies and when to send an informational notice of deficiency. The guidelines state:

> "If the file is sufficiently documented for the reviewer to judge that a reversal is improbable, then the documentation cannot be

so inadequate that it does not permit a judgement as to the appropriateness of the allowance or denial and the case cannot be returned to the DDS * * * [for corrective action]." (Disability Determination Service)

The judgment of whether reversal is improbable is a subjective one, and allows differing opinions on the same case.

In the 1978 study discussed in chapter 2, SSA reviewers examined 2,013 cases adjudicated by 10 State agencies and determined that 381 had SPAR deficiencies (either decisional or documentation). The 381 deficient cases were then given to a second SSA reviewer. The second reviewer felt that only 214 of the cases were deficient, thus disagreeing with the first reviewer in 167 (44 percent) of the cases. The reliability of SSA's accuracy measurement system is questionable if two Federal reviewers, supposedly with the same training and using the same criteria, disagree in almost half of the cases they review.

SSA officials identified yet another problem which makes the SPAR statistics misleading as a means of providing feedback to the State agency. The results of initial case review by SSA are entered into the SSA data base. SPAR accuracy statistics are developed from the data base and reported to the State agency every 3 months. Data on cases which are correctly adjudicated by the State agency but are incorrectly returned as SPAR deficiencies by SSA case reviewers are never edited from the data base. As a result, the information provided to the State agencies on their performance in meeting accuracy goals is questionable.

SSA officials are considering revising the SPAR system. Proposed changes address some of the problems discussed above. Possible changes include revising the decisional error categories to include all decisional errors and making SSA medical consultants--not the SSA case reviewers--responsible for determining the adequacy of medical documentation in hopes of making this part of the evaluation more uniform. These changes, however, are still in the proposal stage.

SSI case processing time

The SSI Initial Claims Processing Times Report system has been in use for SSI cases since before the time goals were established. SSA officials stated that the system provides accurate overall processing time statistics, but it cannot accurately measure processing time at the State

agency level. In a letter to the Bureau of Disability Insurance in May 1978, a State agency official questioned the wisdom of using the system to monitor State agency processing time for SSI initial claims. SSA responded:

> "We agree that because of the way the data is being presently produced, it is impossible to determine whether a DDS [State agency] is actually meeting the 36 day goal * * *. We recognize the shortcomings of this report and have requested changes in the system to reflect DDS time from dates of receipt to clearance. Due to many programming priorities, these revisions probably will not be made for some time, but we are continuing to pursue them."

In September 1978 SSA also cautioned the Regional Commissioners against using data from the system to monitor State agency processing time.

Because of the problems with the system, SSA dropped the SSI State agency processing time goal in December 1978, and SSA is now attempting to correct the system, with a target date of fiscal year 1980.

SSA's measurement system is incomplete

An important aspect of any measurement system is how completely or inclusively it measures performance. For example, in a manufacturing operation, a system that measures only the number of products produced would be considered incomplete, while one that measures production, scrap, quality, and cost effectiveness would be more complete. Similarly, the time and accuracy standards in the DI and SSI programs are not complete measures of how well the program is meeting its objective. While these standards--if used properly--can help determine how well the claimant is being served, they do not measure how efficiently the program is operating. A State agency could be meeting the time and accuracy standards but, because of an inefficient operation, could be overstaffed--using unnecessary overtime and purchasing unnecessary consultative examinations.

Even though SSA periodically pressures State agencies to conserve consultative examination funds, (see ch. 2) there is no cost goal for the State agency operation, nor is there

any attempt to measure the reasonableness of this cost. A complete measurement system should address the efficiency of State agency operations and, as a minimum, evaluate how well State agencies follow prescribed development practices.

SSA's quality assurance review for the disability programs deals primarily with the accuracy of the State agency disability determinations and the adequacy of documentation found in the case files; it does not routinely measure compliance with case development guidelines.

During our review, program officials stated that it would be desirable to include an analysis of case development practices in the quality assurance review. They thought it would be impractical, however, because of incomplete recordkeeping by State agency personnel and unfamiliarity with local factors affecting development practices. They said that evaluation of State agency case development practices is primarily left to the State agency management. In July 1978 SSA provided new guidelines for State agency quality assurance systems. As a part of their ongoing sample review, State agencies are now required to monitor the appropriateness of medical evidence purchased and compliance with established medical evidence development practices. In addition, SSA requires that State agencies conduct periodic studies of

--the effectiveness and appropriateness of consultative examinations;

--case development practices, including the appropriateness of questions asked, consideration of all proper sources of medical evidence, and timeliness and follow up on requested evidence; and

--processing time at all work stations.

