December 2014

2014 Disability Policy Panel: Continuing Disability Reviews

Report to the
Social Security Advisory Board

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MEMBERSHIP OF THE DISABILITY POLICY PANEL

Bernadette Franks-Ongoy
Executive Director for Disability Rights Montana, Current Social Security Advisory Board (SSAB) member

Manasi Deshpande
Ph.D. Candidate in Economics at Massachusetts Institute of Technology (MIT) and Pre-doctoral Fellow at the National Bureau of Economic Research (NBER)

Elaine Fultz, PhD
Independent consultant, formerly professional staff member, House Ways and Committee, Social Security Subcommittee and official of the International Labor Organization, Social Security Department

Marsha Rose Katz
Project Director at the University of Montana Rural Institute in Missoula, Retired; Former SSAB Acting Chair

Renée M. Landers
Professor of Law and Director Health and Biomedical Law Concentration, Suffolk University Law School

Nicole Maestas, PhD
Director, RAND Center for Disability Research; Director, RAND Economics, Sociology and Statistics Department

Ken Nibali
Associate Commissioner for Disability, Social Security Administration, Retired

James Smith
Budget and Policy Manager, Vermont Division of Vocational Rehabilitation

Arthur Spencer
Associate Commissioner for Disability Policy, Social Security Administration, Retired

SOCIAL SECURITY ADVISORY BOARD STAFF

Jacqueline Chapin, PhD
Policy Chief

Jeremy Elder
Policy Analyst

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ERRATA

A correction was made on 3/19/15 to the wording of the following two sentences on page 15.

Old Language:

To test the effectiveness of the profiling process, SSA regularly conducts full medical CDRs on a random sample of cases whose profile scores a mailer only. Cessation rates in the one recent profile sample were only 0.8% compared to 3.8% in the sample whose profile scores indicate they should receive a full medical review.

New Language:

To test the effectiveness of the mailer process, SSA regularly conducts full medical CDRs on a random sample of cases, including cases whose mailer replies do not indicate a need for a full medical CDR. Cessation rates for these sample cases are typically 0.8% for cases that do not indicate a need for a full medical CDR compared to 3.8% for cases that do.

EXECUTIVE SUMMARY

The Social Security Advisory Board (SSAB) appointed this independent Panel to review the Social Security Administration's (SSA's) Continuing Disability Review (CDR) process, including the Medical Improvement Review Standard (MIRS) that must be applied in conducting CDRs.[1]

In general, the Panel found the CDR an effective tool for enhancing OASDI and Supplemental Security Income (SSI) program integrity. CDRs not only identify beneficiaries who no longer meet program eligibility criteria but also raise awareness of SSA oversight. CDRs are highly cost-effective, providing an estimated nine to one payback ratio of benefit savings to administrative costs over 10 years. This favorable ratio results in part from SSA's use of statistical profiling and CDR mailers that focus full medical reviews on those cases where it considers medical improvement most likely.

While generally giving the CDR process high marks for fulfilling its core function, the Panel also notes that CDRs are a less useful and appropriate tool for addressing other dimensions of program integrity. Alternative tools include quality control, pre-effectuation reviews, focused reviews, and Cooperative Disability Investigation (CDI) anti-fraud units. Getting the disability determination right the first time is considerably more efficient and equitable than relying on CDRs for subsequent error correction.

Based on its analysis, the Panel formulated recommendations to Congress, SSA, and the SSAB in five issue areas: 1) the funding of CDRs, 2) MIRS, 3) CDRs in relation to SSA's other payment integrity efforts, 4) the integration of CDRs with support for return to work, and 5) CDRs issues specific to SSI children and youth.

PROVIDE CONTINUING DISABILITY REVIEW (CDR) FUNDING THAT IS ADEQUATE, PREDICTABLE, AND SUSTAINED

Among the most pressing CDR issues today is the lack of funding to carry out the reviews. As a result of inadequate appropriations by Congress, the agency has a backlog of over 1.3 million overdue CDRs. This backlog prevents SSA from taking timely action to discontinue payments to beneficiaries who are no longer eligible, thus causing misuse of program resources. It also harms beneficiaries by delaying return to work efforts, which become progressively more difficult with time. Failure to perform CDRs may also create a misimpression that eligibility is permanent, regardless of disability status. Ultimately, the backlog places SSA out of compliance with the Social Security Act, which threatens public support.

For all these reasons, the Panel urges Congress to provide the funding needed to eliminate the CDR backlog in the near-term and prevent its recurrence. One scenario calculated by the SSA actuaries that meets these criteria would eliminate the backlog by 2018 and enable SSA to remain current through 2023.[2] The administrative cost is $1.1–$1.3 billion per year. If initiated in 2014 as assumed, and sustained through 2023, the net federal benefit savings over fiscal years 2014 through 2023 would be $42.8 billion.

To ensure that these savings are realized and that CDR backlogs do not recur, CDR funding should be provided exclusively through a mandatory spending account. Since new hires need extensive training and

[1] While SSA also conducts CDRs based on evidence of work, the Panel was charged only with reviewing medical CDRs.
[2] See section *Provide CDR funding that is adequate, predictable, and sustained* for further discussion of this topic.

mentoring before they are able to contribute fully to processing the CDR workload,[3] funds credited to this account should be available for a period of at least two years.

RETAIN THE MEDICAL IMPROVEMENT REVIEW STANDARD (MIRS) AND STRENGTHEN ITS IMPLEMENTATION

SSA cannot terminate disability benefits unless it first finds substantial evidence of improvement in the individual's impairment(s) enabling him/her to engage in substantial employment. The 1984 law that established MIRS also provides eight exceptions to the requirement to show medical improvement, including exceptions for cases involving fraud, failure to cooperate, and errors on the face of the record of the original allowance.

Congress enacted MIRS in response to widespread dissatisfaction with the Administration's use of CDRs to terminate large numbers of Disability Insurance (DI) and Supplemental Security Income (SSI) beneficiaries in the early 1980s. These terminations caused severe hardship and shook public confidence in the agency. Congress enacted MIRS unanimously to end the crisis and reestablish the integrity of the disability program.

The Panel strongly supports MIRS, and believes that it provides an essential guarantee of fairness in the DI and SSI programs. Under MIRS, a person's benefits cannot be ceased to reflect updates in SSA disability criteria, nor can adjudicators who perform CDRs substitute their own judgment for that of the original decision maker. These restrictions make it more difficult for SSA to terminate eligibility than to continue it. This protection is the core of the MIRS statute.

SSA's use of MIRS exceptions is more difficult to assess. We found that disability examiners report insufficient training in this area, and that SSA coding errors make it difficult to understand CDR adjudicators' relative use of different exceptions. A small, nonrandom sample of cases suggests that benefit cessations based on some exceptions are reversed at high rates on appeal.

The Panel thus recommends that SSA evaluate the use of MIRS exceptions nationwide. On this basis, it should provide any needed clarification or revision to the regulations. The agency should also provide disability adjudicators with additional guidance on their use and include this guidance in core training, which should be the same for all adjudicators. The Panel further recommends that SSA establish a formal process by which adjudicators can clarify the use of exceptions. The Panel offers these recommendations to clarify the current use of exceptions and sharpen adjudicators' ability to use the legislated exceptions in the limited number of cases in which such use would be appropriate.

STRENGTHEN OTHER PAYMENT INTEGRITY TOOLS

As noted, CDRs are one element in a complex system for determining disability. As the components of this system interact, other SSA program integrity efforts influence CDRs and vice versa. One part of the Panel's analysis, therefore, focused on the role of CDRs in a broader organizational context.

SSA's two most relevant complementary programs are the SSA Appeals Council's (AC) quality reviews and efforts by Cooperative Disability Investigation (CDI) units to combat fraud. Both initiatives have the potential

[3] State disability examiners who conduct medical CDRs generally receive 3-6 months of in-class training and achieve journeymen status after 2 years in the position, according to National Association of Disability Examiners (NADE) and other state Disability Determination Service (DDS) experts consulted during the writing of this report.

to boost the accuracy of disability awards, which, as noted earlier, should be the centerpiece of efforts to enhance program integrity.

The AC uses the results of its quality reviews to promote the policy compliance of both Administrative Law Judge (ALJ) and Disability Determination Services (DDS) examiners. The AC's main approach is to provide targeted, individual feedback and training. For ALJs, this training consists of modules focusing on specific issues where focused reviews show that a judge's decisions do not comply with law or regulation. As revealed by the AC focused reviews, feedback for DDSs focuses primarily on initial benefit denials that were not policy compliant. In both cases, feedback increases decision makers' adherence to law and regulations and helps to improve the documentation used in the conduct of CDRs.

CDIs units coordinate efforts of the Office of the Inspector General (OIG), SSA field operations, and local law enforcement agents to assist state disability examiners who suspect fraud in disability claims. Their effectiveness is evident in a return of $16 in reduced payments per $1 in administrative expenditures (2013).

The Panel strongly supports the work of the AC and CDI units, and urges SSA to expand these other efforts and Congress to support them. These efforts help to ensure the policy compliance of disability decisions and reduce the need to correct errors after the fact.

STRENGTHEN LINKS BETWEEN CDRS AND SUPPORT FOR RETURN TO WORK

In principle, DI and SSI beneficiaries whose disability status is terminated after a CDR should be capable of returning to gainful employment and, facing loss of benefits, should be highly motivated to do so. Yet evidence shows that prolonged detachment from the workforce results in significant loss of capacity, whether or not a person is disabled. To help this group return to work, the Panel recommends that Congress extend the employment support services of Ticket to Work for one year beyond benefit cessation so that either state Vocational Rehabilitation or Employment Network services will be available.

The Panel also recommends that SSA target more intensive services supporting return to work for beneficiaries classified as "Medical Improvement Expected" (MIE), coupling these efforts with explicit expectations for improvement.

CDRS FOR SUPPLEMENTAL SECURITY INCOME (SSI) CHILDREN AND YOUTH

Finally, the Panel recognizes that the CDR process has a profound impact on children receiving SSI. In fact, CDR cessation rates for those under 18 are close to 20 times greater than they are for adults. While the majority of the Panel's recommendations apply to individuals of all ages receiving disability benefits, we recognize that several key issues specific to SSI children warrant unique consideration.

For example, while adult return-to-work issues are similar for 18-year olds, they are especially critical for the latter, an age in which the individual might consider enrolling in college or beginning a career. For many of these youth, early intervention before the age-18 redetermination[4] could make a crucial difference in whether they obtain self-sufficiency or return to public support.

[4] SSI children's cases are reviewed at age 18 using the adult disability standard. Referred to as age 18 redeterminations, adjudicators treat these cases as new applications for the adult SSI program.

The Panel therefore recasts its recommendations regarding return-to-work for adults to reflect the specific needs of children as follows:

- SSA should communicate expectations of independence to youth beneficiaries whose medical improvement is expected or possible.
- As with the adult population, the Panel recommends that Congress continue the employment support services of the Ticket to Work program for one additional year.
- The training recommended for the medical review standard should be extended to include examples unique to children.

Lastly, the Panel suggests that the SSAB convene future panels on three issues; 1) the lessons of current SSA demonstration projects for redesigning DI and SSI work incentives to make employment more attractive, feasible, and likely; 2) the effectiveness of early action to assist persons with disabilities in obtaining or continuing employment to avoid or delay the need to apply for DI or SSI benefits; and 3) issues pertaining to SSI disability benefits for children, inquiring into the use of benefits by families; the extent to which the receipt of benefits helps children overcome impairments; the risk of developmental setbacks if benefits are terminated; and the social return on SSI investment in children.

INTRODUCTION

Most people have some familiarity with the challenges of coping with a disability, either through personal experience or that of a disabled family member, friend, or colleague. These experiences reveal the burdens that a disability poses and underscore the need for public support. Yet designing public policies to target such support effectively poses complex challenges. This difficulty is especially true for the Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) cash benefit programs. Using a definition of disability based on work capacity, the Social Security Administration (SSA) must adjudicate claims to distinguish those people with impairments who can engage in gainful employment from those who cannot. In reality, the severity of a disability is not dichotomous but continuous, often requiring examiners to exercise professional judgment. In addition, as the future course of some disabilities is difficult to predict, SSA must monitor DI and SSI beneficiaries to determine whether they continue to be eligible. The tool by which SSA performs this latter task, the Continuing Disability Review (CDR), is the focus of this report.

The 2014 Disability Policy Panel was created by the Social Security Advisory Board (SSAB) in the spring of 2014 to consider CDRs carried out by SSA. Specifically, the Board asked the Panel to review the stages and procedures that SSA uses to conduct CDRs and to assess their overall effectiveness and impact. It requested that we focus in particular on medical CDRs and, in that context, examine the 1984 Medical Improvement Review Standard (MIRS) that SSA applies in conducting the reviews. The Panel undertook this review during the period from March through October 2014.

While the Panel's mandate is highly specific, CDRs intersect with a number of broader issues that the Board has addressed in detail in earlier work. As this body of analysis framed our deliberations, we laid out a few of its relevant themes at the outset.

The Board has long highlighted the tensions embedded in the current DI and SSI disability programs, in particular, that between the requirement that claimants prove inability to work on the one hand and the provisions for work incentives on the other. Thus, CDRs are embedded in a context where:

> *… [t]he existing Social Security program attempts to limit eligibility for benefits to those who are so disabled that they are unable do any substantial work and then provides various incentives and services aimed at encouraging work on the part of those who have proven themselves unable to work.*[5]

Recognizing that these tensions arise from the definition of disability in the Social Security Act, the Board has called for new approaches to providing support more in keeping with the Americans with Disabilities Act (ADA):

> *The Board believes that we must find a way to revise the Social Security definition of disability in a way that does not undermine the protections afforded by the last resort programs administered by the Social Security Administration but does support an integrated approach that provides and emphasizes an alternative path – one that is directed at self-support, independence, and contribution that can help those who might, … avoid, delay, or minimize their need for programs of last resort.*[6]

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[5] SSAB, "The Social Security Definition of Disability," 2003, p. 23.
[6] SSAB, "A Disability System for the 21st Century," 2006, p. 1.

In addition, the Board has noted that the relationship between the impairments upon which SSA findings of disability are based and individuals' true work capacity has never been validated. While a disability determination may be compliant with law and regulations, its accuracy in selecting all those, and only those, unable to work remains a critical unknown. As the Board stated:

> *… while existing processes for determining eligibility can and should be substantially strengthened, the fundamental questions remain about whether it is appropriate or feasible to base eligibility on an attempt to equate impairments with inability to work.*[7]

Compounded with the absence of data on subsequent labor force participation of those terminated via medical CDRs, this uncertainty hampers both assessment of their current use and efforts at future design.

