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Report To The Honorable Jim Sasser United States Senate

Current Status Of The Federal/State Arrangement For Administering The Social Security Disability Programs

How effective is the joint federal/state administration of the Social Security Disability Insurance and Supplemental Security Income programs, and should the federal government take over the entire administration (federalization) of these programs? To answer these questions, GAO reviewed the operations of four state disability determination services and the oversight responsibility of the Social Security Administration (SSA).

GAO examined two alternative approaches for administering the programs--total federalization and contracting out. GAO concluded that, while neither appeared to produce better disability decisions than the current arrangement nor to save program dollars, improvements can be made in the current administration of the programs. Administrative variations among states that were previously identified still exist, GAO found, but better SSA directives and guidelines would help the states improve program management.

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-217971

The Honorable Jim Sasser
United States Senate

Dear Senator Sasser:

You asked us to review the effectiveness of the federal/ state arrangement for administering the social security disability programs. Specifically, we focused on the operations of the state disability determination services (DDSs) and the oversight role of the Social Security Administration (SSA). Because of your interest in the possibility of the federal government taking over the entire administration of the disability programs (federalization), we also explored advantages and disadvantages of changing the way the programs are administered. Our results are summarized in this letter and discussed in detail in appendix I.

This report is based on our observations of DDSs in California, Kentucky, Maryland, and Tennessee. We judgmentally selected these states, seeking certain operational characteristics, such as geographical location, centralized versus decentralized operations, and operations that were meeting SSA-set national performance standards and others that were below the standards. To get a national perspective on these programs, we obtained information from state and federal officials as well as officials of the National Association of Disability Examiners, seeking their views on the effectiveness of the federal/state arrangement and the advantages and disadvantages of federalization. We also reviewed the disability programs' legislative history and pertinent program procedures, directives, and memoranda.

In establishing the Social Security Disability Insurance program in 1954, the Congress determined that the states should make disability decisions. The same principle applied to the Supplemental Security Income program, established in 1972.

Since the inception of the disability programs, however, questions often have been raised about the adequacy of their joint federal/state administration.

Studies, including several by GAO, found that the joint administrative arrangement contributed to variations among states in rates of accuracy in decision making, purchase rates for medical consultative examinations, employee hiring standards and salaries, organizational structure of state agencies, case processing procedures, and physician participation in the disability determination process.

To strengthen federal management of the disability programs, the Congress amended the Social Security Act in 1980 to strengthen SSA's control and oversight of the DDSs. The amendments directed the Secretary of Health and Human Services (HHS) to

> "promulgate regulations specifying, in such detail as he deems appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function in order to assure effective and uniform administration of the disability insurance program . . ."

The Secretary was given broad discretion to determine what to regulate in the administrative area, including the administrative structure of the DDS. Also, the amendments empowered the Secretary to take over the disability determination function should a DDS fail to make determinations consistent with established guidelines.

It is difficult to determine the impact of administrative differences in DDS operations on the disability programs, including effects on accurate and uniform decisions. Because of resource and time constraints and the methodological complexity involved in determining impact, we did not attempt to predict the effects of such variations on the programs. We elected, however, to determine if variations existed today in the DDSs' operations similar to those identified in previous studies. This would gauge how much progress had been made in rectifying the deficiencies noted in the past.

During visits to selected DDSs, we observed some of the same administrative variations that were identified before. For example, we found that

--state laws and practices influence or control many administrative aspects of the operations, since the personnel are state employees who receive direction from various levels of the state governments;

--because of conflicts between SSA directives and state laws and practices, three states we visited experienced inordinate delays in hiring additional personnel to handle the increased workloads resulting from the congressionally mandated disability reexaminations, while the other experienced no apparent hiring difficulty;

--nationally, there was a significant variance among examiners' caseloads, ranging from 51 in Montana to 147 in Nebraska;

--staffing composition varied widely among the states we visited, including the use of medical and vocational consultants; and

--entry-level education requirements for examiners ranged from a high school education to a 4-year college degree.

This lack of uniformity persists in part because SSA did not regulate DDS administrative practices to the maximum degree authorized by the 1980 amendments.

Recently, the federal/state relationship was strained when some states refused to process certain types of disability cases, particularly those pertaining to disability reexaminations. Most likely, the nature of the current federal/ state arrangement will always result in some tensions, although there are some indications these are lessening.

Over time, the Congress has questioned the effectiveness of the federal/state arrangement and occasionally raised the idea of federalizing the disability programs. After discussions with your office and exploring alternatives to the present arrangement, we examined two approaches for federally administering the disability decision process: (1) total federalization, where SSA administers all disability determination functions itself, and (2) contracting out, where private entities administer these functions.

We selected these approaches because both would give SSA direct control over the disability programs and, in theory, offer greater possibilities of increased uniformity of program administration. Both approaches would eliminate state

government involvement. We estimate, however, that going to total federal administration would add more than 11,000 employees to the federal rolls, and, because federal employees' salary structure is higher than state employees', increase the programs' personnel cost. Contracting out the functions would not increase the federal work force, but would require specific statutory authority and would raise a number of concerns. Among these is whether a major federal program with a very complicated process and the obligation to pay about $23.5 billion a year in benefits should be operated by the private sector. Appendix I presents additional advantages and disadvantages of the two alternatives. Appendix II provides detailed information of what it might cost to operate them.

Changing the operating structure of programs as large and complicated as these raises a number of difficult questions. Among the most important is whether disability decisions would be more accurate and uniform under alternative administrative arrangements. Because of the many structural possibilities in changing the current arrangement, the complex nature of the disability determination process, and the high degree of subjectivity inherent in such an analysis, we did not attempt to answer this question.

In addition, we question whether a change would be supported and accepted at the federal and state levels. In this regard, we are unaware of any major movement towards changing the current arrangement. At the state level, there is no indication that governors are eager or willing to give up their states' role in the disability determination process. Further, what problems would arise during the transition period? Given the annual volume of claims and the likelihood of significant disruption in the ongoing operation, what would happen to processing times and quality control during this period?

We found no evidence that a change from the current arrangement would produce better disability decisions or achieve program cost savings. There is evidence, however, that much can be done to improve administration within the current federal/ state arrangement; e.g., SSA could improve the directives and guidelines it provides to the DDSs. As part of our long-term strategy in the disability area, we plan to undertake several projects that will address SSA's management and administration. Among them, we will focus on relationships between the social security disability programs and vocational rehabilitation services, review SSA's management of the consultative examination process, analyze the effects of decentralizing DDSs, and oversee SSA's implementation of several changes to the

disability programs brought about by the 1984 disability amendments, which established new standards for reexamining the status of current disability payment recipients. In this work, we will concentrate on the administrative issues discussed in this report as they relate to SSA's and the states' program management.

In commenting on a draft of this report, HHS stated that it is committed to strengthening the current federal/state arrangement for administering the social security disability programs. HHS pointed out that states are given responsibility for management of the adjudication process and control of their operations as long as they meet the performance standards published in June 1981. (Every state except four met the standards at that time.) HHS's primary objective is to help any state whose performance becomes unacceptable improve to a level that it can resume its own program management.

