Research Portfolio on Disability

Social Security and State Disability Determination Services Agencies: A Partnership in Need of Attention

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Bob Joondeph, Chair
Nancy J. Altman
Jagadeesh Gokhale
Amy Shuart

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Introduction

The Social Security Administration (SSA) and the state Disability Determination Services (DDSs) share responsibility for initial disability determination decisions and assessing continued eligibility for Social Security Disability Insurance (DI) and Supplemental Security Income (SSI).[1] DDSs also conduct reconsiderations, the first step in appealing a benefit denial. Congress created the SSA/DDS framework in 1954 and has maintained it ever since.

The partnership has inherent tensions and contradictions. While SSA holds ultimate responsibility for policy-compliant disability determination decisions, it does not control the selection of DDS staff that make those decisions. Each DDS is fully funded by SSA and expected to follow SSA's complex legislative and policy interpretations. Each DDS is also subject to the laws and regulations in its state, from employee qualification standards to accounting and fiscal requirements. By the end of Fiscal Year (FY) 2022, over one million initial and reconsidered claims were waiting to be processed at the nation's DDSs.[2] The pandemic heightened communication, technology, and other challenges in the SSA/DDS relationship.

This report outlines the SSA/DDS partnership's history, evolution, and management. It also articulates that the structure of the relationship has remained static for decades even as technology, program integrity, and other requirements have changed. Lastly, it offers examples of how SSA's management approach helps and hinders the relationship and the disability determination process more broadly in both policy and procedure.

Essentially, the SSA/DDS partnership exists to fulfill statutory requirements and support accurate (considered "reliable" state agency adjudication),[3] efficient, timely, and consistent decision-making across the country. DDSs must recruit and train professional staff and deploy them to

[1] 20 Code of Federal Regulations (CFR) §404.1602 defines a state for DI claims as "any of the 50 States of the United States, the Commonwealth of Puerto Rico, the District of Columbia, or Guam. The SSI program regulations at 20 CFR §416.1002 define "state" as any of the 50 states in the United States and the District of Columbia.
[2] At the end of FY 2022, 1,173,488 initial and reconsideration claims were pending across all state DDSs. SSA, *State Agency Monthly Workload* dataset, "All Initial Claims" and "All Reconsiderations" summed for FY 2022, plus "Closing Pending," September 2022.
[3] 20 CFR § 404.1643 and § 416.1043.

achieve those goals.[4] SSA funds each DDS for all staff and medical evidence expenses, and allowable indirect costs. The agency also provides training materials, policies, and performance expectations to inform the process and ensure program integrity.[5] Lastly, Congress is responsible for enacting legislative change, promoting or inhibiting administrative and budgetary flexibility, providing adequate and timely funding, and conducting oversight of SSA to ensure effective public service.[6]

The Social Security Advisory Board ("Board") has previously explored the relationship between SSA and DDSs.[7] Most recently, the Board engaged DDS management and personnel through public roundtable discussions to hear their perspectives on the disability determination process and the support they receive from SSA. The Board also met with former SSA executives to understand how the regulations governing the SSA/DDS relationship facilitate, and potentially complicate, consistent and efficient conduct of the disability determination process.[8] This report builds upon those efforts by providing historical context for the SSA/DDS relationship and highlighting three areas warranting further review: DDS personnel/fiscal issues, information technology (IT), and performance and productivity.

A Brief History of the State Role in the Social Security Disability Process

The shared SSA/DDS responsibility inherent in the disability determination process has a long history. The federal-state partnership has survived despite concerns regarding programmatic consistency and SSA's need to manage a process conducted by state employees.[9] Still, it is helpful to understand why states play such an important role in the DI and SSI programs.

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[4] 20 CFR § 404.1620 and §416.1020.
[5] 20 CFR 404.1603 and § 416.1003
[6] Todd Garvey and Daniel J. Sheffner, *Congress's Authority to Influence and Control Executive Branch Agencies*. Congressional Research Service (CRS), May 2021, 1 – 2.
[7] Social Security Advisory Board (SSAB), *How SSA's Disability Programs Can Be Improved*, 1998; *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change*, 2001; *The Single Decision Maker Pilot: A 16 Year Flight and Still No Clear Landing*, 2015; *Summary of Disability Process Improvement Roundtables*, 2020.
[8] SSAB, *State Agencies' Role in Social Security Disability Determinations*, September 23, 2021.
[9] Metrics such as allowance rate or average processing time can vary widely by DDS. Jack Smalligan and Chantel Boyens, *Improving the Social Security Disability Determination Process*, Urban Institute, July 2019, 7 – 8.

State Administration of Workers' Compensation and Vocational Rehabilitation (VR)

States assessed the effect of disability on work capacity long before the Social Security disability program became law in 1956. Some states were engaged in disability assessment and determination as early as 1911, when individual states began passing workers' compensation legislation.[10] States established medical criteria for evaluating the extent to which a workplace injury (or, less frequently, an occupational illness) curtailed work capacity and qualified an employee to be compensated for full, partial, temporary, or permanent disability.[11] In 1920, Congress established the first civilian VR program for disability assessment, occupational training, and re-employment assistance. State governments held administrative responsibility for this program and were required to match a portion of the federal grant amount with state funds.[12] This dual, federal-state structure created a model for the future.