In our opinion, these new guidelines for State agency quality assurance systems are a step in the right direction. SSA, however, is dependent on State agency self-evaluations for information on compliance with SSA medical development guides and the appropriateness and quality of consultative examinations. To assure that it has a reliable measure of State agency performance, SSA must either evaluate these aspects of performance as a part of its ongoing sample review or regularly monitor the State agency quality assurance system to determine if the data provided are reliable and usable.

Since our review, SSA officials have considered changing their quality review system to include an evaluation of several procedural aspects of case development not addressed by SPAR. These changes are being considered along with those mentioned earlier, (see p. 23) and they are still in the early stages of development.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

Rising program costs together with increasing criticism of the SSA disability decision process have led to proposals to alter the program's administrative structure. These proposals range from strengthening the existing Federal/State structure to completely federalizing the process.

In our August 31, 1978, report, we recommended that the Secretary of HEW develop a plan for strengthening the disability determination process by bringing it under complete Federal management. In his June 21, 1979, comments on our report, the Secretary stated that the administration has submitted a legislative proposal providing HEW with the authority to establish procedures and performance standards for the State disability decisionmaking process. Each State will have the option of continuing to make disability determinations in compliance with these regulations or turning that responsibility over to the Federal Government. If a State elects to continue making disability determinations but later fails to comply with the regulatory standards, HEW would be authorized to assume direct responsibility.

This proposal, if enacted, would give SSA clear authority to establish and enforce standards of quality in the disability decisionmaking process. With this authority, it would be essential for SSA to develop meaningful performance standards and improve its ability to accurately measure and evaluate their implementation. Until this is done, SSA cannot truly bring about progress toward program objectives, identifying major problems, and initiating corrective actions. This is true regardless of whether the disability decision is made by State or Federal employees.

Differences within SSA over the consultative examination budget demonstrates the need for an improved measurement system. SSA budget officials have attempted to control the growth of the consultative examination rate by limiting budget increases, admittedly on an arbitrary basis, until program officials could justify the increases. However, because SSA does not accurately and fully measure State agency performance and evaluate key issues affecting consultative examination purchases, the appropriate spending level for such examinations has still not been determined.

We believe that consultative examinations are essential to the disability decision when medical evidence from other sources is inadequate or unavailable. Funds should be available when such examinations are needed--it is foolish to save about $107 in consultative examination funds if it results in incorrectly paying about $29,000 in benefits. At the same time, there is a need for improved accountability over alloted funds and better management of the consultative examination process.

Despite the many studies of the consultative examination process, there is little reliable information on the quality of the medical information purchased. Program officials have not analyzed how frequently the State agencies have paid for consultative examinations which were more comprehensive or extensive than needed or which were incomplete or inadequate. However, it is evident that some consultative examinations are so inadequate that a disability decision cannot be made without further information.

SSA's failure to measure State agency performance is not limited to the management of the consultative examination process. The objective of the disability determination process is to provide quality, uniform decisions to claimants in the least possible time and at the lowest cost to the Government. Taken together, these standards--quality, timeliness, and cost--can help identify problems and assess the effect of proposed solutions. However, SSA emphasizes them separately and uses them individually to measure performance. This practice encourages State agencies to adopt expedients to meet the short-term goal being emphasized--usually at the expense of other goals and the overall program objective.

Meaningful program measurement and evaluation is limited further because

--the time and accuracy goals were set arbitrarily and without considering the effect of one on the other,

--not all systems for measuring goal achievement provide valid or reliable data, and

--SSA has no means of measuring how efficiently the program is operating.

Although we have previously addressed weaknesses in SSA's administration of the disability program, implementation of corrective action since our August 1976 recommendations is still incomplete. Until the weaknesses above in the disability determination process are corrected, there is no assurance that a reasonable degree of uniformity and efficiency will be achieved in these ever-growing, very expensive programs.