In addition, HHS' comments described its initiatives to strengthen federal exercise of control of the state agencies administering the programs. These initiatives include a plan to improve DDS performance management, a new computer system to monitor DDS spending and productivity, streamlining the DDS financial management process, and new regulations being developed to give HHS further authority to intervene in a state's management of its program to improve performance. (See app. III.)

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

Sincerely yours,

Richard L. Fogel
Director

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ABBREVIATIONS

CDR	Continuing disability review
CE	Consultative examination
CEMS	Cost Effectiveness Management System
DDS	Disability determination service
DHS	Deloitte Haskins and Sells
DI	Social Security Disability Insurance
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
MEOR	Medical Evidence of Record
NADE	National Association of Disability Examiners
QA	Quality assurance
RFC	Residual functional capacity
SSA	Social Security Administration
SSI	Supplemental Security Income
TMA	Technical and management assistance

GAO OBSERVATIONS ON
THE FEDERAL/STATE ARRANGEMENT
OF THE SOCIAL SECURITY DISABILITY PROGRAMS

INTRODUCTION

The two social security disability programs[1] are administered by 54 state disability determination services[2] (DDSs). The DDSs make disability determinations under arrangements with the Secretary of Health and Human Services (HHS). At the federal level, management of the programs rests with the Social Security Administration (SSA). Administration costs, both SSA's and those of the state DDSs, are borne entirely by the federal government and totaled, respectively, about $2.1 billion[3] and $647 million in fiscal year 1984. These administrative costs account for about 10.5 percent of total program costs.

SSA gives DDSs guidelines to develop and process disability claims and criteria by which to make disability determinations. The legislative history of the programs suggests that they are intended to be uniformly administered. Because the personnel involved are state employees, however, state laws and practices control many of the administrative actions. Thus, there are significant variations in how DDSs administer the programs.

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[1]The Social Security Disability Insurance (DI) program, established in 1954 under title II of the Social Security Act, provides benefits to disabled workers and their families. The Supplemental Security Income (SSI) program, established in 1972 under title XVI of the act, provides cash assistance to needy aged, blind, and disabled persons. The statutory definition of disability is substantially the same for both programs.

[2]One agency in each state (except South Carolina, which also has an agency for the blind), the District of Columbia, Guam, and Puerto Rico.

[3]This figure includes $1.2 billion of operating cost for the disability program under title II of the Social Security Act and operating costs of $.9 billion for all title XVI programs.

OBJECTIVES, SCOPE, AND METHODOLOGY

Senator Jim Sasser asked us to examine the issue of federalizing the disability programs and evaluate the effectiveness of the federal/state arrangement, particularly how efficiently benefits are delivered to eligible disabled individuals. These concerns arose because reports of gross disparities and inequities in the administration of the programs have brought the system under increased scrutiny since 1980.

After discussions with the Senator's staff, we agreed to (1) identify advantages and disadvantages of putting the programs under complete federal control and (2) review the current federal/state arrangement to determine whether administrative variations previously identified still existed.

We conducted our study at SSA headquarters in Baltimore, SSA regional offices in Atlanta, Philadelphia, and San Francisco, and state DDSs in California, Kentucky, Maryland, and Tennessee. These four states were selected because they had (1) both centralized and decentralized operations, (2) locations that were geographically dispersed and under different regional offices, (3) at least one large (claim volume) state, and (4) both operations that were meeting national performance standards set by SSA, and others that were below the standards and were receiving technical and management assistance from SSA.

Using a structured interview format, we obtained information from SSA and DDS officials. They and officials of the National Association of Disability Examiners (NADE) gave us their views on the federal/state arrangement and the advantages and disadvantages of total federal administration of the disability programs. We reviewed SSA's program operations manual, HHS audit reports, and state program directives and memoranda. We searched the literature on the federal/state arrangement of the disability programs and examined the history and congressional intent of the 1980 Disability Amendments (Public Law 96-265).

In addition, we obtained state financial data from SSA's Cost-Effectiveness Management System[4] and estimated what the personnel and medical costs would be were the programs totally federal. Our cost estimates were based on a methodology

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[4]This system (or model) provides comparative costs of operating 52 state agencies. (The Guam DDS and the South Carolina state agency for the blind were excluded because of their small size.)

developed by the accounting firm Deloitte Haskins and Sells (DHS) in its September 1984 study. Because SSA's Cost-Effectiveness Management System excluded data for Guam and the South Carolina agency that determines disability caused by blindness, we excluded them from our cost estimates. Because of the relatively small size of these two state agencies, excluding them should not significantly affect our cost estimates. We did not verify the figures used or the calculations made in the DHS study. (For details of these estimates, including our assumptions, see app. II.) Our estimate of operating costs for a federal DDS was limited to personnel and medical costs, which comprise about 85 percent of total DDS costs. Although other support costs vary, we believe the net effect of including them would be insignificant. For the majority of the support items (e.g., rent, supplies, and equipment), cost differences are not dependent on which sector (federal, state, or private) procures such items.

Our review was conducted in accordance with generally accepted government auditing standards and covered the period March 1984 through January 1985. We provided a draft of this report to the Department of Health and Human Services. For comments received from agency officials, see appendix III.

CAUSES OF CURRENT CONCERNS

Before 1980, DDSs operated under formal agreements with SSA. In response to a 1976 GAO report[5] critical of SSA's management role, SSA revised the agreements in 1978 to place stronger administrative requirements on states. The revised agreements required DDSs to comply with guidelines issued by SSA for organizational structure, physical facilities, personnel, and medical consultative services. The revisions empowered SSA to terminate an agreement if the state did not comply with the guidelines. Partly because the states regarded the revisions as infringements on their traditional prerogatives, SSA was able to get only 21 of 54 DDSs to sign the revised agreements. The remaining DDSs operated under the old agreements.

Passage of 1980 disability amendments

To strengthen SSA management of the disability programs, the Congress in 1980 amended the Social Security Act to

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[5]"The Social Security Administration Should Provide More Management and Leadership in Determining Who is Eligible for Disability Benefits" (GAO/HRD-76-105, Aug. 7, 1976).

allow greater SSA control and oversight of the DDSs. The 1980 Disability Amendments required states to comply with federal regulations and other written guidance.

The amendments called for regulations specifying performance standards, and could, as the Secretary of HHS saw fit, be used to regulate:

--the administrative structure of the DDS,

--the relationship among units of the state agency and organizations performing tasks for the DDS,

--the physical location of the DDS,

--DDS's performance criteria (decision accuracy, timeliness, HHS review of procedures, and other items),

--fiscal control procedures, and

--when and in what form reports should be submitted to SSA.

The Congress recognized that the Secretary might have to assume the disability determination functions if a DDS failed to make determinations consistent with established guidelines or if a DDS decided to stop participating in the programs. Therefore, the Secretary submitted the required plan for assuming these functions to the Congress on November 20, 1980.

In addition, the amendments required SSA to increase its review of DDS decisions to award or continue benefits before any payment action was taken. From fiscal 1983 forward, this "preeffectuation review" by SSA was required to cover 65 percent of decisions. Also, after 1981, all disability beneficiaries were to be reviewed for eligibility through "continuing disability reviews" (CDRs). Timing of reviews for the permanently disabled was left to the Secretary's discretion; other beneficiaries were required to be reviewed at least once every 3 years.