Finally, the Board has lamented the difficulty of designing policies to remedy particular operational problems when the sources of those problems are obscured by chronic resource shortages:

> *In a system that has too long operated under the pressures of inadequate resources, it is difficult to sort out the problems that are attributable to administrative limitations from those that are attributable to inadequate policy development.*[8]

The shortfalls in Congressional funding of CDRs in recent years make this dilemma particularly applicable to the Panel's work.

Mindful of these constraints, the Panel discussed the proper depth and scope of our review. CDRs are, after all, a key tool where many of the considerations just mentioned come into play – the relationship between program eligibility criteria and actual ability to work, the need for follow-up to assist those with manageable limitations terminated from the disability rolls, the need for high levels of program integrity to ensure proper use of scarce resources, and the importance of staff training to ensure both consistency and policy compliance with complex laws and even more complex regulations.

Our choice came down to conducting a wide-ranging review of CDRs that would touch many key SSA administrative issues versus a focus on CDRs narrowly defined. Given that ours is the first of a series of panels to address disability issues, we opted for the latter approach. At the same time, recognizing the interactions of CDRs with other dimensions of the disability program, the Panel has offered several suggestions for consideration by subsequent Board-sponsored panels.

In constituting the Panel, the Board selected specialists in disability policy and administrative law; former disability managers; researchers; and practitioners in vocational rehabilitation. This diversity has assured a broad view of our subject. It has also assured that we have not been in perfect agreement on all topics. This diversity, notwithstanding, Panel members are unanimous in supporting the thrust of the recommendations presented in our report.

The Panel held eight day-long meetings in the period from March through October 2014. These sessions were devoted to the consideration of presentations by, and discussion with, representatives from all relevant SSA programs, Congressional staff, the SSA Office of the Inspector General, claimant representatives, and independent researchers.

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[7] SSAB, 2003, as previously cited, p. 17.
[8] Ibid.

The report is organized in three parts. The first part sets out the history and statutory basis for the conduct of CDRs and then describes the process by which SSA conducts the reviews. It offers, as well, statistics on numbers of people affected by CDRs. Part two presents the Panel's findings and recommendations. These relate to CDR funding, MIRS, CDRs in relation to other agency tools for program integrity, and CDRs in relation to return to work. Part three presents suggestions for the work of future Panels. A set of appendices describes our meetings, those individuals and organizations with whom we had discussions, the documents we reviewed, and some additional descriptive and statistical information on the CDR process.

BACKGROUND

HISTORY AND STATUTORY BASIS FOR THE CONDUCT OF CDRS

SSA's statutory mandate to conduct CDRs dates to the Social Security Disability Amendments of 1980 (P.L. 96-265). The law was adopted in a period of awareness of the expanding disability caseloads, rising DI costs, and public discourse characterized by concerns that individuals who were no longer disabled were continuing to receive benefits. Prior to 1980, SSA had carried out reviews at its own initiative of beneficiaries whom it identified as likely to improve medically, for whom its records indicated work, or who self-reported a return to work. The new law (Section 311) required SSA to carry out periodic review on a three-year basis of DI beneficiaries whose disabilities may not be permanent, and of other beneficiaries at its discretion.

Four years later, in 1984, Congress modified the CDR process by establishing a standard of review (later termed the Medical Improvement Review Standard, or MIRS). This standard was a response to widespread dissatisfaction with implementation of the 1980 law. Beginning in 1981, a new Administration had initiated a large-scale program of CDRs using a de novo standard of review that called for reassessment, in some cases using new eligibility criteria stricter than those applied at the time of an individual's disability determination. As a result, many individuals were terminated without having improved medically. In all, by 1984 about 1.2 million beneficiaries were reviewed. Of these 490,000 received termination notices.[9]

The country reacted on many fronts. SSA's appeals process was quickly flooded with cases and twenty organizations filed class action suits challenging the agency's CDR policy. Many beneficiaries who had lost eligibility became homeless, were unable to obtain medical care, or suffered from food insecurity. A number of terminated beneficiaries died, including deaths by suicide.[10] As might be expected, these hardships received wide media attention. Ultimately, roughly one half of the State DDSs refused to follow SSA's CDR guidelines, and courts in ten of the eleven federal districts reversed SSA cessations, ordered SSA to cease conducting CDRs, or instructed it to apply a "medical improvement standard" or "presumption of disability" in performing CDRs.[11]

Between 1982 and 1984, Congress held twenty-seven hearings on CDRs. After passing several ad hoc measures to restrict the Administration's CDR program, Congress took comprehensive action in the Social Security Disability Benefits Reform Act of 1984. The new law (P. L. 98-460) made no change to the 1980 requirement that SSA conduct CDRs; it largely codified court directives requiring a showing of medical improvement before terminating a benefit. Specifically, it required SSA, in order to terminate disability status, to make at least one of following four findings:

- The beneficiary has both improved medically *and* is able to engage in substantial gainful activity.
- He/she has benefitted from advances in medical or vocational therapy or technology, or undergone vocational therapy, *and* is now able to perform SGA.
- Based on new or improved diagnostic techniques, the individual's impairment is found to be not as disabling as previously thought *and* he/she is able to engage in SGA;

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[9] Kearney, John, "Social Security and the "D" in OASDI: The History of a Federal Program Insuring Earnings Against Disability," *Social Security Bulletin*, Volume 66, No. 3, 2005-6, p. 16.
[10] Zelenske, Ethel. "The Important Role of the Medical Improvement Standard Before Termination of Social Security Disability Benefits," *NOSSCR*, July 2014.
[11] Ibid.

- An earlier determination was in error, as demonstrated by evidence on the record or newly obtained evidence related to that determination.

P. L. 98-460 also provided, regardless of this new standard, that benefits can be terminated if the individual is engaging in SGA, the prior determination was fraudulently obtained, the person cannot be located, he/she fails without good cause to cooperate in a CDR, or he/she fails to follow prescribed medical treatment that would be expected to restore work capacity.[12]

The law received unanimous support in both the House and Senate.

While the 1980 law's requirement that SSA perform CDRs applied only to DI beneficiaries, these reviews have been extended progressively to SSI recipients. In 1994, the SSA Commissioner at the time used discretionary authority under Title XVI of the Social Security Act to require disabled adult SSI recipients to undergo CDRs on the same basis as DI beneficiaries. Congress subsequently set quantitative targets for the agency's conduct of SSI CDRs. In 1996, it required CDRs for children who qualify for SSI on the basis of low birth weight, as well as for children with impairments that are expected to improve. The same legislation required SSA to conduct CDRs using adult criteria to redetermine the eligibility of children receiving SSI when they reach age 18.

HOW SSA PERFORMS MEDICAL CDRS

As just described, the Social Security Disability Act Amendments of 1980 (P.L. 96-265) give SSA broad discretion to set the frequency for CDRs. In regulations promulgated pursuant to this Act, SSA has established frequencies ranging from every six months to every seven years. Depending on SSA's assessment of the likelihood that each beneficiary will experience medical improvement, the agency assigns individual review schedules (this discretion does not extend to the two categories just mentioned where Congress has mandated specific CDR schedules: low birth weight babies who must be reviewed within one year of birth and age-18 redeterminations).

SETTING THE DUE DATE FOR PLANNED CDRS (DIARIES)

It is the responsibility of the decision maker at the time of adjudication (typically a state disability examiner or administrative law judge) to assess an individual's potential for medical improvement. Once the decision maker decides to award benefits, he or she must make a "diary" entry into the case record, which consists of a rating and a schedule for periodic review. Under SSA regulations, the rating falls in one of three categories:

- Medical Improvement Expected (MIE)
- Medical Improvement Possible (MIP)
- Medical Improvement Not Expected (MINE)

The first category, *Medical Improvement Expected*, is used for people who have impairments expected to last longer than twelve months (this requirement is part of the statutory definition of disability) but who are considered likely to improve with treatment. In these cases, diary periods are three years or less, as required by law. MIE also includes cases where the beneficiary is undergoing a program of vocational therapy, education, or training that is expected to increase his/her ability to work, in which case the diary period is set

[12] Collins, Katharine and Anne Erfle, "Social Security Disability Benefits Reform Act of 1984: Legislative History and Summary of Provisions." *Social Security Bulletin*, April 1985, Volume 48, No. 4, page 6.

for the end of the program. It includes as well cases where the treatment itself—such as chemotherapy—is considered debilitating but occurs over a limited period.

MIE is the smallest of the three categories. In a cross-section of DI and SSI beneficiaries in July 2013, only 3.7% were rated *Medical Improvement Expected*. In sharp contrast, 57% of DI and SSI beneficiaries were rated *Medical Improvement Possible*, with a diary period of every three years. The percent of SSI-only beneficiaries with this MIP rating --70% -- was higher still. This rating is for cases in which the disability is *not considered permanent*, but where the prognosis for medical improvement cannot be forecast with confidence. The remaining 39% of cases were rated *Medical Improvement Not Expected*. This designation is for disabilities considered to be permanent and the review frequency is set for every 5-7 years.[13]

DETERMINING WHICH CDRS ARE CONDUCTED (PROFILING)

The diary schedules determine which beneficiaries are due for a CDR in a given fiscal year, but in practice the number of beneficiaries who actually receive a CDR is determined by the annual program integrity budget. Over the past decade, inconsistent and insufficient funding for CDRs has meant that not all beneficiaries due for a CDR in a particular year are actually reviewed. As a result, SSA has accumulated a large backlog of overdue CDRs, totaling 1.3 million (see Panel Recommendations for a more in depth discussion of the backlog problem). To target scarce program integrity resources efficiently, SSA uses a statistical profiling method to select those beneficiaries most likely to meet the requirements for cessation. Prior CDRs are used to estimate the parameters of the statistical algorithm for this selection. Other variables used include age, time on the benefit rolls, type of impairment, indication of work, medical diary type, and number of previous CDRs.

Under this method, beneficiaries assigned a probability of medical improvement greater than 4.22% are automatically selected for full medical review, while those assigned medium or low probability, 2.01%-4.21% and 2.00% or less, respectively, may receive a short screening questionnaire or, alternatively, may be omitted from review as a result of CDR funding shortfalls, thus becoming part of the agency's CDR backlog. Those who receive the questionnaire (formally titled the Disability Update Report, but commonly referred to as the "mailer") must provide a self-report on whether their health status has improved; list any recent medical care, employment, or training activity; and report whether their doctors have told them they can work. The mailer does not require them to undergo medical evaluation or submit medical records. If the beneficiary reports improvement or work activity, this information triggers a full medical review (as does failure to return the mailer). But if the beneficiary does not self-report improvement or work activity (and there are no other reasons to suspect improvement), a full medical review is *deferred* and a new diary date is set. The mailer provides considerable budgetary savings: the average cost is $24, compared to $914 for a full CDR.[14]

To test the effectiveness of the mailer process, SSA regularly conducts full medical CDRs on a random sample of cases, including cases whose mailer replies do not indicate a need for a full medical CDR. Cessation rates for these sample cases are typically 0.8% for cases that do not indicate a need for a full medical CDR compared to 3.8% for cases that do.[15] This suggests the profiling process is internally consistent, accurately identifying those who are most likely to be ceased based on past practice. It does not, however, speak to the external validity of the profiling process, as the relation of the components of the profiling formula to beneficiaries' actual capacity to resume work remains undocumented.

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[13] Data provided by SSA.
[14] Ibid.
[15] Ibid. Data based on a cumulative profile sample taken from FY 2004 through FY 2009.

Once the cases selected for review have been assigned either to full medical review or mailer screening, SSA "releases" the former cases to its field offices (FOs), which notify beneficiaries that their case is under review and collect from them the required information and medical records. Once the update is complete, the FO transmits the file to the state DDS office where it is assigned to a disability examiner for formal review.

As noted above, SSA has the authority to defer full medical reviews on the basis of the CDR mailer responses. It also has the authority to do so if the number of state DDS disability examiners available to adjudicate them is inadequate.[16] Deferral due to inadequate staffing is a common occurrence given the uneven and inadequate funding available for CDRs. Since SSA rarely has enough funding to complete all the CDRs that are due, CDRs are prioritized via profiling and CDRs that SSA is not able to complete move into the backlog.

PRIORITY ORDER

The agency's top priority is timely processing of new disability claims, and for the most part, the same examiners who handle new disability claims handle CDRs as well. Next on the agency's priority list are CDRs required by statute to be conducted on a particular schedule: the age-18 redeterminations of SSI children and low birth weight babies. DI adults are the next priority, followed by SSI children and SSI adults.[17] The numbers of full medical CDRs and estimated cessation rates for each of these categories are shown in Tables D-2 through D-4 in Appendix D.

MEDICAL IMPROVEMENT AND EXCEPTIONS

In the actual conduct of CDRs to implement P.L. 98-460, adjudicators are guided by SSA's regulations and the POMs. Under agency regulations, a disability adjudicator must generally find that a beneficiary has improved medically since the time of the last award *and* has the potential to be able to engage in Substantial Gainful Activity (SGA). In order to terminate benefits, the adjudicator must show both that the beneficiary has improved medically in ways relevant to work and that he/she is, in fact, able to work. For childhood CDRs, an adjudicator does not consider work capacity;[18] rather, the adjudicator uses a three-step review process where he or she determines whether there has been medical improvement in the child's impairment since the last determination; and if so, whether it continues to meet, or is functionally equal to, the severity of the medical listing under which the child qualified for benefits. If not, then a new assessment is made as to whether the child is currently disabled.[19]

SSA regulations include two groups of exceptions to the general requirement to demonstrate medical improvement before terminating eligibility. [20]

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[16] The development of proficient new examiners is a lengthy process. As a result of the complexity of the work, the process requires 18-24 months on the job.
[17] It should be noted that as the last two categories are funded from general revenues, their cessation has no effect on the DI Trust Fund.
[18] An Individual Functional Assessment, formerly used in child disability determinations and CDRs, was eliminated in 1996.
[19] POMS DI 28005.021 Title XVI: Determining Continuing Disability at Step 2 of the MIRS Process for Children Under Age 18 – Functional Equivalence.
[20] See Appendix F for the steps the adjudicator follows when conducting a CDR and a flow chart illustrating this process in Appendix G.

