

ISSUE BRIEF



The Single Decision Maker Pilot *A 16 Year Flight and Still No Clear Landing*

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Executive Summary

Two disability programs administered by the Social Security Administration (SSA) provide cash benefits to workers who can no longer engage in substantial gainful activity because of a disabling condition that is expected to last more than one year or end in death. Adjudicators aim to make these determinations both quickly and accurately; accuracy in this context means that claimants meet SSA's definition of disability. Normally, after a case has been developed by a disability examiner, a medical consultant—a physician or psychologist—must 'sign off' on each case. In 1999, SSA launched the Single Decision Maker (SDM) program—authorizing disability examiners to process some cases without a medical consultant's sign off. The objective was to shorten the determination process, without degrading accuracy. Twenty case processing offices have had SDM authority for the past 16 years.

SSA is now considering whether to extend SDM authority nationally, eliminate the program altogether or possibly extend the authority to a subset of cases that can be decided most easily. Some data exist regarding cost, accuracy, and speed of determination for the SDM.



Unfortunately, the quality of those data is deficient in many ways. High-quality data would have been difficult to develop and generalize as the disability determination process is administered differently in each state. To do so would have required a well-considered research design and data-collection plan with tight administration over the past 16 years. We find little indication of effort by SSA to establish a research design or data collection plan that could have generated the data necessary to make a fact-based recommendation.

Accordingly, the SSAB is unable to recommend whether the SDM model should be extended, terminated, or in some way modified. We say this with regret, as administrative pilots offer a promising way to control administrative costs and improve public satisfaction with the program. Such experiments are important and should continue. However, none should move forward without a clear research design, a plan for collecting data in a form that will lend itself to analysis, and assignment of managers with a clear understanding of the research design and authority to manage the project.

Introduction

SSA administers two disability programs: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). Through its nationwide network of field offices, SSA processes disability applications in conjunction with state agencies known as Disability Determination Services (DDSs). The federally funded DDSs develop medical records and determine whether claimants are disabled or blind under SSA guidelines. SSA field offices help the public submit claims and adjudicate non-medical aspects of the claim. SSA strives for three main objectives in disability determinations: consistency, timeliness, and accuracy.

Implementation

In the early 1990's, demographic shifts and legislative changes led to a rapid expansion of workloads that began to overwhelm SSA's ability to process disability claims. Responding to these pressures, SSA proposed the Disability Redesign in 1994—83 changes to improve the disability decision-making process. One proposal was the SDM—giving authority to DDS examiners to make initial disability determinations without requiring a medical consultant's signature.¹ It was hoped that the SDM would enable earlier decisions and free medical consultants to concentrate on the most difficult cases.

SSA received and addressed public comments on the SDM proposal and in 1995, it finalized rules for the new model. From 1996 to 1999, SSA tested the SDM model at select offices and determined the model to be effective. In 1999, the agency started the SDM pilot at 10 DDS

¹ Some claims—mental impairment denials and childhood disability cases—still require a medical consultant's signature.



offices – referred to as ‘the SDM prototype.’ Later that year, SSA expanded the pilot to 10 additional DDS offices²—referred to as ‘SDM II.’³ These 20 DDSs continue to operate with SDM authority.

Measurements

To determine efficacy of the SDM model, the Board has spoken with current and former SSA executives, DDS administrators, Center for Disability Directors, and disability examiners. The Board has reviewed published reports by SSA from the Office of Quality Performance (OQP) and the Office of the Inspector General (OIG). From our conversations and research, we have determined three areas that should be examined in order to understand the advantages and disadvantages of the SDM model: processing time, accuracy, and allowance rates.

Processing Time

In our discussions with many SSA disability examiners, managers and directors at the DDS’ over the past year, we heard unanimous support for expanding SDM authority nationwide. They stated that the authority allowed them to move cases to a decision faster because they did not have to wait for input from a medical consultant in cases where such input is not required. DDSs using the SDM may still use medical consultants in complex cases.

A recent OQP study analyzed the potential impact of nationwide SDM authority.⁴ The analysis concludes that if SDM authority was used nationwide, it would reduce overall case processing time by approximately 11 days, improving service to the public.⁵

SDM change in DDS processing time (OQP) April 2011—December 2011			
	Overall	SSDI	SSI
Days	-11	-11	-13

Before release of OQP’s updated study, the SSA Office of the Inspector General (OIG) conducted its own study of the SDM. The OIG study examined a random sample of cases

² Florida, Guam, Kansas, Kentucky, Maine, Nevada, North Carolina, Vermont, Washington, and West Virginia.

³ Alabama, Alaska, California (LA North and LA West only), Colorado, New York, Louisiana, Michigan, Missouri, New Hampshire, and Pennsylvania.

⁴ SSA, Office of Quality Performance. Estimating the Effects of National Implementation of Single Decision Maker, August 2013.