SSA implementation of the 1980 amendments

In implementing the 1980 amendments, SSA chose to allow the states maximum managerial flexibility. As SSA officials

reported in a 1980 study,[6] although the Congress authorized the agency to regulate detailed administrative requirements and procedures, SSA felt that such an approach would lead to DDSs withdrawing from the programs. The regulations SSA issued in 1981 allowed the DDSs generally to administer the programs as they wanted as long as they met federal performance standards.

In the 1981 regulations, SSA set the following standards for "acceptable" accuracy and timeliness of disability determinations for both DI and SSI:

--combined Title II (DI) and Title XVI (SSI) decision accuracy of 90.6 percent,

--Title II case-processing time averaging 49.5 calendar days or less, and

--Title XVI case-processing time averaging 57.9 calendar days or less.

SSA expected these performance standards to be relatively easy to meet. (Every state except four was already meeting them.)

The agency decided that, should a DDS perform at an unacceptable performance level for any of the three standards for 2 consecutive quarters, SSA would have the discretion to provide it with technical and management assistance (TMA). TMA would be mandatory if, for 2 consecutive quarters, a DDS's performance were below acceptable in accuracy and in either of the timeliness standards. TMA might include

1. an onsite review of cases processed by the DDS,

2. a fiscal and administrative management review to identify problems and develop a correction plan,

3. a request that necessary administrative measures be implemented,

4. provisions to fund overtime or hire temporary staff above the budget level, and/or

5. provisions for federal personnel to do onsite reviews, conduct training, or perform other functions needed to improve performance.

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[6]"Regulatory Analysis Threshold Study" (SSA, Sept. 4, 1980).

After up to 12 months of mandatory TMA, the DDS is given a 3-month adjustment period. Following that, if the DDS fails to perform acceptably for 2 consecutive quarters in the next 12 months, SSA may take over disability determinations after it has fulfilled certain requirements. Thus far, SSA has not assumed any DDS's functions, but nine DDSs have received discretionary TMA, and Indiana, Maryland, and Washington, D.C., have received mandatory TMA.

Recent difficulties between SSA and the states

Since the inception of the disability program, criticism often has been voiced about the adequacy of the federal/state arrangement. Studies by others, including GAO, found that the arrangement contributed to variations among states in rates of accuracy in decision making, purchase rates for medical consultative examination, employee hiring standards and salaries, organizational structure of state agencies, case processing procedures, and physicians' participation in the disability determination process.

In 1980, citing too much federal intervention, the Wisconsin DDS told SSA that it would drop its disability role in 1981. When it became apparent that this was occurring, SSA at first planned to take over the disability function, but changed when the Office of Management and Budget would not approve the necessary increase in federal employees. After considerable negotiations with SSA, Wisconsin decided to continue its role.

More recently, concern has been fueled by a number of SSA/state disputes that have seen some states rebel at processing certain types of disability cases, particularly those pertaining to disability reexaminations. Since the inception of the mandated CDRs in 1981, there has been controversy over the reexamination process. Much of this controversy is over whether medical improvement has to be shown before an individual on the disability roles is terminated. In 1983, 18 DDSs were ordered by their governors or federal courts to provide evidence of medical improvement before terminating disability beneficiaries. Eight more DDSs were ordered by their governors to discontinue processing terminations.

As the year progressed, this situation worsened and on December 7, 1983, SSA advised all DDSs to temporarily stop processing terminations. On January 24, 1984, the Secretary of HHS wrote all state governors stating that, depending upon court actions, the DDS should implement whichever of the following procedures was appropriate:

1. Resume processing and notification of disability terminations in accordance with court-imposed standards,

2. Resume processing and notification of disability terminations 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 of which the state is part.

All states were asked to comply. Eight (Alabama, Arkansas, Illinois, Maine, Michigan, Massachusetts, New York, and Ohio) ignored the request and continued their self-imposed moratoria on CDR terminations.

In April 1984, the Secretary placed a national moratorium on all CDRs required under the 1980 amendments because of pending legislation in the Congress that could affect the disability programs. The legislation (Public Law 98-460), signed into law on October 9, 1984, established, among other things, a medical-improvement standard for CDRs. The standard generally requires that, before a person can be terminated from the disability rolls, his or her medical condition must have improved since the prior disability decision.

The new law also requires SSA to assume the functions of a state DDS within 6 months of finding that it is failing to follow federal law and SSA guidelines in making disability determinations. Such a finding must be made within 16 weeks of the time that the DDS's failure to comply first came to SSA's attention. SSA is currently developing regulations and guidelines for implementing the new law.

In commenting on a draft of this report, HHS described initiatives it is undertaking to strengthen the federal role over the state agencies. The initiatives include a plan to improve DDS performance management, a new computer system to monitor DDS spending and productivity, streamlining the DDS financial management process, and new regulations being developed that will give HHS further authority to intervene in a state's management in order to improve performance. (See app. III.)

WHAT IS THE CURRENT ADMINISTRATIVE ENVIRONMENT?

Our visits to four states, analyses of national data, and discussions with NADE, DDS, and SSA officials led us to conclude there still are significant variations in the way DDSs administer disability programs. These variations appear to have continued in part from SSA's decision not to exercise direct managerial control over the activities of the state agencies. We have not measured how these variations affect the efficiency and uniformity of disability determinations.

State laws and practices influence administration by DDSs

Since DDS personnel are state employees who receive direction from various levels of the state governments, state laws and practices influence and control many administrative aspects of DDS operations. These laws and practices, when they conflict with SSA directives, can create problems for the DDSs.

Some states exert control over hiring practices, use of overtime, out-of-state travel, and budget preparations. In some cases, these restrictions or individualized preferences may be minor deviations or issues; in other instances, they may hinder efficient operations. For example, of the four DDSs we visited, SSA authorized (with necessary funds) all to increase staff and/or use overtime to handle the increased workload generated by the 1980 amendments. Maryland, under a state hiring freeze, experienced inordinate delays in hiring staff. California, stymied by a state policy requiring funds to actually be available prior to hiring staff, faced delays. (Both DDSs' processing times worsened, and SSA provided TMA.)

Despite backlogs of pending cases, the Tennessee DDS was restricted in hiring staff by the state government. To overcome this impediment and reduce the backlog of cases, SSA officials recommended that the DDS temporarily disband its disability quality assurance (QA) function so the QA examiners could process the backlog of cases. The DDS did so.

A DDS official in Ohio told us that, to the dismay of the DDS management, entry-level requirements for examiners in that state were changed by the parent state agency about 8 years ago. Previously, an applicant for an examiner position needed a college degree; now, only a high school education is required. In Kentucky, the entry-level requirements for an examiner were reduced in February 1983 to allow employees of the parent

agency who lost their jobs because of cutbacks in federal medical insurance programs to be transferred to the DDS. From July to December 1983, about 50 people were transferred to the DDS to become examiners. The requirements were reduced from 4 years of college and/or 4 years of experience in the parent agency, to 2 years of college and/or 2 years of community service experience.

