OFFICE OF
THE INSPECTOR GENERAL

SOCIAL SECURITY ADMINISTRATION

IMPACT OF STATUTORY BENEFIT CONTINUATION ON SUPPLEMENTAL SECURITY INCOME PAYMENTS MADE DURING THE APPEALS PROCESS

May 2006 **A-07-05-15095**

AUDIT REPORT

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- **Prevent and detect fraud, waste, and abuse in agency programs and operations.**
- **Review and make recommendations regarding existing and proposed legislation and regulations relating to agency programs and operations.**
- **Keep the agency head and the Congress fully and currently informed of problems in agency programs and operations.**

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- **Independence to determine what reviews to perform.**
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By conducting independent and objective audits, investigations, and evaluations, we are agents of positive change striving for continuous improvement in the Social Security Administration's programs, operations, and management and in our own office.

SOCIAL SECURITY

MEMORANDUM

Date: May 10, 2006 Refer To:

To: The Commissioner

From: Inspector General

Subject: Impact of Statutory Benefit Continuation on Supplemental Security Income Payments Made During the Appeals Process (A-07-05-15095)

OBJECTIVE

Our objective was to evaluate the financial impact on the general fund when recipients continue to receive Supplemental Security Income (SSI) payments while appealing a medical cessation decision.

BACKGROUND

In 1972, Title XVI of the Social Security Act established the SSI program.[1] SSI is a nationwide Federal cash assistance program administered by the Social Security Administration (SSA) that guarantees a minimum level of income to financially needy individuals who are aged, blind or disabled.[2] SSI benefits are financed from the general fund of the United States Treasury.[3]

Once SSA establishes an individual is eligible for disability benefits under the SSI program, SSA turns its efforts toward ensuring only those who remain disabled continue to receive benefits. Continuing disability reviews (CDR) are performed on SSI recipients to assess whether individuals remain medically eligible for SSI payments.[4] A decision to discontinue benefits is made when a CDR reveals the recipient no longer meets the medical requirements for disability benefits; these are referred to as medical

[1] The Social Security Act § 1601, *et seq.*; 42 U.S.C. § 1381 *et seq.* See also 20 C.F.R. § 416.101 *et seq*.

[2] *Id*.

[3] *Id*.

[4] Generally, the frequency of medical CDRs is dependent upon SSA's assessment of the likelihood of medical improvement. SSA is also required to perform CDRs no later than 12 months after birth for children where low birth weight is a contributing factor to the disability determination and reassess a disabled child's eligibility when they reach 18 years of age.

cessation decisions. Medical cessation decisions are made by disability examiners in the Office of Central Operations and State Disability Determination Services (DDS), as well as disability specialists in the program service centers. See Appendix B for additional background information on CDRs.

Once a decision has been made that an individual is no longer eligible for disability benefits, SSA informs the recipient of its decision. Provided the individual continues to meet the non-disability requirements for SSI, payments continue for 2 months after cessation. The recipient may appeal the decision within 60 days of the date he or she receives notice that SSA has determined that the individual's disability has ceased, or any time thereafter if good cause is shown for late filing.

The current appeals process has three administrative levels of review. First, the recipient can request that the DDS reconsider the cessation decision.[5] Second, if the recipient is dissatisfied with the DDS decision at the reconsideration level, the recipient may request a hearing before an Administrative Law Judge (ALJ) in the Office of Disability Adjudication and Review (ODAR).[6,7] Third, the recipient may appeal the ALJ's decision to the Appeals Council (AC). The AC may deny, dismiss, or grant the request for review. If the AC grants the request for review, the AC either issues a decision or remands the case back to an ALJ.[8]

Public Law 98-460 § 7 provides the recipient the option for benefit continuation through the reconsideration and ALJ levels of appeal in medical cessation decisions.[9] Benefit payments made during the appeals process are considered overpayments if the cessation decision is upheld. See Appendix C for the Scope and Methodology of our review.

[5] Reconsideration hearings are held before a disability hearing officer who reviews the evidence considered in making the initial decision and any other evidence received. Based on this evidence, a decision is made.

[6] ODAR replaced the Office of Hearings and Appeals on April 3, 2006.

[7] The ALJ considers the evidence that is in the file and any new evidence, provides an opportunity for a hearing, applies the SSA disability standards, and issues a new decision, which affirms or reverses the initial decision.

[8] SSA, POMS, SI 04005.010.