⁵ OQP had released an earlier version of this report (2010) but reported that this update used a more reliable indicator of which cases were processed using SDM authority.



involving two impairments: back disorders and genito-urinary disorders.⁶ In their sample, SDM sites processed cases faster than non-SDM sites.⁷

SDM change in DDS processing time (OIG) April 2011—December 2011		
	Back disorder	Genito-urinary cases
Days, SDM to non-SDM	-26	-11
Days, SDM (without MC signature) to non-SDM (with MC signature)⁸	-38	-22

Accuracy

The term ‘accuracy,’ as used by SSA, means determinations that are compliant with SSA’s disability policy requirements. SSA’s OQP is responsible for quality reviews of cases processed at state DDSs. Using data from these samples, the 2013 OQP study found statistically significant differences between SDM and non-SDM sites: “Cases for which SDM was used were associated with lower decision errors and lower rates of case deficiencies.”

The Board urges caution in relying on SSA’s definition of DDS performance accuracy. Overall performance accuracy rates between 2007 and 2014 range from a low of 93.7% to a high of 99.6%. States cannot fall below the performance accuracy threshold of 90.6% for more than two consecutive quarters without SSA intervention.⁹ Cases are counted as inaccurate only if a) the reviewer disagreed with the rationale or basis for the determination of the initial examiner, and b) if the inaccuracy changed the decision.

In our discussions with Appeals Council (AC) representatives, however, we learned that while OQP was reporting similarly high accuracy rates in reviewing administrative law judge

⁶ The OIG chose to focus on two specific impairments: back (because it was the most frequent impairment in their data file) and genito-urinary (based on SSA staff input).

⁷ SSA, Office of the Inspector General. Single Decisionmaker Model – Authority to Make Certain Disability Determinations Without a Medical Consultant’s Signature, August 2013.

⁸ Cases processed at an SDM site may still require review by a medical consultant. This particular comparison specifically compares cases that were processed by the SDM (under the DDS examiner signature) to those cases processed without the benefit of the SDM process (under the medical consultant’s signature).

⁹ If a DDS performance fails to meet SSA’s accuracy standard, SSA must provide technical and management assistance which may include: onsite review of cases, fiscal and administrative management review, a team of experts for case review or training, fiscal aid above the authorized budget, diversion of workload to another case processing unit, stationing of SSA personnel in DDS, or outside contracting of workloads.



decisions, the AC Division of Quality was remanding or issuing a corrective decision in approximately 20 to 25% of favorable cases. The AC standard for review is whether the ALJ reached a legally supportable conclusion that is free of material error.

Allowance Rate

OQP estimates that extending SDM nationwide would slightly increase the allowance rate.¹⁰ As a result, OQP estimates that expanding SDM nationwide would increase the number of awards and benefit payments. The estimate accounts for the percentage of cases, based on historical appeal rates, that the Office of Disability Adjudication and Review (ODAR) would ultimately allow on appeal. In contrast to the OQP study, the OIG analysis of their sample of two impairments reported that SDM II sites have lower final allowance rates than non-SDM sites.¹¹

Overall allowance change for original authority SDM (OQP)		
April – December 2011		
	SSDI	SSI
Rate increase estimate	+0.89%	+0.87%
Case increase estimate	~14,000	~4,000

Overall allowance rates (OIG)		
CY 2011		
	SDM II	Non-SDM
Back disorder	52%	57%
Genito-urinary	74%	78%

In addition, the OIG reported that their finding of lower initial allowance rates for SDM II sites resembled initial allowance rates nationwide (including all impairments and all claims).¹²

Overall allowance rates (SSA)		
CY 2010		
	SDM II	Non-SDM
All impairments	46.5%	50%

¹⁰ SSA OQP, March 2013.

¹¹ The OIG report included a comparison to Prototype states but the removal on the reconsideration step of appeals prevents a clear comparison to these sites.

¹² SSA OIG, August 2013.

The allowance rates in OIG’s random sample of select impairments are in line with nationwide allowance rates, but conflict with the increase in allowance rates found in the OQP study of original authority SDM sites. The OQP study, however, used a more statistically sophisticated method of analysis than did the OIG study, because it controlled for systematic differences by impairment and DDS site.

Nationwide Implementation of SDM for Quick Disability Decisions (QDD) and Compassionate Allowances (CAL)

In November 2010, SSA implemented a new pilot called Disability Examiner Authority (DEA)—implementing SDM authority nationwide on a subset cases known as Quick Disability Determinations (QDD) and Compassionate Allowances (CAL).¹³ QDDs and CALs are used for claimants with conditions that SSA has determined have a high likelihood of being awarded benefits based on the seriousness of the impairment.¹⁴ SSA uses QDDs when its predictive model flags cases that have high potential for quick approval of benefits based on the severity of the impairment and ready availability of medical evidence.¹⁵ CAL cases are for the most severe cases where the claimant’s condition invariably leads to a disabling condition. QDDs or CALs allow SSA to expedite decisions for those most likely to be disabled while focusing resources on other claimants. Like the SDM, the new DEA authority enables disability examiners to make favorable allowance decisions without the approval of a medical consultant.