Variations in DDS management

Some of the criteria and guidelines SSA gives DDSs for administration of the disability determination process are general and open to interpretation. For example, personnel guidelines specify neither educational requirements or qualifications for DDS professional staff nor staffing compositions, only that "the state should provide sufficient qualified personnel . . . ." The DDSs have significant management flexibility to determine their own organizational makeup, case-flow and workload management, training requirements, staffing levels and configurations, employment requirements, and types of equipment.

SSA provides organizational guidance suggesting that the QA function, as an arm of management, should be located under the DDS Assistant Administrator of Management to help insure the objectivity necessary to perform quality reviews. The clerical and medical consultant staffs are expected to report to that individual for more efficient operation of claims processing units.

We found variances in the organizational placement of these functions. In the Tennessee DDS, the QA units report to the Assistant Directors of Operations. In the California DDS, the QA unit reports to the Director of Administration, as SSA suggests. Likewise, in Maryland, the Assistant Director of Operations has responsibility over the DDS clerical and medical consultant staffs; while in Tennessee, the clerical and medical consultant staffs report to the Assistant Director of Administration.

In 1980, the California DDS reorganized. The clerical staff was moved from operational units, where each clerk was responsible to an operational supervisor, to administrative units, where operational supervisors had no authority and control over their performance. SSA was critical of this change and recommended the clerks be placed back under the authority of the operational units, but the DDS administrator disagreed. DDS

employees told us that not having the clerical staff reporting to the operating unit, as SSA suggested, was causing delays in processing cases.

Currently, 17 out of 54 DDSs are decentralized. The Maryland and Tennessee DDSs operate from central locations. The California and Kentucky DDSs use headquarters offices in their state capitals, supplemented by area offices.

Staffing compositions also vary widely. The Tennessee, Maryland, and Kentucky DDSs use only part-time medical consultants, while California uses primarily full-time medical consultants. The examiner-to-clerical ratio in the states we visited ranged from 1.38 to 1 in Tennessee, to 0.85 to 1 in California. The examiner-to-supervisor ratio ranged from 4.5 to 1 in Maryland, to 3.1 to 1 in California. The ratio of examiners to equivalent, full-time medical consultants ranged from 13.3 to 1 in Maryland, to 5.4 to 1 in California.

Likewise, use of professional staff varies widely. Tennessee uses vocational specialists to review all cases requiring vocational determinations. As Maryland has no vocational specialist, examiners make vocational determinations.

Use of medical consultant staff also varies. The California DDS uses medical staff to review consultative examination (CE) requests (medical evidence used to supplement evidence provided by treating physicians) and to develop residual functional capacity (RFC) assessments (assessments of claimants' ability to perform work activity). The Kentucky DDS has supervisors approve CE requests, while examiners develop RFC assessments.

Nationally, we also noted a significant variance among examiners' caseloads. For instance, a June 1984 SSA report showed the average examiner's pending caseload ranged from 51 in Montana to 147 in Nebraska, and the average monthly number of cases adjudicated per examiner ranged from 26 in Iowa to 118 in Louisiana.

For staff training, some DDSs use SSA's basic training package, while others have developed their own methods. The training period, however, may vary. For example, the Tennessee DDS entry-level examiner program consists of 25 days of classroom instructions and 6 months of on-the-job training. The Kentucky DDS training covers 55 days of classroom instructions and 3 months of on-the-job training.

TWO ALTERNATIVES TO THE PRESENT FEDERAL/STATE ARRANGEMENT

Are decisions accurate and uniform? This is the greatest concern of any disability determination system. The statutory definition of disability is necessarily subjective. For this reason, uniform application of the law is difficult to attain and measure. With the complexity of the disability adjudicative process, a certain amount of disagreement in decisions can be expected. We did not address in the review the underlying questions, whether disability decisions are accurate and uniform among the states now, and whether decisions would be more accurate and uniform under an alternative approach.

Keeping in mind this and the fact that there are many possible options or alternatives (each with certain advantages and disadvantages) that could be considered in changing the disability determination process, we chose two possible alternatives to study. These were (1) to federalize existing state disability determination functions or (2) to contract them out to private entities. We selected these approaches because both encompass the major organizational elements, such as staffing, that would have to be considered in any alternative to the present method.

Federalize the DDSs

From a purely operational perspective, a totally federal structure for disability determination appears to be the preferred option. It would give SSA more direct control over the process; eliminate most disputes between SSA and the states; offer many organizational advantages to SSA management; and afford greater uniformity in the disability determination process.

From speaking with federal and state officials and reviewing past studies on the issue, we gathered information on the advantages of federalizing the administration of the programs. Details of these advantages follow:

--SSA would have direct control over the disability programs. This would eliminate dual management, offer a more direct line of responsibility, and promote program accountability.

--State government influence over the federal program would be eliminated. DDS budgets would need to satisfy only federal requirements--not the particular demands of the host state, such as requiring funds to actually be

available before hiring staff. A "federal DDS" would need only one accounting system (currently some DDSs need both a federal and state budget). Thus, money spent on the program would go directly to the entities making the determinations and not filter through state governmental levels.

--There would be greater organizational uniformity and resulting cost savings. Purchasing of supplies and equipment would become uniform and possibly more cost efficient. There would be more consistency and cohesiveness in program operations. For example, the printing of forms would be more cost efficient, because currently every state uses a combination of federal- and state-produced forms. Problems concerning state travel restrictions, CE fee restrictions, and state reporting requirements also would be eliminated or greatly diminished.

--There would be standardized salary qualifications and regulations for personnel, and SSA would select supervisors and administrators. There would be uniform employment requirements, staffing levels, staffing configurations, and retirement and fringe benefit programs. Furthermore, DDSs would not be subject to state hiring freezes, and any federal freeze presumably would be handled uniformly across the country.

--Time spent negotiating with states on policy compliance would be eliminated.

--A closer working relationship between district offices and disability determination units could be developed.

--SSA could select the number, location, and size of offices and provide for greater mobility of personnel.

How much more would such a change cost the federal government? This is one of the most frequently asked questions regarding federalization of the DDSs. We did not attempt to estimate the complete cost, only personnel and medical costs. According to SSA cost data, personnel and medical costs comprise about 85 percent of total DDS costs. These costs would increase by $30 million (in fiscal year 1982 dollars) were the programs run federally.

We did not estimate the other support costs of the DDSs (i.e., rent, equipment, supplies), any necessary start-up costs,

or additional SSA headquarters and regional office operating costs. For the majority of support items, cost differences do not depend on who procures the items. We believe, as does DHS, the firm that contracted with SSA to study the cost of performing disability determinations in the private sector, that most support costs have only minimal impact on net DDS costs. This is because most of these costs would accrue no matter which sector procures them. Also, we believe the configuration of SSA's headquarters and regions under this model would not differ drastically from its current structure.

There would be one-time start-up costs involved such as setting up a transition team within SSA; recruiting, hiring, and training personnel (not all state personnel would convert to the federal system); and adding and replacing equipment. We did not attempt to estimate these costs because of the uncertainties involved, such as the number of state employees who would not convert to the federal work force.