RECOMMENDATIONS TO THE SECRETARY, HEW

We recommend that the Secretary of HEW direct the Commissioner of SSA to:

--Develop and implement, in close cooperation with the State agencies, clear, concise, and attainable documentation guidelines and standards necessary for making an acceptable disability decision. These standards should be formulated by giving full consideration of the effect on timeliness, accuracy, and cost.

--Conduct a national elapsed time study to

(1) determine realistically how long it takes to make a sound disability determination and

(2) identify the best developmental practices used by State agencies.

--Redefine required development practices based on

(1) practices identified during the elapsed time study, management reviews, and regional action plans and

(2) the desired level of time, accuracy, and cost to be achieved by the State agencies.

--Improve the system used to measure State agency performance by

(1) setting goals that are realistic, comprehensive, and compatible--State agencies should participate in setting these goals to increase their understanding and acceptance of the goals;

(2) making the necessary changes to the systems used to measure accuracy and processing time;

(3) developing a capability to evaluate State agency efforts to obtain the medical evidence of records and the appropriateness and quality of consultative examinations on an ongoing basis; and

(4) providing feedback to State agencies based on overall performance, rather than considering the performance standards individually.

--Assist State agencies with correcting problems that limit the achievement of the program objective.

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March 2, 1978

Honorable Elmer B. Staats
Comptroller General of the United States
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Staats;

As you are aware, the determinations of disability under the Social Security and SSI programs are largely dependent upon the medical evidence in an individual's file as supplemented, when necessary, by an independent medical (consultative) examination contracted for by the State agency which determines disability. The Subcommittee on Social Security would like your evaluation of how the consultative examination system is working and recommendations on how it can be improved. I would request that your evaluation include consideration of alternatives to existing procedures which might involve a unified intake, development and disability determination process at the initial level under completely Federal auspices whereby a substantial portion of the medical examinations might be provided on-site by physicians who were employees of the Social Security Administration.

The General Accounting Office pointed out in its 1976 study of a sample of cases the great variation in decisions between State agencies and the findings of the Federal examiners, who examined the sample, that there was not enough evidence in the file to make a decision in half the cases. Lack of medical evidence, or the fact that it is not current, is a major reason for great numbers of reversals and remands in the many layers of review of the initial decisions in disability cases. Moreover, the Social Security Administration policy on the proper role of consultative examinations appears to fluctuate year to year and in the past the States have found consultative medical examinations the item they could most easily adjust in trying to meet budget shortfalls. In 1966 medical examinations were purchased nationwide in

about 40% of the cases but this declined to about 20% in 1973 and since then has been gradually rising. In fiscal 1977 there was a combined figure of 35% for Social Security and SSI, with a lower percentage purchased for title II and a higher one for SSI. The States' purchases of medical examinations vary markedly, and this has been the case over the years. We understand that the Social Security Administration is doing a cost-benefit analysis of the consultative medical examination process in a number of States and this information may be of assistance to you in carrying out your evaluation. Moreover, the State of California is carrying out an Analyst-Medical Consultant Examination Project which emphasizes the development of medical evidence at the initial level, on a face-to-face basis. The results of these experiments seem worthy of study.

The problems of the States in purchasing medical examination because of unrealistic fee schedules should also be examined. Because of this, some States must purchase medical examinations out-of-State which is difficult under the current Federal-State arrangement. The methods States employ in supervising the purchase of medical examinations should be evaluated along with the role of Social Security central and regional offices in this process. We have heard allegations of abuse in the selection, utilization, and payment of physicians under the consultative examination program. The ALJ's appear to be relatively free to order medical examinations in a relatively unsupervised manner, which are ordered through State agencies and are under State budgets.

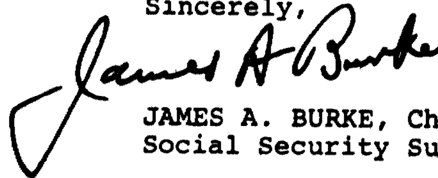
The Center for Administrative Justice, and our own survey of caseworkers, notes claimant allegations of dissatisfaction with consulting physicians who to some are considered rude and hostile. These allegations should be checked out.

Also, if resources permit we would like for you to examine the role of the medical consultants in the decision-making process at the State agency. Mr. Ahart stated in our February 21st Subcommittee hearing that "physician participation in the disability-making process varied greatly among State agencies and among physicians within the same State agency." Subcommittee staff has developed statistical data which supports this conclusion. Determination of the proper role of the disability examiner and physician seems essential in developing a disability program which is uniform throughout the nation.