Processing Time – SDM for QDD/CAL

The 2013 OQP study also analyzed the current impact of the new DEA. The study found that the new nationwide SDM authority for QDD/CAL cases reduced case processing by approximately three days, a reduction of 23% (mean processing time overall for QDD/CAL cases was 13 days).

Accuracy – SDM for QDD./CAL

The OQP was unable to do a similar statistical analysis on the new SDM authority because the sample was too small, but a simple comparison table revealed no statistically significant difference in accuracy when compared to non-SDM cases.

¹³ This new authority has been extended to 11/13/2015. <https://federalregister.gov/a/2014-20535>.

¹⁴ Both quick disability determination (QDD) and compassionate allowance (CAL) cases use predictive modeling to identify claimants with the most severe disabilities to enable expeditious decision-making.

¹⁵ 20 CFR 416.1019.

Allowance Rate – SDM for QDD/CAL

Using post-implementation data, OQP found that the new SDM authority for QDD/CAL cases was associated with a small increase in allowance rates resulting in some new allowances.

Allowance change for SDM with QDD/CAL cases (OQP) April 2011—December 2011	
	SSDI/concurrent and SSI adult cases combined
Rate increase estimate	+0.21%
Case increase estimate	~250

The results of a national rollout of a limited SDM authority demonstrated a decrease in processing time, no change in accuracy, and a small increase in allowances. Because cases flagged for quick processing differ from other cases, it is unclear how these results will compare to a national rollout of SDM for most cases. However, SSA could decide to keep the DEA nationwide while eliminating the SDM.

Further Analysis Needed

Although the OQP study controlled for many variables, it does not conclusively point to success or failure of the program. The number of cases processed using SDM authority differs widely among DDSs. Each DDS uses its own protocol for deciding which cases to process by SDM. For an evaluation to have been useful, SSA would have had to control the implementation of the SDM by imposing uniform policy regarding SDM assignment. Although the OQP model controlled for many variables, it did not control for such relevant factors as adjudicator tenure. ODAR has also noted that the weight given to a determination by an SDM is lower than the weight given to a decision signed by a medical consultant. An initial determination that carries a medical consultant’s signature is considered a state agency medical opinion that is given more weight on review. In contrast, an SDM determination is considered an administrative finding, which, by definition, receives no evidentiary weight. SSA needs to address this discrepancy before SDM is extended to other sites. A consistent national policy should eliminate this evidentiary imbalance between SDM and non-SDM cases.

In our interviews with SDM offices, the Board learned that an SDM might discuss a case with a medical consultant even if the case does not receive formal medical consultant review and signature. ODAR noted that there is currently no way to know if an appealed case received this informal medical consultant input. More detailed information is available about the SDM’s



decision-making process through the electronic Claims Analysis Tool in DDSs, but it does not require a notation by the SDM that the case was discussed with a medical consultant.

Because the higher predicted allowance rate would boost outlays from the trust fund, SSA should evaluate more fully why use of SDMs increased allowance rates. This should be done before the agency decides whether to expand or discontinue use of the SDM. This evaluation would enable the agency to determine whether the higher allowance rate arises because of preselection of cases based on criteria that offices use in assigning cases to SDM authority. SSA should conduct an independent analysis of the accuracy of the decisions. For example, SSA could examine the reversal rate on appeal to ODAR for systematic variation between SDM and non-SDM cases. If the cases are properly allowed, and are allowed at the earliest appropriate time, the SDM authority is in line with agency goals of providing accurate and timely public service.

If in fact, the allowances comply with agency policy, SSA should analyze the reason for the difference. When SSA understands the processes and how they improve decision-making, it can assess how to replicate it appropriately. The improved processes could then be incorporated into the non-SDM cases while keeping the medical consultant step that can be helpful on appeal. If SSA does rescind the SDM authority, the decision will also affect case management, processing time, and employee morale. Any changes to the current structure should be considered carefully and explained fully to affected employees.

Conclusion

The partial use of SDMs leaves the nation without a uniform disability policy. The SDM model streamlined the disability determination process and it appears it did so without reducing administrative quality. The OQP study predicts slightly higher allowance rates, but the reasons for this increase are unclear. SSA needs to better define SDM success. We believe that if SDMs issue faster decisions that still comply with agency policy, the added costs are justified. However, without a meaningful data analysis of the program, it is impossible to say for sure that decisions are accurate and consistent under the program.

The SSAB recognizes that after 16 years, SSA may conclude that it is necessary either to end or to extend nationally the SDM model. The SSAB regrets that it cannot recommend one course over the other, based on the data available. Accordingly, we are silent on that issue. We call upon the agency to pay greater attention to research design and execution so that such a situation does not arise in the future.



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