1) In the first set, SSA must show that the beneficiary can engage in SGA. There are four such cases:
    - The beneficiary has benefitted from advances in medical or vocational therapy or from technology;
    - The beneficiary has undergone vocational therapy;
    - New or improved diagnostic techniques show the beneficiary's impairment to be less severe than judged at the most recent allowance; and
    - There is an error on the face of the record at the most recent allowance. This error exception can be used only when:
        - substantial evidence shows on its face that the prior favorable decision should not have been made;
        - required and material evidence that was missing at the time of the prior evaluation now becomes available, demonstrating that the individual would not have been found eligible; or
        - new evidence relating to the prior determination refutes conclusions based on the prior evidence and, had the new evidence been considered in the prior decision, the claim would not have been allowed or continued.

    In the absence of one of these three circumstances, the reviewing adjudicator may not substitute his/her judgment for that of the original decision maker.

2) The second group of exceptions allows SSA to terminate eligibility without consideration of either medical improvement or ability to work. There are again four exceptions:
    - The prior allowance was obtained by fraud;
    - The beneficiary fails, without good cause, to cooperate with the CDR;
    - The beneficiary cannot be found; or
    - The beneficiary has failed to follow prescribed treatment that would be expected to restore ability to engage in SGA.

Importantly, MIRS does not apply to age-18 redeterminations for SSI children; rather, the adjudicator treats these cases as new applications for the adult SSI program.

When disability adjudicators are in doubt about the application of an exception to a particular case, the agency directs the adjudicator to resolve doubts in favor of the beneficiary: "Do not apply any exception to medical improvement if the file raises reasonable doubt on the part of the current decision maker as to whether it applies."[21]

In practice, SSA's use of MIRS exceptions is difficult to assess. Disability examiners report lack of training and institutional support for their use.[22] SSA coding errors make it difficult to understand CDR adjudicators' relative use of different exceptions. The use of exceptions varies significantly from state to state. A small, non-random sample of cases indicates that benefit cessations based on some exceptions are reversed at high rates on appeal. Panel recommendations to cast light on the use of exceptions and ensure compliance with law and regulation are provided in the section Retain the Medical Improvement Review Standard (MIRS) and strengthen its implementation.

[21] POMS DI 28020.001 C 2
[22] NADE "CDRs and MIRS", presentation to the Panel, July 14, 2014.

DISTRIBUTION OF MEDICAL CDRS ACTUALLY COMPLETED

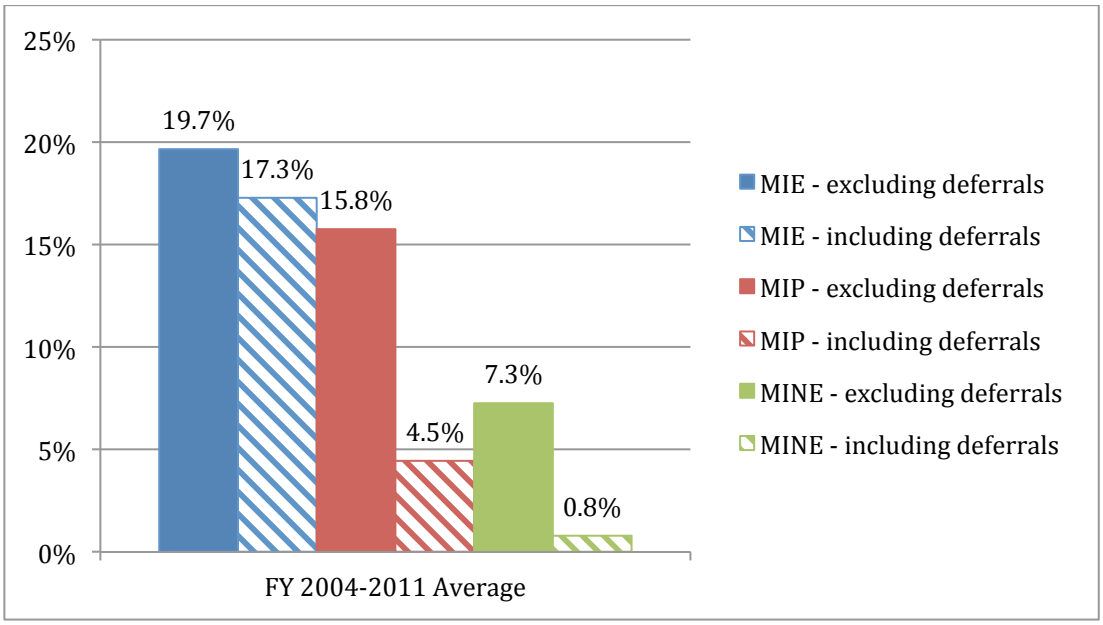
Of the three medical improvement categories, the percentage of those beneficiaries designated MIE (Medical Improvement Expected) who undergo a full medical CDR is considerably greater than the corresponding percentages drawn from the other two categories.

For all CDRs (including CDR mailers), ultimate benefit cessations are estimated to be 6% in 2012. Medically targeted, full CDRs resulted in a 27% initial cessation rate (before appeal) and an estimated 17% following appeal. Cessation rates vary widely across programs and by age. Among adults who received any CDR (mailer or full medical) in 2012, estimated final cessation rates were 1.5% for DI and 1% for SSI adult caseloads. Among those who received a full medical review, estimated final cessation rates were about 7% for DI adults and roughly 6% for SSI adults. For children, who do not receive mailers, estimated cessations were around 42% for age-18 redeterminations, 53% for low birth weight babies, and 26% for other SSI children.[23]

Figure 1 presents average ultimate cessation rates from fiscal year 2004 through 2011 for the MIE, MIP and MINE diary categories, both with and without deferrals resulting from use of the mailer.[24] As previously explained, deferral implies that a review of the beneficiary's answers on a mailed questionnaire did not give any indication of medical improvement that could result in work so a full medical review was deferred for a specified time period. The cessation rates based on full medical CDRs are consistent with the three classifications; that is, highest among MIEs and lowest among MINEs with MIPs falling in the middle range. When deferrals based on mailers are included, the pattern is even more pronounced. The similarity of the ultimate cessation rates with and without deferrals of the MIE category illustrates that this diary categorization alone is a sufficient predictor of the probability of cessation. The much larger differences in ultimate cessation rates for the MIP and MINE diaries demonstrates the effectiveness of the profiling system. The panel finds convincing evidence of the power of the profiling system for prioritizing cases for CDRs when funding is insufficient for reviewing all cases due for review.

[23] SSA, "FY 2012 Annual Report on Continuing Disability Reviews."
[24] Ultimate cessation rates for each of these years can be found in Table D-1 in Appendix D.

Figure 1. Average Ultimate Cessation Rates by Medical Improvement Category, FY 2004-2011



Source: Data provided by SSA

PANEL RECOMMENDATIONS

PROVIDE CDR FUNDING THAT IS ADEQUATE, PREDICTABLE, AND SUSTAINED

Among the most pressing problems identified in this report is SSA's inability to perform CDRs that are required by law. Available evidence indicates that the great majority of beneficiaries have permanent disabilities and that reviews will sustain their eligibility. However, the agency's backlog of over 1.3 million medical CDRs prevents it from taking timely action to discontinue benefit payments to the small portion of individuals who have improved medically and no longer meet program requirements. The savings lost as a result of the backlog are modest in relation to overall DI and SSI program costs but still significant in dollar terms.[25]

Beyond cost, the CDR backlog creates difficulties for beneficiaries since return to work becomes progressively more difficult with the passage of time.[26] In addition, the CDR backlog causes a gap in SSA oversight of the DI and SSI programs that may result in a decrease in voluntary reporting of medical improvement by beneficiaries. Ultimately, it places the agency out of compliance with statutory requirements for DI and SSI administration. For these reasons, the backlog has the potential to erode public support for SSA and SSI disability programs.

The roots of the current backlog reach back to 2003, when an assured stream of funding for CDRs expired. The authorization, in the Contract with America Advancement Act of 1996, appropriated funds for the conduct of CDRs over a seven-year period. In the decade since 2003, Congress has consistently appropriated less than needed to perform all CDRs that are due. As a result, the number of annual CDRs fell on average by roughly one half, thus creating a substantial backlog with respect to what the law and regulation require. Over this period, the well-documented increase in Social Security applications has further inflated the backlog, as the Agency, faced with necessary trade-offs imposed by limited funding, made the processing of new claims the priority while deferring large numbers of required CDRs.[27] In recent years, the backlog has grown further as a result of staff reductions in the DDSs, where CDRs are performed.[28]

In 2011, the Budget Control Act (BCA) authorized additional funding outside the BCA spending caps with the aim of eliminating the CDR backlog over a ten-year period.[29] In so doing, Congress acknowledged the substantial and proven savings over time that result from CDRs. For example, in FY 2013, SSA estimated savings of $9 for every dollar spent on CDRs over a 10-year period.[30] However, in only one of the following three years since the BCA (FY 2014) did Congress appropriate the full amount needed to capture the available

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[25] "Payments of $556 million could have been avoided during 2011 had all CDRs been conducted on time." OIG testimony, Committee on Oversight and Government Reform, November 19, 2013. By comparison, DI and SSI benefit payments total approximately $185 billion. Incorrect payments are thus well under 0.5% of all DI and SSI payments.

[26] The separation from active participation in the labor force is also a problem associated with the lengthy appeals process. For example, the average wait time for hearing requests in FY 2013 was 382 days.

[27] Many people with disabilities that satisfy SSA eligibility criteria prefer work to benefit receipt, but in difficult economic times this group is among the first to lose employment. Therefore, economic downturns are typically associated with an increase in the number of DI and SSI claims filed.

[28] Specifically, claims receipts rose by 15% following the Great Recession, while DDS staff reductions were in the range of 10-15% both before and after the economic downturn. NADE testimony, Committee on Oversight and Government Reform, April9, 2014.

[29] It would have also enabled SSA to perform more non-medical redeterminations of SSI eligibility.

[30] SSA's FY 2013 Budget Justification of Estimates for Appropriations Committees. Includes Medicare and Medicaid savings.

savings and to bring the pace of CDRs in line with the 10-year plan to reduce the backlog.[31] With efforts to implement that plan now off schedule, available funds fall well short of redressing depleted DDS staffing levels.[32]

Furthermore, as the DDSs need to recruit and train additional staff in order to increase the number of CDRs performed, SSA requires considerable lead-time to gear up.[33] Combined with the uncertainties of the annual appropriations process, this time requirement makes it difficult for the agency to utilize a significant increase in CDR funding within a single fiscal year.[34]

Together, these problems point to the need for a CDR funding source that is adequate, predictable, and sustained beyond the annual budget cycle. The Panel offers the following proposals for meeting these three criteria.

Congress should provide adequate CDR funding

We define adequacy as a funding level that enables SSA to comply with the requirements of the Social Security Act, that is, to reduce the CDR backlog in the near term such that all medical CDRs are processed in a timely manner after they come due, and to continue this timely processing in the longer term. One promising scenario modeled by SSA estimated the net Federal benefit savings to be realized by attaining currency on the processing of all medical CDRs by 2018 and enabling SSA to remain current on CDRs until 2023.[35] This scenario envisioned a funding level of $1.1-1.3 billion per year during 2015-2023, with benefit savings per administrative dollar spent of approximately $12 to $1 in 2015, declining to $8 to $1 in 2023. If the funding had been provided based on the scenario conceptualized by SSA, the net Federal benefit reductions over fiscal years 2014-2023 would have been an estimated $42.8 billion (with further savings in future years), with an estimated cost of $11.8 billion in administrative expenses (2014-2023).[36]

Some close observers have expressed reservations about this approach, pointing out that reducing the backlog would result in a progressive reduction of benefit savings in relation to administrative dollars spent on reviews – i.e., a diminishing "return on investment" for CDRs. While the Panel recognizes this reality, we note that the investment returns – even after full elimination of the backlog – are still substantial: more than $8 in lifetime benefit savings per $1 of administrative spending, as shown above. Beyond the net Federal program savings, the Panel also believes that conducting CDRs is necessary for assuring DI and SSI program integrity and compliance with the requirements of the Act.

[31] For FY 2012, the BCA full authorization would have enabled SSA to perform 569,000 medical CDRs called for by the BCA, but Congressional appropriations provided funding for just 443,000. SSA estimated the lost benefit savings as $800 million in FY 2012-22.
[32] NADE as previously cited in footnote 28.
[33] NADE and others, as previously cited in Footnote 3.
[34] NADE, as previously cited in footnote 28.
[35] Scenario also assumed that average costs associated with processing CDRs were consistent with projected growth in inflation, as measured by the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). Estimates provided by Stephen Goss and Michael Stephens, SSA Office of the Chief Actuary. The associated Medicare and Medicaid program effects were estimated by the Office of the Actuary at the Centers for Medicare and Medicaid Services. SSA's Office of Budget estimated the administrative costs for this scenario.
[36] For historical estimated returns on investment by beneficiary type, see Chart D-3 in Appendix D.

Congress should provide predictable CDR funding

The second criterion – predictability – can be achieved by creating a mandatory funding stream for CDRs, available to SSA without need of annual appropriation. Without earmarked funding, SSA uses its limited resources to meet its most pressing operational needs. When the number of claims filed is climbing, the level of resources available for program integrity may become inadequate. One variation on this approach is embodied in the Administration's FY 2015 budget, which would establish a "Program Integrity Administrative Expenses" account beginning in FY 2016 with mandatory funding for both CDRs and SSI non-medical redeterminations of eligibility. A similar approach, House Resolution 4090 introduced by Representative Xavier Becerra, would establish a mandatory spending account available for CDRs and a number of other activities to ensure DI and SSI integrity.[37]

Congress should provide sustained CDR funding

The third criterion – sustainability – calls for funding on a multi-year basis. This need is a reflection of the intricacies of the federal-state partnership in the conduct of CDRs: SSA funds the DDSs, which must then obtain state authorization to hire new staff, recruit them, and train them. This means that, despite SSA's best efforts, some CDR funding may still be in the budget pipeline when a fiscal year closes. Thus, the Panel recommends that funds credited to a mandatory spending account for CDRs be available to SSA for a minimum of two years.