In our study, we compared the DDSs' actual fiscal 1982 personnel and medical costs with the projected costs of a hypothetical federal operation based on an SSA contingency plan to federalize a DDS[7] and a methodology developed by DHS in its September 1984 study, "Estimated Costs of Performing Disability Determinations in the Private Sector."[8]

We estimated personnel costs by using a three-step process similar to that developed by DHS:

1. For processing disability program claims, we used a model based on DDS staffing relationships that appeared to result in high productivity (the average of the 10 most productive DDSs in 1982). The model defined the type of jobs necessary to adjudicate claims and established a relative mix of these jobs. This mix--a ratio of examiners, clericals, managers, and physicians--is the "staffing unit."

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[7]The plan was developed by SSA in 1980 for the possible federal operation of the Wisconsin DDS (see p. 6).

[8]DHS submitted this report as part of its contract with SSA to develop a cost-effectiveness measurement system for the DDSs. DHS felt this report would help SSA by indicating where state DDS and estimated private-sector costs may differ substantially.

2. We set the number of staffing units required to process each state's disability caseload, using the productivity level of the 10th most productive DDS in 1982. We believe this level is reasonable to expect under a totally federal operation, as did SSA officials responsible for the DHS study.

3. To price the functions comprising the staffing units,[9] we used SSA's contingency plan for taking over the Wisconsin DDS and the following wage assumptions:

Examiners	GS-10	($21,499/yr.)
Clerks	GS-4	($11,490/yr.)
Managers	GS-13	($33,586/yr.)
Physicians	$41.52 per hour	($86,362/yr.)

We used medical costs estimated by DHS. (See app. II for more details.)

Actual personnel and medical costs for the DDSs in fiscal 1982 were about $461 million; we estimate the costs for federal DDSs at $491 million (see table II.5). The federal costs would be higher because (1) the federal salary schedule is generally higher than the states' and (2) estimated federal medical costs are higher. The following table shows the difference for the four states we visited:

	Actual DDS cost	Cost under federalization model	Difference
California	$53,084,631	$56,923,722	+$3,839,091
Kentucky	7,764,941	9,480,075	+ 1,715,134
Tennessee	8,617,095	12,801,632	+ 4,184,537
Maryland	5,760,708	7,068,861	+ 1,308,153

Using the productivity levels of the 10th most productive DDS in fiscal year 1982, we estimate that complete federalization would likely add more than 11,000 employees to the federal rolls.

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[9]Our wage assumptions for examiners, clerks, and managers represent an average of possible wage scales. For example, examiners' positions range from a GS-5 to GS-11.

Other disadvantages of federalization include

--loss of expertise and possible workload disruptions because some trained DDS personnel probably would opt not to work for the federal government;

--claims processing probably would be disrupted during changeover periods;

--a new policy and system for purchasing medical services probably would have to be developed; and

--the determination process would become vulnerable to federal restrictions, such as a hiring freeze, or other budgetary measures.

Contracting-out functions to the private sector

Another alternative to the current federal/state arrangement would be to contract-out disability determination functions to private entities. This alternative could achieve many of the advantages discussed under federalization without increasing the federal work force. Such an alternative, however, would require coordination among a number of SSA offices and detailed performance criteria. Also, it would require a change to current law, which allows only state or federal personnel to make disability decisions. We have identified the following advantages:

--The determination process would be less vulnerable to such federal budgetary restrictions as a hiring freeze.

--More direct federal control over operations would be achieved without increasing the federal work force.

--State political and governmental influence over the federal program possibly would be eliminated.

--Greater flexibility in the selection of location and size of offices would be available.

No increase to the federal work force makes the contracting approach the most viable method of assuming a DDS's functions, SSA officials told us, but its disadvantages are

--additional time needed to get contracts planned, awarded, and operational,

--possible loss of DDS examiner expertise,

--possible disruption of claims processing during the changeover periods, and

--potential conflict of interest if a contractor also administers private disability plans tied to SSA determinations.

Aside from securing the legislative authority to carry out a contracting program, this approach raises several significant questions. Should a major federal program with a very complicated process and the obligation to pay about $23.5 billion a year in benefits be operated by the private sector? Are there enough private entities able to process the disability cases? Would current state employees be entitled to the same hiring preference and severance benefits now provided by federal law?

In its 1984 report, DHS estimated the personnel and medical costs of administering the disability programs in the private sector on a state-by-state basis for fiscal 1982. It based the costs on assumptions that private third-party insurance entities would locate in each state a claims processing office that would be operated independently of their private plans.

SSA recently verified and revised the 1982 data used by DHS in its report. Based on these revised data, we estimated that private-sector personnel and medical costs would have been about $454 million for fiscal 1982. This was about $7 million less than what the state DDSs spent during that period for the same costs and about $37 million less than the estimated cost of a totally federal system.

Cost estimates lower under the contracting-out alternative

Under the contracting-out model, a productivity level based on the 10th most productive DDS was assumed; therefore, fewer personnel were required nationwide than under the current arrangement. Also, the private personnel costs for staff positions in some states were less than actual state DDS costs for similar positions. The break-even point (where contracting-out personnel costs equal actual state costs) was at the productivity level of the 18th state.

When comparing costs of the contracting-out and the federal models, the difference lies in the cost projections developed for personnel costs, as follows:

--<u>For the private model</u>, the estimated staffing costs were developed on a state-by-state basis. We used a benchmark position (representing the average job within categories with varying degrees of skilled experience) for the examiner, clerk, and manager functions, and actual hourly rates paid by state DDSs to their medical consultants in fiscal year 1982 for physician salaries. We then increased the examiner, clerk, and manager figures by 25.9 percent to reflect employee benefits.

--<u>Under the federal model</u>, we developed salaries for the examiner, clerk, and manager functions using SSA's plan for the staffing configuration of a federal DDS and determining an average salary for each position. For example, the examiner position under the SSA plan ranged from a GS-5 to a GS-11 grade. Based on SSA's structure for examiners, we estimated the average examiner salary at a GS-10 position. Additional employee benefits for examiner, clerk, and manager positions were estimated based on the 1982 federal rate of 29.5 percent. We based physician salaries on actual hourly rates paid by SSA regional offices to part-time medical consultants in fiscal year 1982.

The following table illustrates differences between private and federal personnel costs:

		Private			
	Federal	California	Kentucky	Tennessee	Maryland
Examiner	$21,449	$17,472	$14,924	$13,312	$17,732
Clerk	11,490	14,772	12,116	12,142	13,156
Manager	33,586	41,181	33,390	35,245	39,326
Physician	86,362	57,950	81,535	61,087	44,216

Our estimates should be viewed with caution, as they are influenced by the assumptions we made. For example, any deviation (away) from the model's high productivity level would increase the costs of the alternative approaches. (If the productivity level for the contracting-out model were based on the average state productivity, the personnel costs would be $13 million higher than the actual state personnel costs.) Also, our methodology did not include estimating possible economies resulting from such factors as economies of scale from centralization or the effects of a competitive market and contracting process.