The Subcommittee in indebted to the General Accounting Office for its very significant efforts in the past in assisting us in our examination of the disability program. We hope this close working relationship will continue with your dedicated staff.

With all good wishes, I remain

Sincerely,



JAMES A. BURKE, Chairman
Social Security Subcommittee

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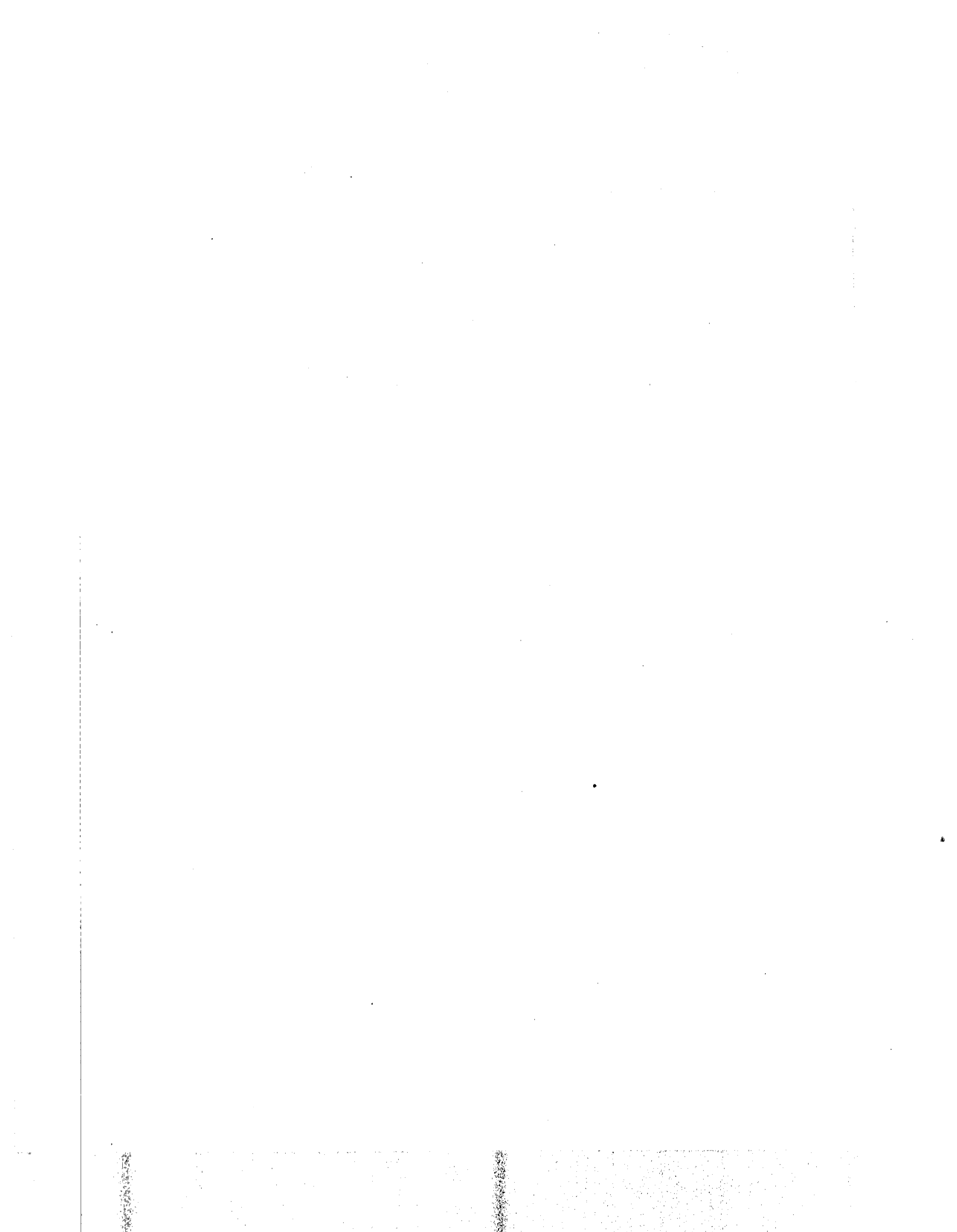

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