[9] Payments are ceased 2 months after the DDS makes a disability cessation decision or immediately following a cessation decision at any level of appeal, but they can be reinstated when a request for appeal to the reconsideration or ALJ level is filed. Furthermore, payments are not continued if the recipient is dissatisfied with the decision issued by an ALJ and the case goes to the AC. However, if the AC remands the case back to an ALJ, benefits can be reinstated.

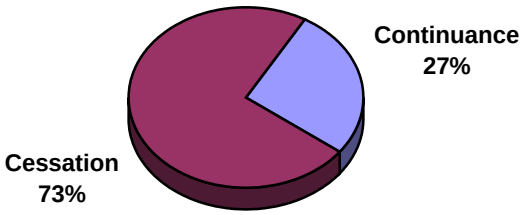
RESULTS OF REVIEW

We estimate that SSA paid approximately $199.5 million in SSI payments to recipients who received an appeal decision from an ALJ between October 1, 2002 and September 30, 2004. Of this amount, we project that about $146.1 million became overpayments when an ALJ affirmed the decision that the recipient was no longer eligible to receive SSI benefits. These large overpayments were incurred because SSA's process for making decisions on medical cessation appeals is not as efficient as it could be.

PUBLIC LAW 98-460

Twenty-seven percent of the recipients in our population whose benefits were continued as a result of Public Law 98-460 § 7 received a continuance by an ALJ (see Chart 1 and Appendix D, Table 1).[10] For these recipients, the intent of the law—to help prevent financial hardship to recipients who appeal a medical cessation decision—was achieved. However, for the remaining 73 percent of the recipients who received a cessation decision on their appeal, we project the application of the law resulted in the recipients being overpaid $146.1 million (see Chart 1).[11]

Chart 1
Population



PUBLIC LAW 97-455

Public Law 97-455 was enacted in 1983 to protect Disability Insurance beneficiaries from being financially disadvantaged while problems in the disability decision and appeals process were addressed—specifically, problems in the lack of uniformity of DDS and ALJ decisions. At that time, approximately 65 percent of DDS medical cessation decisions were reversed by an ALJ, which placed an undue financial burden on the majority of claimants whose benefits were terminated as a result of a CDR. This concern remained in 1984 when the law was extended by Public Law 98-460 to encompass SSI recipients. During the period of our review, the ALJ reversal rate for

[10] A continuance means that it was determined the individual remains medically eligible to receive SSI payments.

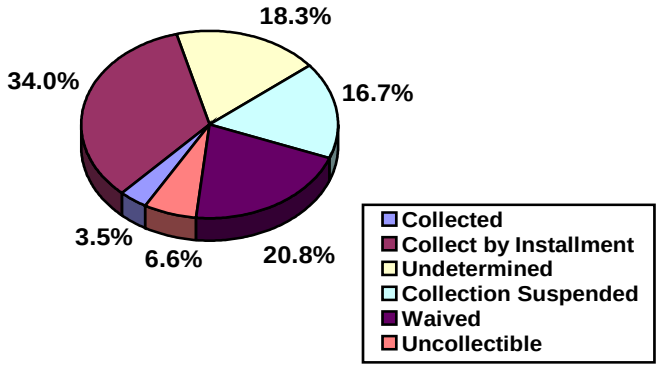
[11] A cessation means that the ALJ confirmed the DDS' decision that the individual is no longer medically eligible for SSI payments.

SSI medical cessation appeals was 27 percent. Therefore, it appears SSA's enhancements to the disability determination process, such as process unification,[12] have improved the uniformity of DDS and ALJ decisions.

OVERPAYMENTS RESULTING FROM CESSATION DECISIONS

Of the projected $146.1 million in overpayments identified for our cessation population, we project that only $5.2 million (3.5 percent) was collected, and approximately $49.7 million (34 percent) is in the process of being collected through installment payments (see Chart 2).[13] Furthermore, we project that SSA has not yet determined what action to take on approximately $26.8 million (18.3 percent) of the overpayments. We project that the remaining $64.5 million (44.1 percent) in overpayments were waived, deemed uncollectible by SSA, or collection of the overpayment was suspended.

Chart 2
SSA's Collection Activity



Waived

We project that SSA waived approximately $30.4 million (20.8 percent) of the overpayments identified in our population (see Chart 2 and Appendix D, Table 2). When overpayments are waived, the recipient is relieved from ever having to repay the funds to SSA. Accordingly, the funds will never be returned to the general fund. SSA grants SSI overpayment waivers when the recipient is not at fault for the overpayment and recovery would:

- be against equity and good conscience;
- impede effective and efficient administration because of the small amount involved; or
- defeat the purpose of SSI. [14]

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[12] The goal of process unification is to achieve correct, similar results in similar disability cases at all stages of the administrative review process.