QUESTIONS TO BE CONSIDERED BEFORE CHANGING MANAGEMENT OF DISABILITY PROGRAMS

Though the present arrangement (federal/state administration of the disability programs) has been criticized since the inception of the programs, it has endured for nearly 30 years. Before massive changes in the federal/state arrangement are undertaken, a number of questions need to be considered.

Given the volume of claims filed annually, would there be significant disruption of the ongoing operation during the transition? What would happen to processing times and quality control? Would the change be supported and accepted politically at the federal and state levels? Would states accept losing joint administration of a program that significantly affects a large portion of their residents?

Finally, what we believe to be the biggest question or concern: Would either alternative improve the accuracy and uniformity of disability decisions? There is no substantial evidence that accuracy and uniformity would change one way or another under either alternative.

There is evidence, however, that determination processes at the DDSs are not uniform and consistent across the nation today. What action or changes, if any, should be made to the current management structure is unknown at this time. There is a continuing need to further study SSA's management of state disability-determination services.

As part of our long-term strategy in the disability area, we plan to undertake several projects to address SSA's management and administration. These projects include

--focusing on relationships between the social security disability programs and vocational rehabilitation services,

--reviewing SSA's management of the consultative examination process,

--analyzing the effects of decentralizing DDSs, and

--overseeing SSA's implementation of several changes to the programs brought about by the 1984 disability amendments.

In performing this work, we will be concentrating on the administrative issues discussed in this report, as they relate to SSA's and the states' program management.

ESTIMATED PERSONNEL AND MEDICAL COSTS OF FEDERAL DDSs AND PRIVATE-SECTOR DDSs

PERSONNEL COSTS

We estimated personnel costs under two options (federalize the state DDSs or contract with a private entity to operate them using a three-step process developed by Deloitte Haskins and Sells:

Step 1. A staffing model for processing disability claims was developed based on DDS full-time staffing relationships that appeared to result in high productivity. We categorized DDS personnel into four principal types of labor skills necessary to process claims--examiner, clerk, manager, and physician. The top 10 DDSs in terms of productivity (number of cases processed per full-time staff per year) in fiscal year 1982 were analyzed to determine the relative proportion of each labor skill.

The staffing model developed by DHS indicates that high levels of productivity can be achieved by a "staffing unit" that combines examiner, clerical, managerial, and physician labor inputs in the following ratio:

Examiner	1.000
Clerk	.930
Manager	.257
Physician	.082
Total	2.269

Step 2. DHS established an expected level of productivity, based on the 10th most productive DDS in fiscal year 1982, of 218.4 cases per full-time staff per year (achieved by the North Carolina DDS).[1]

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[1]DHS used a 229.3 productivity level in its initial estimates of the 1982 private-sector cost. We obtained revised 1982 data that indicated the productivity of the 10th most productive DDS was 218.4 cases a year. In estimating the private and federal sector cost, we used the revised productivity level.

As shown above, one staffing unit requires 2.269 full-time staff per year of the specified mix of functions. Since full-time staff can process 218.4 cases per year at the 80th[2] percentile level of productivity, 2.269 full-time staff can process 495.6 (218.4 x 2.269) weighted cases per year. To determine the total number of staffing units required to process a given state's caseload, we divided that state's total of weighted cases in fiscal 1982 by 495.6 weighted cases per staffing unit. For example, the Tennessee DDS processed 64,900 weighted cases in fiscal 1982, which would have required 130.9 (64,900/495.6) staffing units.

Step 3. Finally, we determined the cost of a "staffing unit." Only in this step did we find a difference between personnel costs under the federal and private-sector DDS models. To estimate the costs, we did the following:

--For the federal DDS model, we obtained compensation estimates from an SSA planning document for a federal DDS. Physicians' salaries were based on actual hourly rates paid by SSA regional offices to their medical consultants in fiscal year 1982. Examiner, clerk, and manager salaries were based on the following GS rankings in fiscal year 1982:

Examiner	GS-10	($21,449)
Clerk	GS-4	($11,490)
Manager	GS-13	($33,586)

--For the private-sector DDS model, DHS surveyed compensation for the examiner, clerk, and manager functions contained in the model staffing unit on a state-by-state basis. Physicians' salaries were based on actual hourly rates paid by DDSs to their medical consultants in fiscal year 1982. Compensation figures

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[2]As the 10th most productive DDS in fiscal year 1982, the North Carolina DDS was considered to be 80 percent productive if the most productive DDS was considered producing at 100 percent (42 DDSs divided by 52 DDSs = .81).

obtained for the examiner, clerk, and manager functions represent fiscal 1982 median base-wages contained in private-sector salary surveys.[3]

The staffing unit costs for each state under the two options is the product of the salaries of the different job functions in a "staffing unit," adjusted by the labor input ratio between that function and employee benefits.[4] For the federal and private-sector DDS models, employee benefits amount to about 29.5 percent and 25.9 percent, respectively, of base compensation.

We combined the number of required staffing units and staffing unit costs to estimate total annual federal and private-sector labor costs for each state. Table II.1 compares estimated federal and private-sector labor costs in each state with actual DDS expenditures for fiscal year 1982.

MEDICAL COSTS

From our review of Deloitte Haskins and Sells' assumptions and computations, we feel its estimate of the private-sector medical costs is also a valid estimate of the costs that would be incurred if the DDS were federalized. The methodology DHS developed for estimating medical costs consisted of two steps:

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[3]"Branch Office Clerical Salary Survey: 1983" (Life Office Management Association, Inc., Human Resources Report No. 127, Atlanta, Georgia), and "1983 Management Compensation Survey of the Insurance Industry" (Sibson & Company, Inc., Princeton, New Jersey, August 1983).

[4]Employee benefits include employer's share of legally required payments, pensions, and insurance payments and other benefit payments made by the employer.

Table II.1

Comparison of Actual 1982 DDS Personnel Costs with Estimated Federal and Private-Sector Personnel Costs

State	Actual DDS	Federal DDS model	Private-sector DDS model
AK	$ 675,453	$ 306,560	$ 404,511
AL	6,136,524	7,682,561	6,140,018
AR	2,856,059	3,986,478	3,091,176
AZ	3,192,105	3,120,086	2,667,146
CA	37,068,428	32,951,009	31,572,432
CO	2,755,272	2,942,856	2,820,768
CT	3,586,321	3,045,243	2,745,677
DC	1,032,063	926,266	911,848
DE	785,162	661,619	640,502
FL	8,830,223	11,288,833	8,645,879
GA	8,569,286	9,241,108	8,332,199
HI	1,021,961	713,710	728,658
IA	1,877,411	2,574,026	2,106,424
ID	1,015,224	993,326	812,097
IL	10,809,246	15,514,810	14,502,169
IN	5,523,290	5,941,995	4,627,760
KS	1,901,723	2,062,694	1,818,788
KY	4,036,074	6,094,078	5,136,328
LA	5,555,291	8,191,499	6,798,499
MA	8,307,425	6,950,290	6,782,322
MD	3,903,721	4,410,991	3,984,000
ME	1,211,923	1,332,818	1,223,588
MI	15,992,553	13,107,236	12,452,476
MN	3,324,092	3,228,460	2,976,384
MO	4,941,200	7,519,103	6,673,698
MS	3,562,579	5,662,379	4,709,681
MT	859,798	913,094	747,830
NC	6,751,284	8,868,086	7,137,273
ND	438,415	564,621	436,562
NE	1,032,249	1,613,631	1,260,074
NH	894,990	901,119	702,850
NJ	9,131,880	9,089,624	8,210,340
NM	1,822,329	1,844,749	1,506,609
NV	1,104,526	1,039,430	829,617
NY	32,109,050	26,868,308	25,251,946
OH	11,666,349	13,664,673	11,889,577
OK	3,248,353	3,431,436	2,930,490
OR	2,996,469	3,106,914	2,676,746
PA	14,945,496	15,301,655	12,647,153
PR	3,240,717	4,517,569	3,206,700
RI	1,370,153	1,107,089	961,517
SC	4,301,001	5,475,569	4,368,658
SD	461,320	640,663	509,042
TN	4,333,961	7,840,631	6,205,721
TX	17,144,004	14,502,324	12,692,046
UT	938,665	919,081	933,648
VA	5,571,565	6,685,044	5,512,495
VT	763,570	696,945	626,604
WA	4,779,417	4,902,565	4,316,877
WI	4,005,880	4,205,021	3,565,156
WV	2,835,099	3,471,553	3,039,196
WY	273,184	291,591	269,988
U.S. total cost	$285,490,333	$302,913,019	$265,739,743