While the Panel sees a mandatory CDR account designed along these lines as the optimal solution to the backlog, it is not the only approach. The SSA Office of the Inspector General (IG) has recommended an alternative. The IG suggests making available to SSA a percentage of the benefit savings resulting from CDR terminations. The IG has suggested 25 percent, with 20 percent for SSA and 5 percent to the IG's own work on CDRs.[38] This approach has the advantage of converting benefit savings to administrative resources, thus moving funds across budget lines that are generally not interchangeable.

However, the proposal also has two downsides. First, as the amounts available would depend on the SSA's past volume of CDRs, it risks a mismatch between current CDR resources and current needs. Second, and more seriously, it would provide the agency with additional administrative revenues for benefit cessations. While the Panel considers it unlikely that SSA would terminate disabled benefit recipients in order to maximize CDR income, such perverse incentives should nevertheless be avoided.

Public trust in Social Security is a crucial form of social capital; its presence strengthens the program while its absence weakens it. The CDR backlog is a barrier to such trust. Given the budgetary savings from CDRs, the backlog is also a barrier that is easily remedied. For both reasons, the Panel urges Congressional action in line with the criteria just presented.

[37] The account created by H.R. 4090 would be available for CDRs, SSI redeterminations, CDI units, pre- and post-payment reviews, and SSA's new "focus reviews" of appeal offices. It would provide $1.75 billion in FY 2015, $1.8 billion during 2016-2020, adjusted thereafter for inflation.
[38] OIG, as previously cited, 19 November 2013.

RETAIN THE MEDICAL IMPROVEMENT REVIEW STANDARD (MIRS) AND STRENGTHEN ITS IMPLEMENTATION

In its charter to the Panel, the SSAB asked that we review the Medical Improvement Review Standard (MIRS) that shapes and constrains SSA's conduct of CDRs. Our review focused on the circumstances of MIRS enactment, the SSA regulations implementing the 1984 law, and disability adjudicators' use of MIRS and its exceptions. We also discussed recent public discourse on MIRS.

The Panel strongly supports MIRS

The Panel believes that MIRS provides an essential guarantee of fairness in the DI and SSI programs. MIRS prevents a person's benefits from being ceased to reflect updates in SSA disability criteria, and it bars disability adjudicators from substituting their judgment for that of the original adjudicator. These restrictions make it more difficult for SSA to terminate eligibility than to continue it. This protection is the core of the MIRS statute.

Concerns that MIRS makes it more difficult to terminate benefits that were granted in error have been noted. The MIRS statute anticipates these concerns by providing an exception for allowances in which there was an error on the face of the evidence (see earlier section on Medical Improvement and Exceptions for a more complete discussion of exceptions and current issues with their implementation).

The Panel is also aware that, when original allowances are not clearly explained, disability adjudicators find it more difficult to establish a baseline against which to measure medical improvement, as required by MIRS. Here the Panel sees the appropriate solution not in MIRS but in improving the quality of disability determinations (see next section).

The Panel, however, found it difficult to quantify the magnitude of MIRS' impact. A May 2014 OIG assessment concluded that, if MIRS did not exist, the number of CDR cessations would be increased, roughly, by just 4,000 – above and beyond the medical CDR cessations of approximately 115,000 annually in recent years.[39] At the same time, they contrast with much higher rates of CDR cessations that occurred in the early 1980s, when MIRS did not exist.[40] The Panel thus urges the OIG to repeat its investigation using a large sample of cases and, if the results are similar, to analyze factors that account for MIRS' seemingly limited impact today compared with the large-scale CDR cessations that gave rise to its enactment in 1984.

With respect to MIRS exceptions, the Panel recommends that SSA take three actions to cast light on current practice and ensure that they are used in accordance with law and regulation:

Evaluate the use of MIRS exceptions nationwide

SSA should review the use of MIRS exceptions as a basis for CDR benefit cessations nationwide and issue a report evaluating current use. Such an evaluation will reveal the need for any regulatory changes, as well as the types of sub-regulatory clarifications that disability adjudicators may need to use the exceptions in

[39] OIG Audit Report, "The Medical Improvement Review Standard During Continuing Disability Reviews," A-01-13-23065, May 2014, p. 4. The 4,000 cases estimated by the OIG would represent an increase of less than 3.5% in potential cessations.
[40] As noted earlier, 450,000 beneficiaries received termination notices within a period of months.

accordance with the law and regulations. We are aware that SSA has already begun this evaluation and is planning to issue a report in the spring of 2015.

- ✓ The Panel urges SSAB to follow this work closely, including a review of its methodology and oversight of SSA's use of the report.

Train all disability adjudicators on the MIRS exceptions

SSA should use the results of its evaluation to update its training of disability adjudicators on the MIRS exceptions.[41] It is of critical importance that all adjudicators receive the same training. Training should clarify key concepts in SSA regulations, including fraud and similar fault, failure to follow treatment, significant medical improvement, and the prohibition against substitution of judgment by disability adjudicators. SSA should also develop training tools similar to those used for the ALJs for providing individualized feedback to adjudicators.

To be effective, training must target not only examiners and ALJs – the adjudicators themselves – but also the DDS management that provides guidance to examiners and the quality assurance reviewers who audit examiner and ALJ decisions.

The Panel also notes that, while training is of high importance, its success depends on other factors. So long as disability adjudicators work under high stress because of unmanageable caseloads, and so long as they face different rates of review, depending on whether they allow or cease a case, they will face incentives to make short-cuts on CDRs that training alone may not overcome. Thus, other recommendations in this report – i.e., on CDR funding, overall program integrity funding, and more equal rates of review for allowances and denials – are essential complements to the training recommendations offered here.

Establish a 'MIRS exception desk'

SSA should establish a formal process by which disability adjudicators can obtain clarification on the application of the MIRS with respect to particular CDRs. This unit would primarily serve the DDSs that deal with the majority of CDR cases, but should also be available to reconsideration-level Hearing Officers and ALJs in a manner consistent with the requirements of the Administrative Procedure Act.[42] The existing Request for Program Consultation (RPC) process, instituted by SSA in 2006, provides a useful model.[43] The MIRS desk should also gather comprehensive data to help identify the needs for further policy clarifications and training, as well as develop national data on trends in the use of exceptions and the types of issues raised.

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[41] From the time this panel started to the writing of this report, SSA has informed us that it has made training available to all disability adjudicators on coding exceptions, evaluating medical improvement, relating medical improvement to the ability to work, how to consider error, and the use of the exceptions of 'failure to cooperate' and 'whereabouts unknown'.

[42] The separation of functions provisions of the Administrative Procedure Act, 5 U.S.C. § 554(d), prohibit an ALJ or other person presiding at a hearing, from consulting with any person inside or outside of the agency concerning a fact issue. Additionally, an agency staff member who has engaged in an adversary function in a case--such as the functions of prosecution, investigation, or advocacy--may not participate or advise in an adjudicatory decision in that case or a factually related adjudication. These provisions do not prohibit an ALJ from receiving advice on law or policy from agency staff members not disqualified by other participation in the particular matter. See, Michael Asimow and Ronald M. Levin, State and Federal Administrative Law 133 (4th ed. 2014).

[43] Located within the Office of Disability Policy, the RPC panel reviews and resolves disagreements between DDSs and SSA quality reviewers. The panel includes representatives from the disability policy component, the operational component representing the DDSs, and the quality review component, as well as DDS and quality reviewers from the front lines. See Arthur R. Spencer, SSA Associate Commissioner for Disability Programs, Statement for the Record, Committee on Ways and Means, Subcommittee on Social Security, March 20, 2013.

Representation in this unit should include ODAR and the ALJ corps since a number of the issues will involve prior decisions by ALJs. Proper staffing and resources are essential to allow timely reviews and feedback on the cases presented for clarification.[44]

The Panel offers these recommendations to cast light on SSA practice and sharpen examiners' understanding. It does not expect that they will have a large impact on the use of MIRS exceptions, which, by design, apply to a limited number of cases.

STRENGTHEN OTHER PAYMENT INTEGRITY TOOLS

CDRs are one tool in the SSA toolkit for ensuring the integrity of its disability programs. As the contents of the toolkit interact, other agency efforts influence the need for, and impact of CDRs, and vice versa. One part of the Panel's analysis, therefore, focused on CDRs in a broader organizational context.

As shown in Table 1 below, the menu of SSA program integrity tools includes three general groups. The first focuses far upstream in the disability determination process, giving adjudicators information and knowledge to formulate policy-compliant decisions. A second group of tools ensures that disability allowances are policy-compliant and well documented before benefits are paid. The third group, which includes CDRs, is aimed at ensuring that current beneficiaries continue to meet program eligibility criteria.

Table 1. SSA's Major Tools to Monitor Medical Decisions[45]

I. *Improve disability decisions*	
Focused Reviews (Appeals Council)	Results used for policy clarification, targeted training, and feedback
CDI Units	Specialized units that can conduct an investigation when a decision maker is suspicious of a claimant's allegations
II. *Review of decisions (pre-effectuation)*	
Quality Assurance Reviews (OQR)*	Reviews the quality of DDS decisions – 70 favorable decisions and 70 unfavorable from all DDSs on a quarterly basis resulting in a statistically valid sample
Pre-Effectuation Reviews (OQR)	Targeted review to insure integrity– 50% of all SSDI and SSI adult favorable DDS decisions
Targeted Denial Review	Targeted integrity review to insure integrity – DDS unfavorable decisions – 1% of all denials in FY 2014 (the number varies by year depending upon resources)
Own Motion Reviews (Appeals Council)	Based on random and selective sampling and referrals from other SSA components - within 60 days of final action
III. *Review of current payments (post-effectuation)*	
CDRs	To determine whether the beneficiary continues to medically qualify
Focused Reviews (Appeals Council)	Reopenings and redeterminations to conform agency actions and address technical problems that prevent implementation of SSA decisions (primarily for new and material evidence or error on the face of the evidence)

*OQR = Office of Quality Review

[44] SSA has informed us that it has promoted the use of an already existing online tool for adjudicators to use if they have questions on the use of the exceptions to which staff policy analysts can respond. The tool allows for tracking of trends and will help identify future training needs.

[45] Since the Panel's work focuses on medical reviews, other tools such as SSI redeterminations and work CDRs have not been included in this table.

Given the range of available options, it makes sense to choose those tools for particular purposes whose characteristics are well suited to what needs to be done. Looked at this way, the Panel asks, for what purposes are CDRs best suited, and for which ones are they less well adapted?

The Panel finds that CDRs are both efficient and equitable in achieving their primary purpose, determining whether disability, as defined in a benefit allowance, still exists.

In terms of efficiency, the Panel believes that SSA's profiling and mailers work well in targeting full medical CDRs on those beneficiaries most likely to meet criteria for cessation. In terms of equity, MIRS prevents disability adjudicators from terminating benefits in the absence of documented medical improvement. Beneficiaries are thus protected from arbitrary losses of eligibility resulting from a disability adjudicator's substitution of his/her own judgment for that of the original examiner.

CDRs can also be helpful in identifying possible fraud and similar circumstances.[46] However, this is a marginal function, since the timing of CDRs (based on likelihood of medical improvement) is not well suited for prompt detection of fraud, nor does the prospective application of CDR decisions allow SSA to recoup past payments. Here CDI units and redeterminations are the tools of choice.[47]

CDRs are also ill-suited for correcting improper allowances. They are mismatched to this task, first, because MIRS precludes benefit cessations in the absence of medical improvement (unless SSA can show an error on the face of the record). But even if a CDR cessation were possible, the desirability of this approach is open to question. These are likely beneficiaries who represented themselves honestly in applying for DI or SSI, were found disabled by SSA, and have been on the rolls for some years. Many will have since become sufficiently disabled to satisfy SSA disability criteria, have reached retirement age, or have died.[48] Many will have also lost work skills and most will have lost their footing in the labor market.

SSA should expand, and Congress should support, the most promising tools for avoiding errors in allowances, those that help ensure policy compliance of disability decisions in the first place.

These are the tools shown in groups I and II in Table 1 above: pre-effectuation reviews, own motion reviews, targeting training based on the results of focused reviews, and fraud detection by CDI units – all of which are aimed at ensuring policy compliance of disability decisions. In particular,

- *The Appeals Council (AC)* – On its own motion, the AC conducts quality reviews of ALJ appeal decisions, based on random and selective sampling and referrals from other SSA components.[49] AC quality reviews must be initiated within 60 days of a hearing decision. For allowances, payments are deferred pending the results of the review.

  The AC also reviews effectuated claims to identify the need for training or policy clarification. Through focused reviews, the AC can examine any appeal decision or a set of cases concerning any adjudicative issue. For ALJs, training consists of modules focusing on specific issues where focused reviews find that a

[46] OIG. "The Social Security Administration's Ability to Prevent and Detect Fraud." September 2014.
[47] Redetermination here refers to the authority provided in sections 205(u) and 1631(e) of the Social Security Act, not to the annual reevaluation of technical eligibility for SSI beneficiaries, which also bears this title.
[48] SSA Appeals Council, "CDRs and Other Authorities for Reviewing Disability Determinations and Decisions: A Presentation to the Disability Policy Panel," September 5, 2014.
[49] By regulation, the AC may not target individual ALJs or hearing offices, a restriction aimed at protecting ALJs' independence in deciding individual cases. The AC uses data analytics to identify agency-wide patterns of errors in determining its choice for focused reviews.

judge's decisions do not comply with the law or regulations. Importantly, the feedback is provided only as training, not as a directive on how to adjudicate individual claims. This process is in place now and the Panel fully supports continuing this important feedback that promotes full compliance with SSA disability policy.

Recently, the Appeals Council has begun capturing some data about the quality of DDS decisions in its random sample of cases that are reversed at the hearing level. In addition, through focused reviews it has begun identifying specific quality problems in DDS determinations. The AC is providing both types of information to the Office of Disability Determinations, which oversees the DDSs. This feedback has the potential to help the DDSs "get it right the first time," thus paying benefits to entitled claimants sooner and eliminating the need for appeal. The Panel supports the full implementation of this initiative provided that resulting directives are vetted with other SSA components responsible for policy interpretation and development because there must clearly be only 'one' policy interpretation for all disability policy.

- *CDI units* – These units aim at identifying fraud at the front end of the disability determination process. Established jointly by SSA and the OIG in conjunction with DDSs and state or local law enforcement agencies, CDI units receive referrals of claims that DDSs or SSA workers identify as suspicious. Where CDI units believe warranted, they gather information to help the examiner make a more informed decision. These units have proven highly effective, contributing to $340 million in projected savings in SSA disability programs in FY 2013 and more than $2.8 billion since their inception in 1997.[50]

By increasing the policy compliance of the initial determinations, these tools reduce pressures to use CDRs for purposes for which they are not well suited. Moreover, it is far more efficient and humane to get it right the first time than to rely on post-effectuation strategies for program integrity.