[13] For the purposes of this report, we considered collection decisions of cross-program recovery, collection by installment payments, and SSI check adjustment to be collections by installment payments. Until the $49.7 million is actually collected, there remains the possibility that these monies will never be collected.

[14] SSA, POMS, SI 02260.001 (A)(1) and (2).

Collection Suspended

We project that collection was suspended for approximately $24.5 million (16.7 percent) of the overpayments identified in our population (see Chart 2 and Appendix D, Table 2). Debt in which collection is suspended is eligible for future benefit offset should the individual return to SSA's benefit rolls.[15]

Uncollectible

We project that approximately $9.6 million (6.6 percent) of the overpayments identified in our population were deemed uncollectible (see Chart 2 and Appendix D, Table 2). When an overpayment is deemed uncollectible, the recipient is relieved from ever having to repay the funds to SSA. Accordingly, the funds will never be returned to the general fund.[16]

LENGTH OF APPEAL

SSA's process for making decisions on medical cessation appeals could be more efficient to help reduce the amount of overpayments recipients incur during the appeals process. Specifically, SSA does not require medical cessation appeals to be given processing priority at the reconsideration level, even though they involve benefit outlays. Furthermore, although ALJs have instructions for medical cessation appeals to be given priority processing, the results of our review show that these cases need to be expedited more than the instructions currently require. Since reconsideration and ALJ appeals are not being processed timely and they involve benefit outlays, large overpayments are incurred. Given that medical cessation appeals often result in large overpayments, they should not be processed in the same manner as those cases that are not receiving payments. Therefore, appeals that involve benefit payments should be processed separately from those that do not involve payments to avoid or minimize overpayments.

Of the projected $146.1 million in overpayments incurred by individuals that were determined to be no longer eligible for SSI payments, we project:

- $43.9 million occurred at the reconsideration level of appeal;
- $88.3 million occurred at the ALJ level of appeal; and
- $13.9 million occurred between levels of appeal.

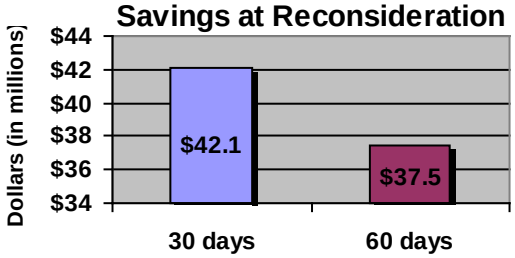
[15] SSA does not maintain statistics that isolate the dollar value of collections attributable to SSI debt in which collection was suspended.

[16] SSA has classified information regarding debt which has been deemed uncollectible or collection has been suspended as sensitive, not to be shared with the public. Therefore, we are not reporting the instances in which these classifications would be applied to an overpayment or the supporting citations.

Reconsideration

We project that SSA paid approximately $43.9 million in SSI payments during the reconsideration level of appeal to recipients in our cessation population.[17] The median processing time for the reconsiderations was 195 days. A reconsideration appeals process with a median processing time of 195 days is not financially efficient because it results in larger than necessary overpayments to SSI recipients. To minimize overpayments, SSA needs a process that results in timely decisions on medical cessation reconsiderations. If SSA would have completed the reconsiderations in our population within 30 to 60 days, we project that overpayments of between $37.5 and $42.1 million could have been avoided (see Chart 3 and Appendix D, Table 4).[18]

Chart 3
Savings at Reconsideration



Under the Commissioner's New Approach to improve the Social Security disability claims process, the reconsideration level of appeal will eventually be eliminated. It is our understanding that the reconsideration stage will be replaced by a Federal reviewing official who would review initial State agency denials if a claimant appeals. However, the new process, as it was presented in the Notice of Proposed Rule Making, is not clear as to what impact it will have on medical cessation appeals.[19]

[17] Since our sample was taken from those recipients who received an ALJ decision between October 1, 2002 and September 30, 2004, we did not have a complete population of reconsideration decisions. Therefore, the projected amount of overpayments that occurred during the reconsideration process is conservative.

[18] The evidence needed for a reconsideration decision is obtained during the CDR process with additional case development undertaken only when there is a reasonable basis to do so. If SSA's business process allows these cases to be processed immediately upon receipt, it is reasonable to expect a reconsideration decision on medical cessations within 30 to 60 days.