Step 1. CE expenditures for each state were estimated using data from the DHS study and the Health Care Financing Administration's (HCFA's) "1983 Medical Directory of Prevailing Charges." Cost data obtained from the DHS study indicate the percentage contributions to CE cost per case for all major medical services to be as shown in table II.2.

Table II.2

Medical Service Market Basket

Medical service	Weighted percentage to CE cost	
Medical examination:		
General	17.4	
Cardiovascular	2.7	
Neurological	3.9	
Orthopedic	6.6	
Psychiatric	21.7	
All other examinations	6.8	
Total	59.1	
Medical tests:		
Radiology	17.9	
Pulmonary	7.4	
Laboratory	3.2	
All other tests	12.4	
Total	40.9	
Total, all medical services		100.0

The above information indicates that, if a disability case were randomly selected, on average, 17.4 percent of the total CE costs in that case would be for general examinations, 2.7 percent would be for cardiovascular examinations, and so on.

HCFA's "Medical Directory" was used to develop the reasonable charges for each cost category. For example, the average CE costs per case in Tennessee were $58.80, which was compiled as shown in table II.3.

Table II.3

Average Consultative Examination Cost
Per Case in Tennessee

Cost category	Reasonable charges	x weight (percent)	= Adj. charge
General exam	$ 36.00	17.4	$ 6.26
Cardiovascular exam	80.00	2.7	2.16
Neurological exam	80.00	3.9	3.12
Orthopedic exam	80.00	6.6	5.28
Psychiatric exam	49.80	21.7	10.81
All other exams	80.00	6.8	5.44
Radiology tests	35.60	17.9	6.37
Pulmonary tests	214.50	7.4	15.87
Laboratory tests	12.10	3.2	0.39
All other tests	25.00	12.4	3.10
Total		100.0	$58.80

We computed total estimated CE costs by multiplying the average CE cost per state by that state's total cases processed in fiscal year 1982.

Step 2. To estimate the Medical Evidence of Record (MEOR)[5] and claimant travel expenses, we assumed that the current policies used by the state DDSs would continue to be used under both the federal and private-sector models. The actual DDS MEOR and claimant travel expenses were added to the estimated CE costs.

To determine total estimated medical costs for each state for fiscal year 1982, we added estimated CE costs to actual DDS MEOR and claimant travel expenses. A comparison of actual DDS medical costs in fiscal year 1982 with estimated medical costs is presented in table II.4.

[5]Medical Evidence of Record is the medical evidence that the beneficiary supplies the DDS to support his/her claim of being disabled.

Table II.4

Comparison of Actual DDS and Estimated Medical Costs, FY 1982

State	Actual DDS medical costs	Estimated medical costs
AK	$ 439,532	$ 308,889
AL	5,241,387	5,941,996
AR	2,549,501	3,020,564
AZ	2,236,650	1,756,129
CA	16,016,203	23,972,713
CO	2,038,030	1,752,748
CT	1,496,302	1,687,213
DC	842,662	585,290
DE	381,007	457,429
FL	7,675,365	8,020,493
GA	6,249,851	6,152,983
HI	296,718	483,530
IA	1,717,401	1,404,098
ID	474,345	703,773
IL	6,558,535	7,215,002
IN	4,210,097	3,934,152
KS	1,148,314	1,244,713
KY	3,728,867	3,385,997
LA	4,301,698	4,853,867
MA	5,508,010	4,509,489
MD	1,856,987	2,657,870
ME	610,485	748,886
MI	6,960,250	8,496,059
MN	2,427,936	2,255,268
MO	4,655,760	3,590,277
MS	3,311,053	3,497,478
MT	582,352	736,025
NC	5,588,072	5,831,515
ND	239,058	417,737
NE	1,012,069	880,193
NH	323,191	616,107
NJ	3,418,009	4,599,994
NM	961,681	1,238,796
NV	507,626	633,553
NY	17,072,718	14,744,061
OH	7,328,785	8,785,515
OK	2,004,663	1,757,027
OR	1,881,890	1,956,425
PA	8,079,775	9,378,249
PR	3,336,002	2,379,258
RI	407,890	612,019
SC	2,100,718	2,782,103
SD	329,391	345,684
TN	4,283,134	4,961,001
TX	9,658,325	9,580,748
UT	438,310	606,423
VA	4,208,577	4,048,463
VT	453,071	431,047
WA	2,557,245	3,193,245
WI	2,556,518	2,226,215
WV	2,902,457	2,482,544
WY	159,162	189,933
U.S. total cost	$175,323,635	$188,050,786

TOTAL COSTS

Personnel and medical costs account for 85 percent of the total actual DDS expenditures in fiscal year 1982. We believe, as does DHS, that most of the support costs (15 percent) would continue and have minimal effect on the final estimates; therefore, support costs were not estimated for comparison purposes.

A comparative analysis of personnel and medical costs for the actual DDSs, the federal DDS model, and the private-sector DDS model appears in table II.5.