The Panel does not believe, however, that SSA's current allocation of tasks among program integrity tools is optimal. With Congressional cuts of $1 billion annually in SSA's administrative budget during the three years prior to 2014, the AC's rate of own motion reviews of appeal decisions falls far below that of pre-effectuation reviews of DDS allowances (where a 50% review rate is required by law). The rate of quality review of DDS denials is tiny, just over 1%.[51] With unequal review of allowances and denials, many examiners reportedly provide more rigorous documentation for the more frequently reviewed type of decision – for DDSs, this is allowances and for ALJs, it is denials of appeals.[52] Weakly supported denials can be unfair to claimants and fuel rates of appeal to subsequent levels, creating backlogs in the disability determination process. Weakly supported allowances can be a source of improper payments and are especially problematic for disability adjudicators during the CDR process, due to the need for a clear baseline against which to measure medical improvement.

Cuts in SSA's administrative budget have also forced the agency to trade off program integrity against its core mission of income support. Faced with work backlogs, DDS examiners may have little incentive to gather the extensive documentation required to support a MIRS exception for a CDR termination.[53] Facing staffing

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[50] OIG Fraud Report, as previously cited, September 2014, p. 13.
[51] As noted, the Office of Quality Review also selects 70 favorable and unfavorable medical determinations made by each state DDS per calendar year. For FY 2012, there were a total of 33,940 initial decision reviews and 7,084 reviews of reconsiderations, about equally divided between allowances and denials.
[52] NADE, as previously cited, April 9, 2014.
[53] NADE, as previously cited, April 9, 2014.

shortfalls, DDSs are nevertheless transferring skilled examiners to CDI units, diminishing the DDS's capacities for both processing new claims and performing CDRs.

SSA needs full and predictable funding for program integrity as a whole.

The approach recommended earlier for CDRs, a mandatory spending account, can be applied to SSA's program integrity budget in its entirety. For example, as stated previously, H.R. 4090 provides mandatory funding not only for CDRs but also for CDI units, prepayment reviews of allowances by DDSs and ALJs, and recoupment of overpayments.

The Panel recommends that the Board consider the best strategy by which SSA can conduct quality reviews to equalize the probability of detecting errors at each stage in the disability determination process, including both erroneous awards and erroneous denials. A balanced quality review process that detects both erroneous awards and erroneous denials at all levels of adjudication is of critical importance; it reduces any unintended role the process might have in creating incentives to deny or allow the more ambiguous cases.

- ✓ The Panel is aware that quality review is high on the SSAB's agenda and urges a future Panel to investigate the feasibility of this option.

STRENGTHEN LINKS BETWEEN CDRS AND SUPPORT FOR RETURN TO WORK

Regardless of political persuasion, close observers of the DI and SSI programs agree on the need to reorient these programs toward work. Nearly a decade ago, the SSAB observed that the Social Security Act's definition of disability is inconsistent with the Americans with Disabilities Act (ADA) and called for a new definition that encourages program participants to achieve their full work potential.[54] Think tanks across the political continuum have sponsored research that draws similar conclusions.[55] Over the years, Congress has passed a number of DI and SSI program reforms to encourage beneficiaries to return to gainful employment;

- DI Trial Work Period (TWP) and Extended Period of Eligibility (EPE) that provide continued eligibility for DI beneficiaries who try to re-enter the workforce;
- SSI 1619(a) provision that provides for continued eligibility and receipt of cash benefits while gradually reducing the SSI payment amount when recipients work and increase their earnings;
- SSI 1619(b) provision that continues Medicaid coverage when recipient earnings eliminate cash benefits;
- Plan for Achieving Self Support (PASS) that provides the option to use countable earnings to help achieve an approved work goal without those earnings cause any reduction in the amount of the SSI check; and
- Ticket to Work that affords both SSI and SSDI recipients a choice of rehabilitation providers to help them find and maintain employment.

Yet relatively few beneficiaries respond to these work incentives. One major analysis (2011) shows that only 13% of SSA disability program beneficiaries reported any work in a recent year.[56]

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[54] SSAB, 2006, as previously cited.
[55] For example; Jeffrey Liebman and Jack Smalligan, "An Evidence-Based Path to Disability Insurance Reform," Washington, D.C.: the Brookings Institution, Hamilton Project, February 26, 2013, and Jagadeesh Gokhale, "SSDI Reform: Promoting Gainful Employment while Preserving Economic Security, Washington, D.C.: Cato Institute, No. 762, October 22, 2014.
[56] Livermore, Gina, "Social Security Disability Beneficiaries with Work-Related Goals and Expectations, *Social Security Bulletin*, Volume 71, No. 3, 2011, Table 5.

To encourage higher rates of return to work, Congress has funded SSA demonstration projects to test new approaches.[57] The results of these efforts generally fall short of expectations, underscoring the challenges of encouraging return to work within the framework of programs predicated on work inability.

The Panel shares the sentiments behind these pro-work initiatives. There is a need for more effective DI and SSI work incentives as grounded in Americans' belief that everyone should have a chance to achieve his/her full potential. Thus, in one part of our deliberations, the Panel looked at CDRs through the lens of return to work, asking to what extent, and how, CDRs can promote this outcome.

The first point to be made is that work *disincentives* are deeply rooted in both programs. They reside in the Social Security Act definition of disability, which requires a demonstration of inability to work, and in the lengthy statutory waiting periods for DI and Medicare, which may lead claimants to focus narrowly on proving that work is no longer possible.[58] Still, we believe that CDRs can have modest, second-order impacts in encouraging return to work. The Panel offers three recommendations.

For individuals whose benefits are ceased after a medical CDR, Congress should continue eligibility for the employment support services of the Ticket to Work program for one year.

Most beneficiaries who are terminated after a CDR have a strong financial motivation to return to work. Yet today they receive no support for pursuing employment. To assist them, the Panel recommends that Congress extend for one year the eligibility for the Ticket to Work employment services to individuals terminated after a medical CDR. Exercising this option would not continue cash benefits, but it would enable the person to receive rehabilitation services from a public or private rehabilitation service provider of his or her choice. SSA should inform terminated individuals of their continuing eligibility for Ticket to Work employment services in the termination letter and include detailed instruction on how to access and use the Ticket.[59]

SSA should communicate expectations of return to work for beneficiaries designated MIE.

Today most individuals categorized as Medical Improvement Expected are unaware of this designation. The Panel believes that SSA should be more transparent to the beneficiary regarding the expectation for medical improvement and communicate the availability of the Ticket to Work program. The most important message to convey is that beneficiaries who initiate work efforts *before* their first CDR can take advantage of key program work incentives and protections, whereas those who wait cannot. The incentives include:

- Ticket to Work entitles beneficiaries to services to help them start or resume work. By using a Ticket, beneficiaries can choose the service provider that they find most suitable and can delay having a CDR for at least two years.

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[57] For example, Project Network provided social services to disabled program beneficiaries, the State Partnership Initiative (SPI) tested modifications in work rules to enable DI and SSI beneficiaries to earn more, and Benefit Offset National Demonstration (BOND) is testing a benefit offset for the DI program. The SSAB has issued a report objecting to BOND due to problems with implementation of the project. See *The Case for Terminating the Benefit Offset National Demonstration*, August 2013.

[58] Autor, David; Nicole Maestas; Kathleen Mullen; and Alexander Strand; "Does Delay Cause Decay? The Effect of Administrative Decision Time on Labor Forced Participation and Earnings of Disability Applicants," Ann Arbor: University of Michigan Retirement Research Center Working Paper, WP 2011-258.

[59] The notification to the individual should be modeled on SSA's existing notification of Section 301 options. See page 25 of SSA's Redbook for more details on Section 301 provisions: http://www.ssa.gov/redbook/documents/TheRedBook2014.pdf

- Continuation of Benefits after Medical Cessation (the "Section 301 option") enables beneficiaries who are determined to have medically recovered after a CDR to continue to receive cash benefits while completing a plan for rehabilitation that was initiated prior to the CDR. The plan can be an Individual Plan for Employment (IPE) with a state vocational rehabilitation (VR) agency or a private rehabilitation provider, an Individual Education Plan (IEP) with the school, or an SSA approved PASS plan which allows the beneficiary to receive SSI after setting aside certain countable income for use in achieving a work goal.[60]

SSA should intensify its communication of beneficiaries' responsibility to report changes in their circumstances, both medical improvement and earnings.

SSA's systems for monitoring earnings are subject to substantial lag times and, as noted, large numbers of CDRs have been delayed in recent years due to administrative funding shortages. In these situations, beneficiaries who fail to report medical improvement or return to work may incur large overpayments. Beneficiaries' proactive reporting to SSA *and* a commitment by SSA to take needed action timely can avert this risk.

In addition to relying on CDRs to find beneficiaries who may no longer be eligible for disability benefits, SSA should communicate early and often that beneficiaries are required to report changes in their own situations to SSA. In the same vein that the Internal Revenue Service (IRS) expects taxpayers to report their earnings accurately under penalty of perjury, so also should SSA expect beneficiaries to report medical improvement and earnings. While the IRS expects compliance but still uses audits as a method to keep all taxpayers compliant, so too should SSA expect accurate reporting but use CDRs as an audit tool.

SSA currently informs beneficiaries of their reporting responsibilities when claims are first allowed but the message may get lost at a time when a new beneficiary is thinking more about other priority issues, e.g., receipt of monthly benefits, payment of back benefits, and Medicare/Medicaid eligibility. Reiterating the message would both communicate to the beneficiary the seriousness of the responsibility and communicate to the public that disability benefits are not a guaranteed lifetime benefit. Whenever SSA communicates with a disability program beneficiary, the reporting responsibility should be highlighted. While the medical CDR continuance notice does identify medical improvement as a reporting responsibility, other vehicles should also be used such as the DI cost of living adjustment (COLA) mailings (currently it is included in the SSI COLA notice but buried in other reporting responsibilities), as a general message on the SSA webpage, and as a targeted message on the MySSA web portal.

CDRS FOR SSI CHILDREN AND YOUTH

Children and youth receiving SSI are heavily affected by the CDR process. In 2011, while age-18 redeterminations accounted for around 29% of all full medical reviews, they accounted for an extraordinary 59% of estimated final cessations. Overall, about 40% of age 18-redetermination cases are ceased with rates as high as two-thirds for some common mental conditions.[61] CDR cessation rates for children under 18 can exceed 20%, compared to the low single digits for adults.

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[60] Also Tribal Vocational Rehabilitation and/or Veterans Vocational Rehabilitation. See page 25 of SSA's Redbook for more details on Section 301 provisions: http://www.ssa.gov/redbook/documents/TheRedBook2014.pdf

[61] Hemmeter, Jeffrey, and Elaine Gilby, "The Age-18 Redetermination and Post-Redetermination Participation in SSI," *Social Security Bulletin*, Volume 69, No. 4., 2009.

Most of the Panel's recommendations apply to all individuals receiving disability benefits. However, some issues specific to SSI children merit special consideration. We outline here a few of the more important ones and then consider how our core recommendations apply to children and young adults.

Many of the issues related to return to work for adults are applicable to children and youth. Just as adults who are ceased may have difficulty transitioning back to work after a prolonged absence from the labor market, ceased SSI youth may have difficulty achieving long-term self-sufficiency if they or their families do not invest in education and skills during their time on SSI.

For 18-year olds, return-to-work issues are similar to those for adults but particularly critical at this formative time. Since MIRS does not apply to age-18 redeterminations, SSI children who do not meet the adult disability standard can be ceased, even if their condition has not improved, and the youth and family may be caught unprepared. For these youth, appropriate interventions before the age-18 redetermination may make a critical difference in whether they chart a path to self-sufficiency or return to public support.[62]

For younger children, analogous questions apply to educational achievement and the development of skills to promote self-sufficiency in adulthood. Some critics have argued that SSI discourages educational achievement and work experience among youth because families fear losing benefits if the child appears to have improved.[63] More evidence is needed to determine the validity of these criticisms, which, if true, would increase the difficulty of the transition to adulthood for ceased children.

The Panel recasts its recommendations for adults on return-to-work to reflect the particular needs of children and youth as follows:

SSA should communicate expectations of independence to youth beneficiaries designated MIE and MIP.

SSA should communicate at the initial decision or last CDR that cessation rates are high for age-18 redeterminations, and since children with MIE and MIP diaries have the highest cessation rates, let these beneficiaries know early and often of the expectation for improvement. SSA needs to remind families of the student earned income exclusion, which allows children and young adults who are attending school to exclude up to about $7,000 per year in earnings from SSI benefit calculations. Student beneficiaries should also receive encouragement to finish secondary education.

Well before the age-18 redetermination, SSI children and their families should be notified of 301 options[64], which can smooth the transition to life without benefits by continuing payments while the ceased beneficiary is enrolled in a VR program.

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[62] Hemmeter and Gilby, as previously cited, find that approximately 10% of those with a final age-18 cessation decision successfully reapply within four years. The number of those who attempt to reapply is likely much higher.
[63] See, for example, Patricia Wen, "The Other Welfare," *Boston Globe*, December 12, 2010; Nicholas D. Kristof, "Profiting from a Child's Illiteracy," *New York Times*, December 7, 2012; and Richard V. Burkhauser and Mary C. Daly, The *Declining Work and Welfare of People with Disabilities: What Went Wrong and a Strategy for Change*, AEI Press, August 11, 2011.
[64] The Section 301 option was described earlier in this report in Strengthen links between CDRs and support for return to work.

As with the adult population, Congress should continue eligibility for the employment support services of the Ticket to Work program for one year.

The families of younger children who are ceased may benefit from information on home and school support services. Ceased 18-year-olds should receive extended eligibility for the employment support services of the Ticket to Work, as recommended for adults above.

MIRS training should be extended to include examples specific to children

Our core recommendations on the Medical Improvement Review Standard, outlined in section 2.b, hold for children as well as adults. The Panel recommends that training and guidelines on MIRS include clarification and examples that are specific to children, to ensure policy compliance with the standard and the proper use of exceptions in children's cases.

SUGGESTED TOPICS FOR FUTURE SSAB ADVISORY PANELS

In its discussions the Panel repeatedly encountered broad questions relevant to, but still outside, its mandate. The Panel suggests these matters as possible topics of inquiry for future panels.