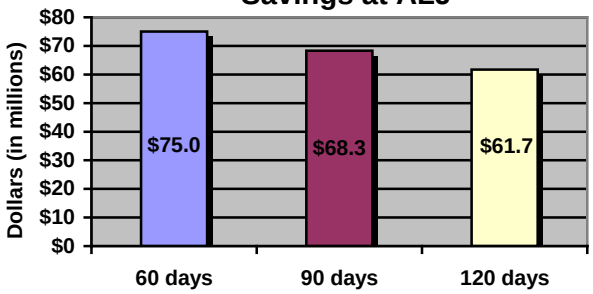
[19] Administrative Review Process for Adjudicating Initial Disability Claims, 70 Federal Register, pages 43589-43624 (2005).

Administrative Law Judge Appeals

We project that SSA paid approximately $88.3 million in SSI payments to recipients in our population during the ALJ level of appeal. While ALJs are instructed to assign disability cessation cases immediately to avoid or minimize overpayments,[20] the results of our review show that the instructions are not effective[21] because large overpayments are being incurred.[22]

The median processing time for ALJ appeals in our sample was 366 days. A process, with such a lengthy median processing time, is not financially efficient for claims that are receiving benefit payments. SSA needs to develop a process to make ALJ decisions on medical cessation appeals more timely. If SSA would have completed the ALJ appeal on cases in our population within 60 to 120 days, we project that overpayments of between $61.7 and $75 million could have been avoided (see Chart 4 and Appendix D, Table 5). [23]

Chart 4
Savings at ALJ



[20] HALLEX I-2-1-55.

[21] The average processing time for cases in our sample was 393 days and the average processing time for cases involving ALJ appeals was 420 days in Fiscal Year 2004.

[22] We recognize that recipients can increase the processing time for ALJ decisions by delaying the hearing, which will ultimately result in a larger overpayment. However, we did not consider this characteristic during our audit to determine how frequently this occurs, as it was outside the scope of our audit.

[23] Because the claimant is awaiting a hearing before an ALJ, and the length of time that has elapsed since the acquisition of evidence obtained during the CDR, it may not be reasonable to expect an ALJ appeal decision in less than 60 days. However, if SSA's business process allowed for medical cessation appeals to be processed immediately upon receipt at the hearing office, it is reasonable to expect the decision within 60 to 120 days.

Payments Stopped Untimely

We project that SSA paid approximately $13.9 million to SSI recipients in our cessation population between levels of appeal (see Appendix D, Table 6). This entire amount was avoidable because benefits were not terminated timely when a CDR, reconsideration,[24] or ALJ decision was made to discontinue benefits and the recipient had not yet appealed to the next level.[25] After a recipient has been notified of SSA's initial or reconsideration decision, and a timely request for appeal has not been made, payments should be ceased.[26] However, payments can be reinstated when a request for appeal to the reconsideration or ALJ level is filed.[27] Payments may not be timely stopped following a medical cessation decision, or an upheld appeal decision, if the proper coding is not entered in the computer system.

CONCLUSION AND RECOMMENDATIONS

We found that 73 percent of individuals in our population who appealed a CDR decision, and continued to receive payments throughout the appeals process, were overpaid. The overpayments were increased because SSA's process for deciding medical cessation appeals is financially inefficient. Medical cessation appeals should not be processed in the same manner as cases not receiving payments. Therefore, appeals that involve benefit payments should be processed separately from those that do not involve payments to avoid or minimize overpayments.

The President's Management Agenda introduced the initiative of improved financial performance throughout Government agencies. By making SSA's process for medical cessation determinations more efficient it would be better aligned with the President's vision. If SSA would develop a process for making decisions on medical cessation appeals in a timely manner, financial performance of the SSI program could be greatly increased. For example, if SSA decreased the processing time on the reconsideration and ALJ medical cessation appeals to 60 and 90 days, respectively, we project overpayments of $105.8 million could have been avoided for Fiscal Years (FY) 2003 and 2004. Based on the average of these 2 years, we estimate SSA could have

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[24] Some cases in our sample went directly to the ALJ level of appeal; therefore, they did not receive a decision at the reconsideration level of appeal.

[25] We only included the overpayments incurred after the ALJ appeal decision in our analysis if the claimant filed an appeal to the AC. If there was no further appeal filed after the ALJ decision, our overpayment analysis stopped as of the ALJ decision date.