Table II.5

Comparison of 1982 Personnel and Medical Costs for Actual DDS, Federal DDS, and Private-Sector DDS Models

State	Actual DDS	Federal DDS model	Private-sector DDS model
AK	$ 1,114,985	$ 615,449	$ 713,400
AL	11,377,911	13,624,557	12,082,014
AR	5,405,560	7,007,042	6,111,740
AZ	5,428,755	4,876,215	4,423,275
CA	53,084,631	56,923,722	55,545,145
CO	4,793,302	4,695,604	4,573,516
CT	5,082,623	4,732,456	4,432,890
DC	1,874,725	1,511,556	1,497,138
DE	1,166,169	1,119,048	1,097,931
FL	16,505,588	19,309,326	16,666,372
GA	14,819,137	15,394,091	14,485,182
HI	1,318,679	1,197,240	1,212,188
IA	3,594,812	3,978,124	3,510,522
ID	1,489,569	1,697,099	1,515,870
IL	17,367,781	22,729,812	21,717,171
IN	9,733,387	9,876,147	8,561,912
KS	3,050,037	3,307,407	3,063,501
KY	7,764,941	9,480,075	8,522,325
LA	9,856,989	13,045,366	11,652,366
MA	13,815,435	11,459,779	11,291,811
MD	5,760,708	7,068,861	6,641,870
ME	1,822,408	2,081,704	1,972,474
MI	22,952,803	21,603,295	20,948,535
MN	5,752,028	5,483,728	5,231,652
MO	9,596,960	11,109,380	10,263,975
MS	6,873,632	9,159,857	8,207,159
MT	1,442,150	1,649,119	1,483,855
NC	12,339,356	14,699,601	12,968,788
ND	677,473	982,358	854,299
NE	2,044,318	2,493,824	2,140,267
NH	1,218,181	1,517,226	1,318,957
NJ	12,549,889	13,689,618	12,810,334
NM	2,784,010	3,083,545	2,745,405
NV	1,612,152	1,672,983	1,463,170
NY	49,181,768	41,612,369	39,996,007
OH	18,995,134	22,450,188	20,675,092
OK	5,253,016	5,188,463	4,687,517
OR	4,878,359	5,063,339	4,633,171
PA	23,025,271	24,679,904	22,025,402
PR	6,576,719	6,896,827	5,585,958
RI	1,778,043	1,719,108	1,573,536
SC	6,401,719	8,257,672	7,150,761
SD	790,711	986,347	854,726
TN	8,617,095	12,801,632	11,166,722
TX	26,802,329	24,083,072	22,272,794
UT	1,376,975	1,525,504	1,540,071
VA	9,780,142	10,733,507	9,560,958
VT	1,216,641	1,127,992	1,057,651
WA	7,336,662	8,095,810	7,510,122
WI	6,562,398	6,431,236	5,791,371
WV	5,737,556	5,954,097	5,521,740
WY	432,346	481,524	459,921
U.S. total cost	$460,813,968	$490,963,805	$453,790,529

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

AUG - 8 1985

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

Thank you for the opportunity to comment on your draft report, "Current Status Of The Federal/State Arrangement For Administering The Social Security Disability Programs." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "CURRENT STATUS OF THE FEDERAL/STATE ARRANGEMENT FOR ADMINISTERING THE SOCIAL SECURITY DISABILITY PROGRAMS" (HRD 85-71, DATED JULY 1, 1985)

GENERAL

The objectives of the General Accounting Office's (GAO) study were to review the effectiveness of the Federal/State arrangement for administering the social security disability programs, and to explore the advantages and disadvantages of changing the way the disability programs are administered.

GAO found no evidence that a change from the current Federal/State arrangement for administering the social security disability programs would produce better disability decisions or achieve program cost savings. The report does not show what evidence was considered or what areas were explored by way of investigating whether another type of arrangement would produce better disability determinations. At this time we are committed to strengthening the current Federal/State arrangement of the disability programs; however, we welcome any suggestions for improving the decisionmaking process.

The disability programs under title II and title XVI of the Social Security Act are administered under a Federal/State mechanism having its origins in the disability freeze provisions of the 1954 amendments to the Social Security Act. At that time, Congress specified that determinations of disability should be made by State agencies under agreement with the Secretary. Wherever possible, the State rehabilitation agency was to be the contracting agency to encourage rehabilitation contacts by disabled persons and to take advantage of the medical and vocational expertise of those agencies.

In 1980, out of concern for uniform program administration, Congress enacted section 304 of the 1980 amendments, which increased our statutory authority to improve State performance by requiring the promulgation of regulations establishing standards of performance and administrative requirements for the States to follow to ensure effective and uniform administration of the disability programs. Performance standards were therefore promulgated effective June 1, 1981, requiring the State Disability Determination Service (DDS) to meet standards in accuracy and processing time and other administrative and procedural areas.

The current Federal/State regulations do not provide for direct Federal control over the States. Instead, they give the States responsibility for management of the adjudication process and control of their operations as long as performance is adequate under the standards which we have set for accuracy and timeliness of decisions. These regulations permit more intensive Federal

involvement in the State's activities only if a State's performance becomes unacceptable under the standards. Under these circumstances, our primary objective is not to interfere in the State's operation, but to help the State to improve its performance with the ultimate goal of withdrawing our assistance and allowing the State to resume its own management of the program.

Within these parameters we and the States have done well on the whole. Very few States have had to come under mandatory technical and management assistance. In those cases as well as in others where our involvement was necessary, we provided assistance to the States to help improve their performance.

We believe that any report of the general effectiveness of SSA's management of the disability programs and the Federal/State relationship would be incomplete without recognition of initiatives we are taking to strengthen the Federal role in exercising control of the State agencies.

Some of these are:

--Proposed Rules Strengthening Federal Role in DDS Management

A draft Notice of Proposed Rulemaking (NPRM) covering State agency compliance with our performance standards and other written guidelines is being developed to implement section 17 of the Disability Benefits Reform Act of 1984. The current regulations only address the issue of State agency non-compliance in terms of failure to meet national performance standards. The proposed regulations will give us further authority to intervene in a State in order to improve performance.

Also, as part of this NPRM, we are proposing an expansion of our performance support process. Performance support is the guidance, assistance, and resources we provide DDSs to improve performance or enhance their operations. Under the proposed changes, we will consider offering or granting, upon request, performance support to DDSs when our monitoring reveals that such support could enhance performance. This will allow for performance support, including State requested support, in a much broader range of circumstances than under the current regulations.

--DDS Cost Effectiveness Measurement Studies (CEMS)

This system will provide the means for us to more efficiently monitor DDS spending and productivity.

--Streamlining the DDS Financial Management Process

This effort will streamline the formulation and execution process of DDS budgets using budget information provided by CEMS.

--DDS Management Forum

This activity provides the opportunity for the free exchange of information between Federal and State managers to analyze DDS problems and find solutions.

--Disability Examiner Outstationing

This initiative stations DDS examiners in targeted district offices (DO) to expedite and make more accurate DO disability case processing.

--DDS Performance Management

We are developing a comprehensive plan to improve DDS performance management. This effort will increase regional office oversight of DDS performance, increase our monitoring activities, and lend assistance to DDSs more quickly.

OTHER MATTERS

Appendix I

Page 1, footnote 2. The total number of DDSs is 54, not 52. The list should include the DDS in Guam and the South Carolina agency which determines blindness. The difference could have an impact on estimations.

Page 8. "We have not measured how these variations affect the efficiency and uniformity of disability determinations." The variations mentioned are the different ways the States administer the disability programs. Yet in the Cover Summary it is stated, "This lack of uniformity results from the substantial flexibility SSA allows the States in administering the programs." These statements are incompatible.

Page 15. It should be noted in the discussion of contracting out that, under current law, we cannot contract out the disability decisionmaking function; this function can only be done by State or Federal personnel. We can only contract out the medical documentation and other claims processing functions of a State's DDS workload that must be assumed.

GAO note: Page references in this appendix have been changed to agree with page numbers in the final report.

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