DISABILITY INSURANCE (DI) AND SSI DEMONSTRATION PROJECTS TO ENCOURAGE RETURN TO WORK

Two reasons are frequently cited for low rates of employment by SSA disability beneficiaries: 1) the contradiction that lies at the heart of a program that encourages beneficiaries to work while requiring them to prove their inability to do so; and 2) the fear and misunderstanding of the impact of working on eligibility for both cash benefits and healthcare programs (Medicare and Medicaid).[65] For an average beneficiary or layperson, the miscellaneous complications of the work rules and incentives built into the DI and SSI programs are daunting. They are particularly so for the 10% of program beneficiaries who receive both DI and SSI and who thus have to cope with two sets of work incentives: SSI's gradual $1 for $2 earnings offset (after a small income exclusion of $85), and the DI program's nine-month Trial Work Period (nonconsecutive) followed by a 36-month Expended Period of Eligibility (consecutive). Additional SSA regulations add further incentives but also greater complexity, e.g., Impairment Related Work Expenses (IRWE), Subsidies, Plans to Achieve Self Support (PASS) and the Student Earned Income Exclusion. Additionally, earnings can affect eligibility for other state and federal benefits such as the Supplemental Nutrition Assistance Program (commonly referenced as the food stamp program), housing subsidies, and fuel assistance.

The complications also make the DI and SSI work incentives challenging for SSA to administer. The agency has considerable difficulty keeping timely records of months in which a worker engages in work above their threshold, resulting in a high proportion of overpayments and underpayments. SSA and others have advocated streamlining of work incentives to make them easier for both beneficiaries to grasp and SSA to administer.[66]

Beyond the complications of work rules, a structural disincentive to work is built into the DI program. This is the so-called "cash cliff," which arises from the earnings threshold. After a Trial Work Period, earnings above the threshold may cause abrupt cessation of DI benefits. The threshold is low: just $1090 per month in 2015, which is below the poverty line for a two-person household. While Congress has attempted to mitigate the threat of loss of eligibility through the Extended Period of Eligibility, many observers hold that the cash cliff nevertheless leads beneficiaries to limit their earnings.[67] Related criticisms are made of the SSI $1 for $2 offset, established as a work incentive but often perceived by beneficiaries quite differently – as a penalty for work.

While lowering marginal tax rates on work may encourage more beneficiaries to increase their work efforts, the net effect on program costs is less clear. Program costs would decrease to the degree beneficiaries choose to offset a portion of their benefits with earnings. But program costs would increase to the degree people who choose work instead of benefit receipt under current policy, would under a more generous tax policy

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[65] For example, Morton, William, "SSDI Reform: An Overview of Proposals," Washington, DC: Congressional Research Service, April 2013.
[66] See, for example, the Obama Administration's Work Incentive Simplification Project (WISP) for DI beneficiaries.
[67] During an Extended Period of Eligibility (EPE), former beneficiaries may use expedited procedures to reestablish DI eligibility if their earnings fall.

seek to combine work and benefit receipt to achieve a higher monthly income. Research suggests this latter effect, known as induced entry, is likely to be modest.[68]

As discussed previously in this report, SSA has conducted a number of demonstration projects that expand or suspend work rules to encourage higher rates of employment.[69] In general, these projects point to the complexity of encouraging return to work. At the same time, they also offer important lessons.[70] We believe that the time is right to consider the implications of this body of research for designing more effective encouragement of return to employment.

- ✓ The Panel recommends that the SSAB convene a future Panel to address this question.

THE FEASIBILITY OF EARLY INTERVENTION

The modest impacts of recent SSA return-to-work demonstration projects point to the need for additional support *before* people with impairments start to receive DI and SSI. This perspective is reinforced by research demonstrating that the longer people are detached from the labor force, the less likely they are to work again.[71] It is possible that the DI application process itself encourages people to give up on the idea of return to work, because claimants must demonstrate that their impairments prevent them from engaging in work above the threshold. These work disincentives are magnified by SSA's large backlogs of claims, which cause long waits for eligibility determinations and still longer waits for appeal decisions. The need for a prolonged demonstration of inability to work is particularly harmful for individuals who are eventually found ineligible.

Earlier intervention could help to avoid this syndrome, enabling people with manageable limitations to continue working through a health crisis, to find new work as an alternative to applying for benefits, and to avoid falling into poverty. Depending on how precisely it is targeted, early intervention could also save DI and SSI resources.

Yet while there are strong reasons for earlier intervention, practical research is limited and inconclusive. Project Network (1992-4) provided intensive, employment-focused case management to SSDI applicants as well as beneficiaries but achieved only modestly better results with the former group. The Youth Transition Demonstration (YTD) (2003-2008) provided employment supports to young SSI program beneficiaries as well as youth who were at risk of becoming SSI beneficiaries after leaving school. However, the project impacts were limited for both groups. The Panel notes the Administration's FY 2015 budget proposals for rigorous demonstrations on early intervention, including projects targeting prime working age people with

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[68] Maestas, Nicole, Kathleen Mullen, and Gema Zamarro. 2010. "Research Designs for Estimating Induced Entry into the SSDI Program Resulting from a Benefit Offset." Santa Monica, CA: *RAND Labor and Population Technical Report*, TR-908-SSA.

[69] See footnote 57 for examples.

[70] Livermore, Gina, David Wittenburg, and David Neumark, "Finding Alternatives to Disability Receipt," *IZA Journal of Labor Policy*, 2014, 3:14, p. 6. The results also provide some surprises. e.g., the availability of a DI benefit offset caused some workers who were working above SGA to decrease their work efforts, as they were able to achieve the same total income with less effort, p. 14.

[71] Autor, David, Nicole Maestas, Kathleen Mullen and Alexander Strand. "Does Delay Cause Decay? The Effect of Administrative Decision Time on the Labor Force Participation and Earnings of Disability Applicants." MRRC Working Paper #2011-258, September 2011; updated version October 2014.

disabilities in the labor market, retention of workers who are injured or develop a disability, and state-local community based programs to return young workers with disabilities to the labor market.[72]

To guide these and other efforts, the Panel suggests that SSAB examine the financial costs and benefits of early intervention from SSA's perspective. This examination should give particular attention to the demographic and impairment profiles of individuals for whom early intervention is most likely to be successful and, on this basis, suggest possible designs for early intervention projects that maximize DI and SSI savings.

SSI CHILDREN AND YOUTH

The Medical Improvement Review Standard (MIRS) raises child-specific issues that should be considered by future Panels. The first is whether there should be special guidance for cases in which the SSI benefit itself facilitated medical improvement through treatment, therapy, increased family stability, or other positive changes in the child's environment. For example, a recent media account describes a child with ADHD whose behavior had improved substantially, according to family members, as a result of day care, private tutoring, and medication paid for with SSI benefits, as well as regular physician visits provided by the Medicaid eligibility that accompanies SSI.[73] In cases where the SSI benefit enables medical improvement, it is important to consider the possibility of relapse if the benefit is suspended. Though also relevant to adults, this issue is critical for children given increasing evidence that early childhood experiences and environments affect mental, emotional, and physical development.[74] A future Panel should consider whether special guidance is appropriate, and the extent to which it can counter any perverse incentives that discourage health and behavioral improvements.

A related consideration for children is that SSI cash benefits are controlled by a parent or guardian, with the intention that the resources will be used to benefit the child. This system may call for special attention to how the SSI cash benefits are used and how terminating benefits would affect the child.

Second, the Panel calls on the Board to research the effect of CDRs on the long-term outcomes of SSI youth. Recent research finds that SSI youth who lose benefits via age-18 redeterminations recover only one-third of the lost SSI income with earnings, leading to a large drop in lifetime income.[75] SSA's demonstration projects for SSI youth in transition – including the Youth Transition Demonstration and Promoting the Readiness of Minors in Supplemental Security Income – are promising efforts to determine which supports are most effective in facilitating future self-sufficiency among SSI children whose benefits are ceased. The Panel calls for additional research into how CDRs (and SSI itself) affect the educational achievement, health, and well-being of children and young adults.

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[72] "Early Intervention Demonstrations" FY 2015 Administration Budget.
[73] Jenny Gold, "Benefits for Severely Disabled Children Scrutinized," *Kaiser Health News*, August 18, 2011.
[74] See, e.g., Greg Duncan and Katherine Magnuson, "The Nature and Impact of Early Achievement Skills, Attention Skills, and Behavior Problems," *Whither Opportunity?: Rising Inequality, Schools, and Children's Life Chances*, 2011; and Jonathan Guryan, Erik Hurst, and Melissa Kearney, "Parental Education and Parental Time with Children," *Journal of Economic Perspectives* 22(3), 2008.
[75] Manasi Deshpande, "Does Welfare Inhibit Success? The Long-term Effects of Removing Low-Income Youth from Disability Insurance," MIT Job Market Paper, November 2014.

ADDITIONAL RESEARCH ON CDRS

The limited evidence on the effect of CDRs on children is part and parcel of a paucity of evidence on CDRs. Although we have estimates of the return on investment of CDRs for DI and SSI program budgets, there is another, arguably more important, *social* return on investment that takes into account the well-being of beneficiaries and their family. The panel thus calls for inquiry into the social return on investment, including:

- How CDR cessations affect the long-term health and well-being of former beneficiaries, including both adults and children;
- How CDR cessations affect family members of the ceased beneficiary (e.g., spousal labor supply and child college attendance); and
- To what extent beneficiaries turn to other public support at the federal, state, or local levels after cessation of benefits.

Earlier in this report, we called upon Congress to provide adequate and predictable funding for CDRs. Until that happens, however, SSA could use the limited availability of CDRs to assign CDRs in a way that allows SSA to evaluate the effects of CDRs on beneficiaries, family members, and other government programs. Properly implemented, randomized control trials could yield important evidence of the effects of CDRs. Such work would be cost-effective because they use SSA's existing infrastructure for allocating CDRs, and some outcomes, such as earnings would be available through SSA's own databases. By conducting the randomized control trials within the category of beneficiaries with the highest assigned probability of medical improvement, SSA could continue devoting CDR resources to the highest-return group while assessing the effect of CDRs for the most policy-relevant population. The Panel suggests that the Board consider the feasibility of this approach and guide SSA accordingly.

In addition, the Panel calls for research to assess the effects of benefits and services provided prior to CDR cessation on subsequent outcomes. One encouraging step in this direction is the PROMISE evaluation for SSI children, which aims to improve the provision and coordination of services for transition-age youth, including case management, benefits counseling, career and work-based learning experiences, as well as parental training and information.

APPENDICES

APPENDIX A: THE 2014 DISABILITY POLICY PANEL

BERNADETTE FRANKS-ONGOY

Bernadette Franks-Ongoy is the Executive Director for Disability Rights Montana (DRM), an organization that protects and advocates for the human, legal, and civil rights of Montanans with disabilities. She manages and oversees the day-to-day activities of DRM and sets the tone to ensure that the organization's mission to advance dignity, equality, and self-determination is being accomplished. Ms. Franks-Ongoy says, "I was raised by a mother with a disability and a father who did not realize he was a feminist." She lived in an accessible house before the ADA was the law. Her mother's wheelchair could access every room. "After all mom needed to have access to my brothers and sisters rooms with her wheelchair." Ms. Franks-Ongoy is the youngest of eight siblings to include a brother with a mental illness. Ms. Franks-Ongoy grew up in the sugar plantation town of Waialua, Hawaii. With the support of Job Corp, Social Security and other financial aid, she attended and graduated from Chaminade University with a Bachelor of Science Degree in Criminal Justice and a Bachelor of Arts degree in Sociology. She graduated from the University of San Diego, School of Law in 1983. Her past legal experience includes: Law Clerk for the First Judicial Circuit Court in Hawaii, Founding Executive Director of the Hawaii Bar Foundation, Deputy Corporation Counsel for the City and County of Honolulu, and the Attorney and Director of Programs for the Protection and Advocacy system in Hawaii. She is licensed to practice law in Hawaii and with the United States Court of Appeals for the Ninth Circuit. Ms. Franks-Ongoy has served as president of the National Disability Rights Network and most recently was a member of Montana's Equal Justice Task Force. Her current term on the Social Security Advisory Board is from January 2013 through September 2018.

MANASI DESHPANDE

Manasi Deshpande is a Ph.D. candidate in economics at the Massachusetts Institute of Technology and a pre-doctoral fellow at the National Bureau of Economic Research. Her research interests include the interaction between social insurance and labor markets and the effects of social insurance on consumption, health, and well-being. Prior to graduate school, she was a policy advisor at the White House National Economic Council and a research assistant at The Hamilton Project at Brookings. She is a Harry S. Truman Scholar and holds a B.A. with highest honors in economics, mathematics, and the Plan II Honors Program (humanities) from The University of Texas at Austin.

ELAINE FULTZ

Elaine Fultz is retired from the International Labor Organization (ILO) and currently works as a consultant and an associate at JMF Research Associates in Philadelphia. She is the former Director of the ILO office for Russia, Eastern Europe, and Central Asia. Located in Moscow, the office covered ten countries of the former Soviet Union. Prior to serving in Moscow, Fultz was a social security specialist with the ILO, based in Budapest, where she covered Central and Eastern Europe. She provided advisory services on social security reform to governments, workers, and employers. She also managed a regional technical cooperation project on social security reform and commissioned and edited a study on disability pension reform in the former Soviet Bloc countries, *Disability Pensions in Transition*. Prior to working in Central Europe, she was based in Zimbabwe, where she worked on development of social security systems in nine countries in southern

Africa. Before joining the ILO, Fultz was Staff Director of the National Commission on Childhood Disability and a professional staff member of the Subcommittee on Social Security for the House Ways and Means Committee. In the latter position, she was responsible for disability pensions and SSA service delivery issues. She also taught and studied at the Wagner School of Public Service, New York University. A member of the National Academy of Social Insurance since 1993, Ms. Fultz received her Ph.D. in public administration from New York University.