[26] Provided the individual continues to meet the non-disability requirements for SSI, payments continue for 2 months after a DDS medical cessation. Claimants are given 10 days (plus 5 days mailing time) to request benefit continuation following the notice of a reconsideration decision that his or her disability has ceased, never existed, or is no longer disabling. However, payments should be ceased immediately following an ALJ cessation decision.

[27] SSA, POMS, DI 12027.055 (B) and 20 C.F.R. § 416.996(a).

avoided an additional $52.9 million in overpayments in FY 2005. Furthermore, we project SSA could have avoided overpayments of approximately $13.9 million if payments were timely stopped between levels of appeal.

The President's Management Agenda also emphasizes the Government's need to reform its operations in how it conducts business and how it defines business. SSA owes it to the American people to ensure that the resources entrusted to the Federal Government are well managed and wisely used. It is not only beneficial, but necessary for SSA to increase performance and citizen satisfaction by expediting cases that receive payments during the appeals process. To operate more efficiently, SSA needs to develop a new business process for cases in which benefits are being continued throughout the appeals process. Therefore, we recommend that SSA:

1. Enhance the business process to allow more timely decisions on medical cessation appeals.

2. Remind SSA components of the proper procedures for terminating SSI benefits following medical cessation decisions.

AGENCY COMMENTS

SSA agreed with all of our recommendations. The full text of SSA's comments is included in Appendix E.

Patrick P. O'Carroll, Jr.

Appendices

Acronyms

AC	Appeals Council
ALJ	Administrative Law Judge
CDR	Continuing Disability Review
C.F.R.	Code of Federal Regulations
DDS	Disability Determination Services
FY	Fiscal Year
HALLEX	Hearings, Appeals, and Litigation Law Manual
ODAR	Office of Disability Adjudication and Review
POMS	Program Operations Manual System
SSA	Social Security Administration
SSI	Supplemental Security Income
SSR	Supplemental Security Record
U.S.C.	United States Code

Background on Continuing Disability Reviews

The Social Security Administration (SSA) is required to conduct periodic continuing disability reviews (CDR) on individuals who receive Supplemental Security Income (SSI) payments. The purpose of CDRs is to assess whether individuals remain medically eligible for SSI payments. CDRs are conducted at various intervals. Specifically:

- Individuals with a significant potential for medical improvement are selected for review within the first 6 to 18 months of eligibility;
- Individuals with a lower probability of medical improvement are reviewed every 3 years; and
- Individuals with no expectation of medical improvement are scheduled for review every 7 years.[1]

In addition, SSA is required to perform:

- disability redeterminations for 18-year-old recipients using adult eligibility criteria for initial claims;
- CDRs not later than 12 months after birth for children where low birth weight is a contributing factor material to the determination of disability; and
- CDRs at least once every 3 years for children under age 18 with impairment(s) that are likely to improve (or, at the option of the Commissioner, recipients whose impairments are unlikely to improve).[2]

SSA is required to report to Congress the number of CDRs performed each year to meet legislative or regulatory requirements:

- Title II of the Social Security Act requires SSA to report to Congress annually on the results of periodic CDRs under the Social Security Disability Insurance program.[3]
- Title XVI of the Social Security Act requires SSA to report on the number of SSI CDRs and redeterminations in an annual report on the SSI program.[4]

[1] 20 C.F.R. § 416.990(d).

[2] Section 1614(a)(3)(H) of The Social Security Act, as amended (42 U.S.C. § 1382c(a)(3)(H)).

[3] The Social Security Act § 221(i), 42 U.S.C. § 421(i).

[4] The Social Security Act § 1637(a)(6), 42 U.S.C. § *1383f(a)(6).*

Processing CDRs

SSA conducts CDRs using one of two methods: full medical reviews or questionnaires (mailers).

Full Medical Reviews

Full medical reviews are primarily conducted by Disability Determination Services (DDS) located in each State and the District of Columbia in accordance with Federal regulations.[5] SSA's field offices send CDR cases to the DDSs throughout the year for processing. SSA initiates these CDRs for various reasons, including:

- routine scheduling of a medical review (this is sent out as a "direct release");
- responses to a CDR mailer indicating that the individual's medical condition may have improved;
- receipt of information that an individual's condition has improved and/or the individual has been working (this is sent out as a "work CDR"); or
- testing the reliability of SSA's systems and/or verifying assumptions through a full medical review.

SSA's folder processing centers send the case folder (which contains background and medical information on the individual) selected for a full medical CDR to the appropriate SSA field office for development. Field office personnel review the information in the case folder, interview the individual, and update pertinent facts in the folder prior to sending the case to the DDS for a full medical review. DDS medical examiners, using information in the case folder, determine if additional tests are necessary. Based on this information, a decision is made as to whether the individual is still disabled.

CDR Mailer Questionnaires

CDR mailers are questionnaires sent to disabled individuals asking whether the recipient has been employed, attended school or training, been told by a doctor whether he or she can work, has gone to a doctor or clinic for treatment, or has been hospitalized or had surgery.[6] If the answers to the questions indicate the individual's condition may have improved, the case is referred to a DDS office for a full medical review to determine whether the individual is still disabled.[7]

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[5] 20 C.F.R. § 416.1001 *et seq.*

[6] Normally, only individuals determined to have a low likelihood of medical improvement are sent mailers. Cases that are profiled as having a mid-range to high likelihood of medical improvement are scheduled for full medical CDRs rather than mailer questionnaires.

[7] CDR mailers were not included in our review because the review focused on medical CDRs in which the initial DDS decision was a medical cessation. If SSA sends out a mailer and, based on the information supplied in the response, they feel it is possible the recipient's disability has ceased, then they will open the case for a full medical review.

Scope and Methodology

To accomplish our objective we:

- Reviewed -
  - Program Operations Manual System DI 12027, DI 28080, GN 02201, SI 02201, SI 02260, SI 04005, SI 04030, SM 00614, and SM 01601
  - Hearings, Appeals, and Litigation Law Manual I-2-1-55
  - 20 Code of Federal Regulations Sections 416.101, 416.110, 416.990, 416.996, 416.1001, and 416.1417
  - Public Law 98-460 § 7
  - Sections 221, 1601, 1614, 1631, and 1637 of The Social Security Act
  - 42 United States Code Sections 421, 1381, 1382, and 1383

- Reviewed prior Office of the Inspector General audit reports related to overpayments and continuing disability reviews (CDR).

- Interviewed Social Security Administration (SSA) staff from the Office of Disability and the Office of Disability Adjudication and Review (ODAR) to obtain an understanding of (1) the CDR process, (2) appeals process for disability cessations, and (3) the treatment of overpayments.

- Obtained a file from the Office of Disability and Income Security Programs of all 25,786 individuals who received an Administrative Law Judge (ALJ) decision for medical cessation between October 1, 2002, and September 30, 2004. From this file, we identified a population of 23,198 individuals who continued receiving Supplemental Security Income payments while appealing SSA's CDR decision that they were no longer disabled.

- Separated the population of 23,198 into two groups:
  - 6,261 recipients (27 percent) who received a continuation at the ALJ level of appeal and
  - 16,937 recipients (73 percent) whose cessation was affirmed at the ALJ level of appeal.

- Selected a random sample of 250 cases from each of the two groups for a total sample size of 500 cases.

- Analyzed recipient information available on SSA's electronic systems—including the Supplemental Security Record (SSR)[1] and the ODAR query—and projected our results to the population.

We conducted our audit in Kansas City, Missouri between February and December 2005. We determined that the data used for this audit was sufficiently reliable to meet our audit objective. The entity audited was SSA field offices and program service centers under the Office of Central Operations and ODAR. We conducted our audit in accordance with generally accepted government auditing standards.

[1] We relied on the overpayment amount that was posted by SSA on the SSR; therefore, we did not determine if the posted overpayments were accurate.

Population and Sample Results

Of the 25,786 recipients who received an Administrative Law Judge (ALJ) decision for medical cessation between October 1, 2002 and September 30, 2004, we identified a population of 23,198 recipients who continued to receive Supplemental Security Income payments during the appeals process. An ALJ affirmed the cessation decision for 16,937 recipients and continued benefits for 6,261 recipients.

Our analysis of 250 cases where benefits were ceased identified 234 recipients who received payments during the appeals process totaling over $2.1 million that were subsequently considered overpayments. In addition, we conducted analysis on the overpayments to determine what the Social Security Administration's (SSA) recovery activities were for each individual. Our analysis of 250 cases allowed to continue to receive benefits identified 242 recipients who received payments during the appeals process totaling over $2.1 million. The following tables reflect the sample results and projections based on our audit.[1]

Table 1: Population and Sample Size			
	Continuance	**Cessation**	**Total**
Population size	6,261	16,937	23,198
Percent of total population	27%	73%	100%
Sample size	250	250	500
Number of Cases			
Cases Identified in Sample	242	234	476
Point Estimate	6,061	15,853	21,914
Lower Limit – Quantity	5,908	15,322	
Upper Limit – Quantity	6,159	16,247	
Associated Dollar Amount			
Payments Identified in Sample	$2,130,675[2]	$2,156,480[2,3]	$4,287,155
Point Estimate	$53,360,614	$146,097,190	$199,457,804
Projection Lower Limit	$49,673,526	$136,617,822	
Projection Upper Limit	$57,047,702	$155,576,558	

[1] All projections in the following tables were calculated at the 90-percent confidence level.