MARSHA KATZ

Marsha Rose Katz was a Project Director at the University of Montana Rural Institute in Missoula from 1999 until her retirement in 2013. Her work concentrated on assisting persons with disabilities to utilize Social Security work incentives to start their own businesses or engage in wage employment. Katz has focused on providing training and technical assistance on both employment and SSI/SSDI to rural, frontier and tribal communities across the country. Previously, she worked for nearly 20 years in a disability rights community based organization, the Association for Community Advocacy (ACA), a local Arc in Ann Arbor, Michigan. She served as both Vice President of ACA, and Director of its Family Resource Center. It was at ACA that Katz began her nearly 30 years of individual and systems advocacy regarding programs administered by SSA, especially the SSI and SSDI programs. Her Bachelor's and Master's Degrees are from the University of Michigan. Katz is also a former member of the Social Security Advisory Board, having served a term of office from November 2006 to September 2012.

RENÉE LANDERS

Renée Landers is Professor of Law and Faculty Director of the Health and Biomedical Law Concentration at Suffolk University Law School. From 2003-2004, she served as president of the Boston Bar Association. She was the first woman of color and the first law professor to serve in that position. She currently teaches health law, constitutional law and administrative law. Before joining the Suffolk University Law School faculty in 2002, Landers served as counsel in the health law group at the Boston law firm of Ropes & Gray for five years. She previously served as deputy general counsel for the U.S. Department of Health and Human Services and Deputy Assistant Attorney General in the Office of Policy Development at the U.S. Department of Justice. Before entering government service, Landers taught at Boston College Law School. Landers serves as Secretary of the Board of Directors of the National Academy of Social Insurance, was a member of NASI's study panel on "Strengthening Medicare's Role in Reducing Racial and Ethnic Health Disparities," and co-chaired the 21st NASI conference on "Social Insurance, Fiscal Responsibility, and Economic Growth." She is also Vice President of the Section of Administrative Law and Regulatory Practice of the American Bar Association. Landers received her J.D. from Boston College Law School.

NICOLE MAESTAS

Nicole Maestas is a senior economist and director of the RAND Center for Disability Research, and research department director of the Economics, Sociology, and Statistics Department at the RAND Corporation. Maestas's research addresses the economics of retirement, health, and disability – specifically, work after retirement ("unretirement"); how longer work lives could ameliorate the economic effects of population aging; the work disincentive effects of the Social Security Disability Insurance program; and the effect of the Medicare program on disparities in health care utilization, treatment intensity, and mortality. She is director of the RAND Postdoctoral Training Program in the Study of Aging and a professor of economics at the Pardee RAND Graduate School, where she teaches microeconomic theory. Maestas received her B.A. from Wellesley

College; her M.P.P. from the Goldman School of Public Policy at the University of California, Berkeley; and her Ph.D. in economics, also from UC Berkeley.

KEN NIBALI

Ken Nibali served as Associate Commissioner for Disability at the Social Security Administration from 1998-2002. In this position, Mr. Nibali was the top official responsible for the nation's disability program, and ran a $1.5 billion budget that covered the operations of 54 states and territories as they carried out the adjudication of claims for disability throughout the country. During this time, he was also responsible for the policies and procedures used to make determinations on disability claims, whether by the state agencies or by administrative law judges upon appeal. Mr. Nibali was particularly involved in assuring that legislative changes to the Supplemental Security Income Program for disabled children were regulated and implemented in as fair a manner as possible for the more than one million children affected. Prior areas of leadership included equal employment opportunity and management analysis. Among awards and honors, Mr. Nibali received the Commissioner of Social Security's Leadership Award in 1998 and the President of the United States' Meritorious Executive Award in 1999. After 31 years of service at SSA, Mr. Nibali is currently retired from federal service and works as a private consultant on issues relating to the Social Security disability programs. He recently served as an expert witness in class action lawsuit involving disability insurance companies requiring policyholders to file claims with SSA. He has also been involved in several projects with the National Academy of Social Insurance. Mr. Nibali holds a BA in Economics from Western Maryland College and a JD with Honors from the University of Maryland School of Law. He was admitted to the Maryland Bar in 1978.

JAMES SMITH

James Smith is currently the Budget and Policy Manager at the Vermont Division of Vocational Rehabilitation. Currently Mr. Smith oversees budget and policy and is the deputy to the director for the Vermont Division of Vocational Rehabilitation. As Budget and Policy Manager he oversees the division budget ($25 million in FY 13). Mr. Smith has been a key player in implementing performance based contracting including performance incentives and holdbacks for the Vermont supported employment programs. Mr. Smith also oversees the Vermont Division of Vocational Rehabilitation's, Work Incentives Initiative which includes a statewide benefits counseling program for SSI and SSDI beneficiaries across programs. Mr. Smith also served on the Adequacy of Incentives Advisory Group for the SSA Ticket to Work program in 2004. In 2004 Mr. Smith was co-author of a research article that that demonstrated a link between benefits counseling and increased earnings for Social Security Disability beneficiaries (*Journal of Rehabilitation*, Volume 70, Number 2). In 2012, Mr. Smith participated on the Technical Advisory Panel for the SSA Work Incentive Simplification Project (WISP). Prior to his involvement in Social Security and work incentive issues, James worked for fourteen years in the supported employment arena in Vermont and New York City.

ARTHUR R. (ART) SPENCER

In 1973, Art began his career with the Virginia Disability Determination Services (DDS), the State Agency adjudicating Social Security disability claims for Virginia. He received a series of promotions, including line and QA supervisor; led all statewide training; and for seven years was the Regional Director in Roanoke, Virginia, leading DDS operations for the southwest quadrant of the State. In 1993 he was selected to be the Director of the Delaware DDS; in 1994 was a Disability Program Administrator in the Philadelphia Region and in 1995 became the Director of the New Jersey DDS, where he served for seven years. Beginning in 2002, he

was with the Office of Disability Programs in Central Office, focusing on the development and interpretation of disability policy, primarily non-medical and evaluation policies and procedures. He led the development of the Request for Program Consultation (RPC) process, a new way to resolve questions and disagreements on complex disability issues nationwide. In July 2008, Art was selected for SSA's Senior Executive Service (SES) development program. His first assignment was within the Office of Disability Systems, coordinating the development tasks for the Disability Claims Processing system, and his second assignment took him to the San Francisco region where he led operations for six Teleservice Centers. Between June 2010 and January, 2014, Art was the Associate Commissioner for the Office of Disability Policy responsible for the nation's Social Security's disability policy. Art has a BS degree from Virginia Commonwealth University and the MPA from Virginia Tech and is a member of the National Academy of Social Insurance. Now retired, Art makes stained glass windows, plays with grandchildren, plays the guitar and continues to be involved in Disability program issues.

APPENDIX B: INDIVIDUALS AND ORGANIZATIONS CONSULTED

The 2014 Disability Policy Panel also wishes to recognize and thank the following individuals who provided expert knowledge, advice, and data on CDR-related issues that were instrumental in the formulation of this report.

SOCIAL SECURITY ADMINISTRATION

Michelle Bailey, Economist, Office of Research, Demonstration, and Employment Support

Steve Goss, Chief Actuary, Office of the Chief Actuary

Phillip Hanvy, Audit Manager, Office of Audits, Office of the Inspector General (Boston Region)

Jeffrey Hemmeter, Economist, Office of Research, Demonstration, and Employment Support

Judge Patricia A. Jonas, Executive Director, Office of Appellate Operations, Office of Disability Adjudication and Review

Erik Jones, Associate Commissioner, Office of Public Service and Operations Support, Office of the Deputy Commissioner for Operations

Paul O'Leary, Project Director for Ticket-to-Work, Office of Research, Demonstration, and Employment Support

Judge Gerald Ray, Deputy Executive Director, Office of Appellate Operations, Office of Disability Adjudication and Review

Steve Schaeffer, Assistant Inspector General for Audit, Office of the Inspector General

Bob Somers, Program Analyst, Office of Public Service and Operations Support, Office of the Deputy Commissioner for Operations

Melissa Spencer, Acting Deputy Associate Commissioner, Office of Disability Policy

Lori Vandeventer, Team Leader & Program Analyst, Office of Public Service and Operations Support

Cheryl A. Williams, Office Director, Office of Disability Policy, Office of Medical Policy

Susan Wilschke, Deputy Associate Commissioner, Office of Research, Demonstration, and Employment Support

Ray Wise, Director, Division of CDR Support, Office of Public Service and Operations Support, Office of the Deputy Commissioner for Operations

Daniel Zabronsky, Division Director, Office of Budget, Finance, Quality, and Management

EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT AND BUDGET

Jack Smalligan, Branch Chief, Income Maintenance Branch

U.S. CONGRESSIONAL STAFF

Kim Hildred, Staff Director (Majority), House Committee on Ways and Means, Subcommittee on Social Security

Kathryn Olson, Staff Director (Minority), House Committee on Ways and Means, Subcommittee on Social Security

Tom Klouda, Senior Domestic Policy Advisor, Senate Committee on Finance

Jeff Wrase, Chief Economist, Senate Committee on Finance

NATIONAL ASSOCIATION OF DISABILITY EXAMINERS (NADE)

Jennifer Nottingham, President

NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES (NOSSCR)

Ethel Zelenske, Director of Government Affairs

NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS (NCDDD)

Trudy Lyon-Hart, President

NATIONAL COUNCIL OF SOCIAL SECURITY MANAGEMENT ASSOCIATIONS (NCSSMA)

Billie Armenta, Vice President

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APPENDIX D: FINAL & ESTIMATED CDR CESSATIONS, BY PROGRAM

Table D-1: Final CDR Cessations by Medical Improvement Category, FY 2004-2011

	MIE		MIP		MINE	
FY	Excluding Deferrals	Including Deferrals	Excluding Deferrals	Including Deferrals	Excluding Deferrals	Including Deferrals
2004	14.4%	13.7%	9.6%	3.6%	6.4%	1.5%
2005	16.7%	14.8%	12.2%	3.7%	7.2%	1.0%
2006	16.2%	12.8%	12.4%	2.8%	7.4%	0.6%
2007	18.2%	15.7%	24.0%	6.1%	6.5%	0.5%
2008	22.0%	15.5%	18.3%	4.0%	9.5%	0.8%
2009	29.0%	24.8%	19.4%	5.3%	6.5%	0.9%
2010	29.5%	24.6%	20.0%	6.4%	7.1%	1.1%
2011	21.7%	20.7%	24.3%	5.9%	7.8%	0.5%

Table D-2: Estimated CDR Cessations by Program, Fiscal Year 2013

Beneficiary Type	Number of Full Medical CDRs	Percent of Total**	Number of Cessations	Cessation Rate***
SSDI Only	149,362	35%	19,018	13%
Concurrent SSI/SSDI	52,074	12%	6,920	13%
SSI Adult	35,094	8%	4,091	12%
SSI Child	164,910	38%	81,877	50%
Other*	27,128	6%	3,488	13%
Total	428,568	99%	115,394	27%

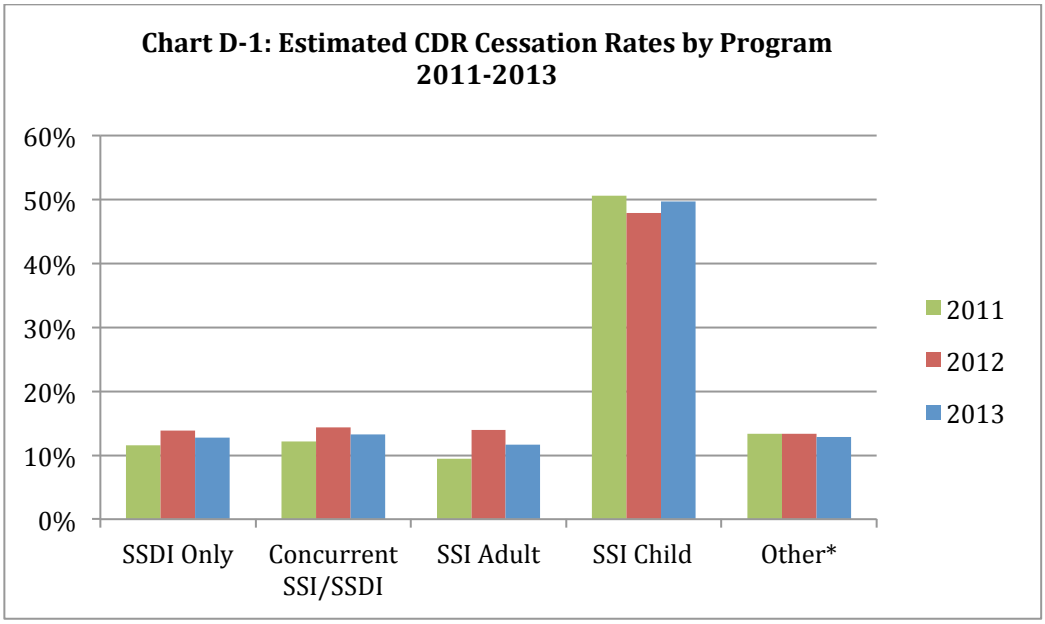
Table D-3: Estimated CDR Cessations by Program, Fiscal Year 2012

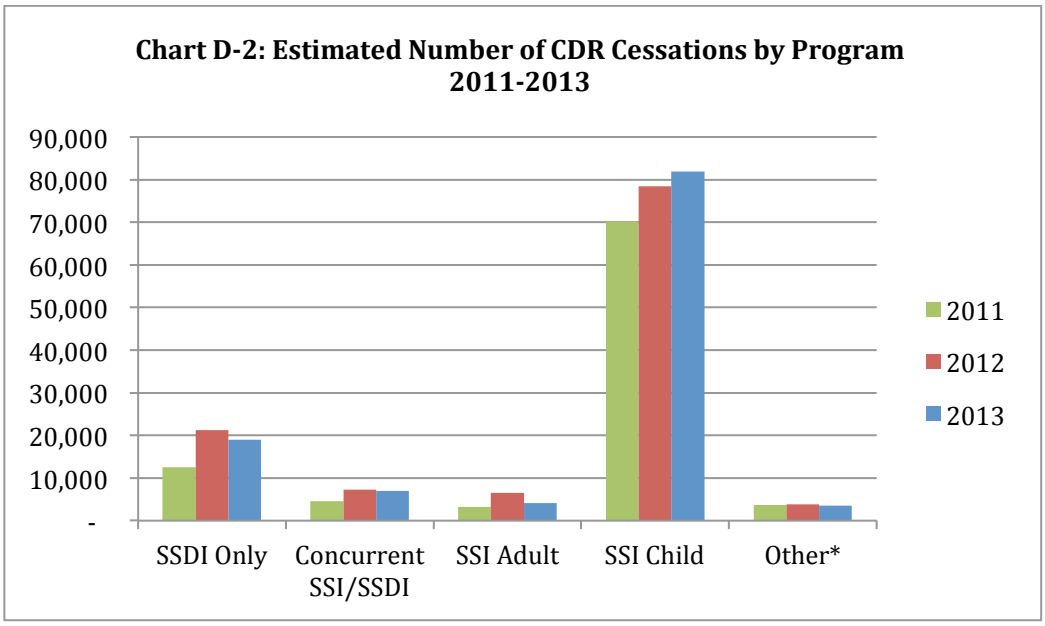
Beneficiary Type	Number of Full Medical CDRs	Percent of Total	Number of Cessations	Cessation Rate***
SSDI Only	153,372	35%	21,222	14%
Concurrent SSI/SSDI	50,778	11%	7,306	14%
SSI Adult	46,547	11%	6,485	14%
SSI Child	163,781	37%	78,477	48%
Other*	28,755	6%	3,839	13%
Total	443,233	100%	117,329	26%