[2] A portion of this amount includes State supplements, which are monies paid to the recipient by the Federal Government on behalf of the State.

[3] Approximately $62,000 (3 percent) of this amount was payments made to recipients who received an ALJ decision in our timeframe, but has since re-appealed the decision. Since these cases are still in appeal, the overpayment will be reversed if the final decision is favorable.

Table 2: Overpayment Recovery Activities						
	Collected	Collection In Process	Waived	Collection Suspended	Uncollectible	Undetermined
Identified in Sample	$76,226	$733,390	$448,661	$360,966	$141,811	$395,426[4]
Percent of Sample[5]	3.5%	34%	20.8%	16.7%	6.6%	18.3%
Point Estimate	$5,164,186	$49,685,691	$30,395,907	$24,454,694	$9,607,401	$26,789,310
Projection Lower Limit	$3,325,007	$40,420,941	$23,164,063	$18,133,447	$5,192,779	$19,793,023
Projection Upper Limit	$7,003,365	$58,950,442	$37,627,751	$30,775,941	$14,022,024	$33,785,596

Table 3: Breakdown of Overpayments Incurred By Level of Appeal[6]			
	Reconsideration	ALJ	Between Levels of Appeal
Identified in Sample	$647,472	$1,303,186	$204,722
Percent of Sample	30%	60.4%	9.5%
Point Estimate	$43,864,941	$88,288,261	$13,869,533
Projection Lower Limit	$40,065,597	$81,039,956	$11,891,401
Projection Upper Limit	$47,664,285	$95,536,565	$15,847,666

Table 4: Savings at Reconsideration		
	Reconsideration Appeal not Complete in:	
	30 Days	60 Days
Identified in Sample	$621,433	$553,983
Percent of Sample[7]	96%	85.6%
Point Estimate	$42,100,858	$37,531,256
Projection Lower Limit	$38,337,972	$33,836,936
Projection Upper Limit	$45,863,745	$41,225,576

[4] Approximately $11,000 (3 percent) of this amount are payments that SSA has not recognized as an overpayment due to appeal proceedings and input errors. Until there is action taken to assess the overpayment, SSA will not attempt to collect the funds.

[5] This is a percentage of the total overpayments for cessation decisions ($2,156,480).

[6] Although payments should not continue through the Appeals Council level of appeal; we found two cases in our sample that received a payment. Since the number of cases and the amount of the payments were immaterial for these cases, we did not include these payments in our analysis of cases by level of appeal.

[7] This is the percentage of the total amount of overpayments incurred at the reconsideration level of appeal ($647,472).

Table 5: Savings at ALJ Level			
	ALJ Appeal not Complete in:		
	60 Days	90 Days	120 Days
Identified in Sample	$1,106,729	$1,008,464	$910,249
Percent of Sample[8]	84.9%	77.4%	69.8%
Point Estimate	$74,978,670	$68,321,399	$61,667,546
Projection Lower Limit	$68,276,628	$61,845,670	$55,437,378
Projection Upper Limit	$81,680,713	$74,797,129	$67,897,714

Table 6: Overpayments Incurred Between Levels of Appeal				
	Before Reconsideration	Before ALJ	Before Appeals Council	Total
Identified in Sample	$20,163	$178,422	$6,138	$204,723
Percent[5]	.9%	8.3%	.3%	9.5%
Point Estimate	$1,365,979	$12,087,745	$415,809	$13,869,533
Projection Lower Limit	$782,482	$10,247,073	$179,186	
Projection Upper Limit	$1,949,475	$13,928,417	$652,433	

[8] This is the percentage of the total amount of overpayments incurred during the ALJ appeal ($1,303,186).