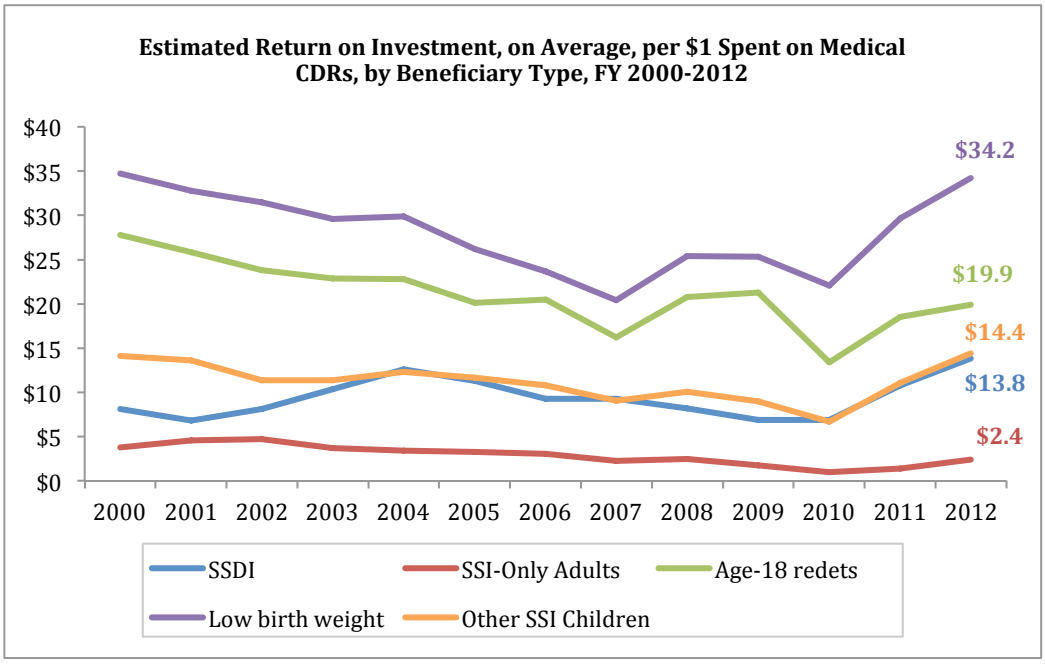
Table D-4: Estimated CDR Cessations by Program, Fiscal Year 2011

Beneficiary Type	Number of Full Medical CDRs	Percent of Total	Number of Cessations	Cessation Rate***
SSDI Only	107,952	31%	12,507	12%
Concurrent SSI/SSDI	37,994	11%	4,605	12%
SSI Adult	33,535	10%	3,169	9%
SSI Child	138,779	40%	70,244	51%
Other*	27,232	8%	3,631	13%
Total	345,492	100%	94,156	27%

*Other CDRs include CDRs initiated for reasons other than the maturing of a CDR diary (such as beneficiaries voluntarily reporting they may no longer be disabled) or CDRs closed administratively (for example, when a beneficiary dies before the CDR is completed).
**Numbers do not equal 100% due to rounding.
***Cessation rate does not take into account the estimated number of ultimate cessations after appeals.







Source for Table D-1: Unpublished data provided by SSA.
Sources for Tables D-2 through D-4 and Charts D-1 and D-2: FY 2011 & FY 2012 *Annual Report on Continuing Disability Reviews*; for 2013: unpublished data provided by SSA.
Source for Chart D-3: Unpublished data provided by SSA, Office of the Chief Actuary.

APPENDIX E: CURRENT REGULATORY LANGUAGE ON THE ERROR EXCEPTION IN MIRS

(SEE CFR 404.1594. SEE ALSO 404.1590, 404.1593)

- (4) SUBSTANTIAL EVIDENCE DEMONSTRATES THAT ANY PRIOR DISABILITY DECISION WAS IN ERROR. We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in your file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 or a medical/vocational rule in appendix 2 of this subpart was misapplied).

Example 1: You were granted benefits when it was determined that your epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by EEG evidence and by a detailed description of a typical seizure pattern. A history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of your seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether you were still considered to be disabled would be based on whether you could currently engage in substantial gainful activity.

Example 2: Your prior award of benefits was based on vocational rule 201.12 in appendix 2 of this subpart. This rule applies to a person age 50-54 who has at least a high school education, whose previous work was entirely at a semiskilled level, and who can do only sedentary work. On review, it is found that at the time of the prior determination you were actually only age 46 and vocational rule 201.21 should have been used. This rule would have called for a denial of your claim and the prior decision is found to have been in error. Continuation of your disability would depend on a finding of your current ability to engage in substantial gainful activity.

(ii) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

Example: You were found disabled on the basis of chronic obstructive pulmonary disease. The severity of your impairment was documented primarily by pulmonary function testing results. The evidence showed that you could do only light work. Spirometric tracings of this testing, although required, were not obtained, however. On review, the original report is resubmitted by the consultative examining physician along with the corresponding spirometric tracings. A review of the tracings shows that the test was invalid. Current pulmonary function testing supported by spirometric tracings reveals that your impairment does not limit your ability to perform basic work activities in any way. Error is found based on the fact that required, material evidence which was originally missing now becomes available and shows that if it had been available at the time of the prior determination, disability would not have been found.

(iii) Substantial evidence which is new evidence which relates to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the claim would not have been

allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: You were previously found entitled to benefits on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments. The prior record shows that you had "brittle" diabetes for which you were taking insulin. Your urine was 3+ for sugar, and you alleged occasional hypoglycemic attacks caused by exertion. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator feels, however, that your impairment clearly does not equal the severity contemplated by the listings. Error cannot be found because it would represent a substitution of current judgment for that of the prior adjudicator that your impairment equaled a listing.

(iv) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see § 404.988) are met.

APPENDIX F: THE SEQUENTIAL EVALUATION PROCESS IN ADULT MEDICAL CDRS

Step 1- Is the individual engaging in **Substantial Gainful Activity** (SGA)? (This step is generally handled by field office personnel.)

Step 2 - Does the individual's impairment **Meet or Equal** the severity requirements of a current listing? If yes - we continue eligibility; if no - we proceed to step 3.

Step 3 – Has there been any **Medical Improvement** in impairment(s) we found disabling at the last favorable decision? If yes - we proceed to step 4. If no - before we can continue eligibility, we must consider *any* exceptions to medical improvement (Step 5).

Step 4 - **Related to the ability to work** – Does the improvement in the individual's impairment increase his or her ability to perform basic work-related functions? If yes - we proceed to step 6. If no - before we can continue eligibility, we must consider *any* exceptions to medical improvement (Step 5).

Step 5 - **Group 1 Exceptions** - We consider these if we decided that there was no medical improvement OR any medical improvement was not related to the ability to work. If none of the exceptions applies, we continue eligibility. If one of the Group 1 exceptions applies, we must still evaluate the ability to engage in SGA by proceeding to Step 6.

Step 6 – Are the individual's current impairments severe? We consider all impairments at this step. If yes - we proceed to Step 7. If no - we cease eligibility.

Step 7 - Does the individual have the ability to do past relevant work? If no - we proceed to Step 8. If yes - we cease eligibility.

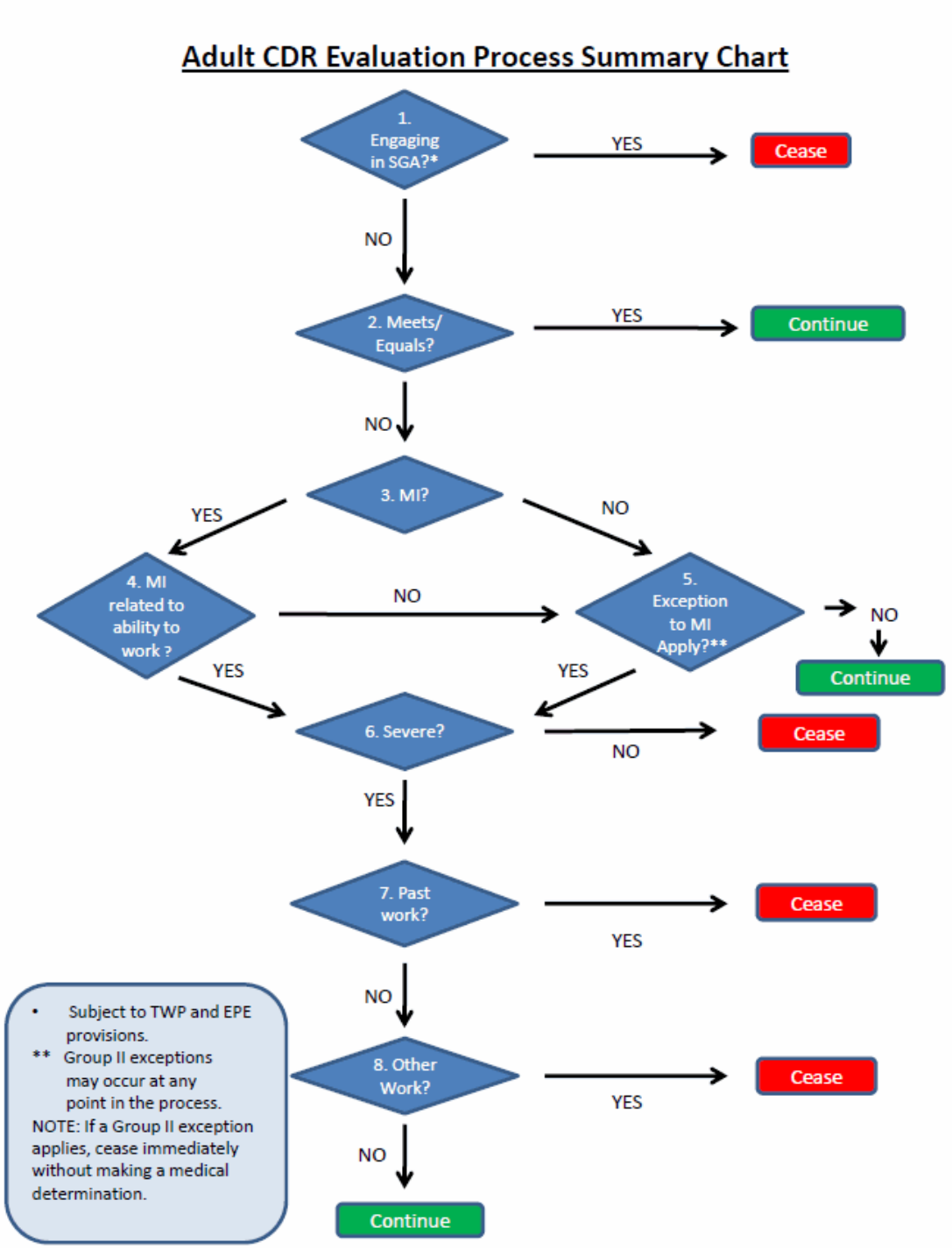
Step 8 - Does the individual have the ability to do other work? If no - we continue eligibility. If yes - we cease eligibility.

Group 2 Exceptions (see list below) can apply *at any point* in the process and are a basis for cessation without considering medical improvement or the ability to engage in SGA.

- Prior decision fraudulently obtained
- Failure to cooperate
- Whereabouts unknown
- Failure to follow prescribed treatment that is expected to restore the individual's ability to engage in SGA

Source: Office of Disability Policy, SSA

APPENDIX G: ADULT CDR EVALUATION PROCESS



Source: http://policy.ssa.gov/poms.nsf/lnx/0428005010

APPENDIX H: PANEL RECOMMENDATIONS AT A GLANCE

- **Provide CDR funding that is adequate, predictable, and sustained.**
  - Congress should provide adequate CDR funding.
  - Congress should provide predictable CDR funding.
  - Congress should provide sustained CDR funding.

- **Retain the Medical Improvement Review Standard (MIRS) and strengthen its implementation.**
  - The Panel strongly supports MIRS.
  - The Panel recommends evaluating the use of MIRS exceptions nationwide.
  - The Panel recommends that all disability adjudicators be trained on MIRS exceptions.
  - The Panel recommends that SSA establish a MIRS exception desk.

- **Strengthen other payment integrity tools.**
  - The Panel finds that CDRs are both efficient and equitable in achieving their primary purpose, determining whether disability, as defined in a benefit allowance, still exists.
  - The Panel recommends that SSA should expand, and Congress should support, the most promising tools for avoiding errors in allowances, those that help ensure policy compliance of disability decisions in the first place.
  - The Panel recommends that SSA needs full and predictable funding for program integrity as a whole.

- **Strengthen links between CDRs and support for return-to-work.**
  - For individuals whose benefits are ceased after a medical CDR, the Panel recommends that Congress continue eligibility for the employment support services of the Ticket to Work program for one year.
  - SSA should communicate expectations of return-to-work for beneficiaries who are designated as "Medical Improvement Expected (MIE)".
  - SSA should intensify its communication of beneficiaries' responsibility to report all changes in their circumstances, including both medical improvements and earnings.

- **CDRs for SSI children and youth.**
  - SSA should communicate expectations of independence to youth beneficiaries designated as "Medical Improvement Expected (MIE)" and "Medical Improvement Possible (MIP)"
  - As with the adult population, the Panel recommends that Congress continue eligibility for the employment support services of the Ticket to Work program for one year for youths whose benefits are ceased due to a medical CDR.
  - The Panel recommends that MIRS training should be extended to include examples specific to children.

2014 Disability Policy Panel:
Continuing Disability Reviews

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