Agency Comments

SOCIAL SECURITY

MEMORANDUM

Date: May 4, 2006 Refer To: S1J-3

To: Patrick P. O'Carroll, Jr.
Inspector General

From: Larry W. Dye /s/
Chief of Staff

Subject: Office of the Inspector General (OIG) Draft Report, "Impact of Statutory Benefit Continuation on Supplemental Security Income Payments Made During the Appeals Process" (A-07-05-15095)--INFORMATION

We appreciate OIG's efforts in conducting this review. Our comments on the draft report's recommendations are attached.

Please let me know if you have any questions. Staff inquiries may be directed to Ms. Candace Skurnik, Director, Audit Management and Liaison Staff, at extension 54636.

Attachment:
SSA Response

COMMENTS ON THE OFFICE OF THE INSPECTOR GENERAL'S (OIG) DRAFT REPORT, "IMPACT OF STATUTORY BENEFIT CONTINUATION ON SUPPLEMENTAL SECURITY INCOME PAYMENTS MADE DURING THE APPEALS PROCESS" (A-07-05-15095)

Thank you for the opportunity to review and provide comments on this draft report. Overall, the Agency supports the purpose of this audit but has several concerns regarding the results.

We disagree with the conclusion that appeals for which benefits are being paid should be processed completely separately from appeals where benefits are not being paid. Two of our top goals are to: (1) deliver high-quality, citizen-centered service in a timely and efficient manner; and (2) ensure superior stewardship of Social Security programs and resources. Financial efficiency is not the single goal of the Social Security programs, especially when it comes to needy disabled individuals. We have a duty to serve all citizens in a timely and efficient manner. We also have a duty to follow the requirements of law as set forth in Congressional statutes, Agency regulations and in Federal court decisions, which may dictate priorities that are at odds with financial efficiency considerations alone.

Furthermore, it is unrealistic to suggest that reconsiderations of medical cessations can be completed within 30 days on average or that hearing decisions by an Administrative Law Judge (ALJ) on such cases can be completed within 60 days on average. In this regard, it appears from footnote 18 (page 7) that the report has overlooked the fact that a recipient who requests reconsideration of a medical cessation must be offered the opportunity for a face-to-face evidentiary hearing with a disability hearing officer employed by an adjudicatory unit other than the one that made the decision being appealed (20 C.F.R. §416.1414ff). Scheduling, sending the required notice at least 20 days before the hearing, and holding an evidentiary hearing only adds time to a process where initial disability decisions currently average over 90 days to process. It is incorrect to say that reconsiderations and hearings merely consist of a reexamination of existing evidence. We do not believe that processing disability cessation reconsiderations in approximately twice that time is "untimely." As for ALJ hearings, this report offers no basis for the assumption that such hearing decisions can be successfully completed within 60 days on average.

Recommendation 1

Enhance the business process to allow more timely decisions on medical cessation appeals.

Comment

We agree. Enhancing the business process may allow for improved stewardship and more timely decisions regarding Supplemental Security Income (SSI) cessation cases and benefit continuation during the appeal period. We intend to decrease processing time in all our disability appeals through the implementation of eDib and the new disability regulations.

Processing times reflected in the report indicate that we are following the regulations and ALJs are following HALLEX guidelines that include assignment of continuing benefit disability cessation cases as 7th of 11 categories of priority cases they may be processing. There are significant reasons for the categorization of these priorities and we cannot justify moving this category of cases ahead of the others. Although we recognize our responsibility to stewardship, we must at times balance that against service obligations. Therefore, at this time we are not in a position to support segregating cases that are receiving benefit continuation and processing those cases first.

Recommendation 2

Remind SSA components of the proper procedures for terminating SSI benefits following medical cessation decisions.

Comment

We agree. We will remind the appropriate components of the proper procedures for terminating SSI benefits following medical cessation decisions. Also, it should be noted that SSA implemented systems enhancements in January and April 2004 which automatically handle payment termination in Statutory Benefit Continuation cases with Office of Hearings and Appeals (OHA) or Disability Determination Service (DDS) involvement, respectively. When the termination decision is received from the DDS or ALJ, the SSI system automatically terminates the benefit continuation according to established guidelines. Manual intervention is not required. In addition, systems controls are in place to ensure that these cases can be tracked.

OIG Contacts and Staff Acknowledgments

OIG Contacts

Mark Bailey, Director, Kansas City Audit Division (816) 936-5591

Shannon Agee, Audit Manager (816) 936-5590

Acknowledgments

In addition to those named above:

Khristan Kaufman, Auditor

Kenneth Bennett, IT Specialist

N. Brennan Kraje, Statistician

Cheryl Robinson, Writer-Editor

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