State Administration of Early Social Security Act Programs

The Social Security Act (Act) of 1935 authorized the creation of grants to states designed to support economically disadvantaged people who were blind and children, including those with disabilities. State welfare departments primarily administered the programs.[13] Congress debated adding broader federal disability benefits to the 1935 legislation and raised the issue again during consideration of the proposed 1939 and 1950 amendments but did not include disability insurance as part of those amendments.

In a 1948 report to the Senate Committee on Finance, that year's Social Security advisory council recommended the creation of disability insurance for adults determined to have total and permanent disabilities. The recommendation included a dissent arguing for a federally funded but state-administered welfare program paying income support to people with disabilities.[14] At the time of the 1948 report, some policy experts worried that

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[10] Gregory P. Guyton, "A Brief History of Workers' Compensation," *The Iowa Orthopaedic Journal*, 19, 1999, 108.
[11] Ibid, 109.
[12] Richard K. Scotch, "American Disability Policy in the 20th Century," *The New Disability History: American Perspectives*, 2001, 381 – 382.
[13] Titles IV, V, and X, *Public Law 74-271, Social Security Act of 1935*, August 14, 1935.
[14] Edward D. Berkowitz, *Disabled Policy: America's Programs for the Handicapped,* Cambridge University Press, 1987, 67 – 68.

states lacked the administrative capability to oversee a disability-based income support program, while others cited workers' compensation and VR as proof they could.[15]

In 1950, Congress established grants called Aid to the Permanently and Totally Disabled.[16] The law required each state to provide matching funds and submit regular documentation about populations served and other administrative details. Otherwise, Congress left program administration to the states. The law did not establish a specific definition of disability.[17] After enactment of SSI, a sample of conversions from the state-administered programs to the stricter requirements indicated insufficient evidence and significant errors when determining federal program eligibility.[18]

The Disability Freeze and the Origin of the SSA/DDS Relationship

Even though DI would not become an insured Social Security protection until 1956, disability determinations began two years earlier through the implementation of the disability "freeze" enacted in 1954.[19] Because Social Security benefits are based on career averages, workers who left work in the event of disability before reaching retirement age would have lower career averages on which those benefits were based. The freeze addressed that problem.

The statutory language creating the freeze included a strict definition of permanent and total disability.[20] Supporters of the program sought compromises to ensure its passage in the Senate, including a provision that state governments would determine medical eligibility for the freeze.[21] Today,

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[15] Ibid, 68, 71.
[16] Phyllis Hill, "Aid to the Permanently and Totally Disabled," *Social Security Bulletin (SSB) 13*, no. 12, 1950, 11 – 12.
[17] Ibid, 13.
[18] GAO, *A Plan For Improving The Disability Determination Process By Bringing It Under Complete Federal Management Should Be Developed*, HRD-78-146 (August 31, 1978), 32 – 33.
[19] SSA, *Program Operation Manual System (POMS)* DI 25501.240, November 19, 2012.
[20] The Act defines disability as "…inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months…," United States Code (USC) Title 42 §423(d), 1687 and §1382c(a)(3)(A), 2293. For more on developing the first definition, see Berkowitz supra N. 14, 71.
[21] Wilbur J. Cohen, Robert M. Ball, and Robert J. Myers, "Social Security Act Amendments of 1954: A Summary and Legislative History," *SSB 17*, no. 9 (1954), 11.

the SSA/DDS approach remains intact. Some of the reasons cited most frequently for why the state/federal partnership remains are:

1. As stated, there is a longstanding precedent for state entities to conduct medical eligibility determinations.
2. Federal labor costs are generally higher than state labor costs, partly due to state salary ceilings that tend to be lower than those set by the federal government.[22]
3. Regulatory authority given to DDSs calls for establishing relationships with state-level medical providers.[23]

The Federal/State Framework

When it enacted the freeze in 1954, Congress set these statutory parameters for the SSA/DDS relationship:[24]

- Determinations of disability, onset date, and disability cessation were the responsibility of the state agency in the state in which the claimant resides.
- SSA entered into agreements with states to conduct disability determinations (this provision was amended in 1980, as discussed later in this brief). States may decline to adjudicate claims for all or certain classes of claimants within their jurisdiction (in those instances, those declined cases would be determined by SSA's federal DDS).
- The statute authorized SSA to advance funds to or reimburse state DDSs for the costs of carrying out the agreements using Trust Fund resources. Such resources may only be used for functions related to DI determinations; SSI determinations are funded using appropriated general funds.[25]
- SSA was authorized to review initial determinations and reverse or revise any allowance, onset date, or continuation of benefits found non-compliant with disability policy. (In subsequent amendments to the Act,

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[22] GAO, *SSA: Strategic Workforce Planning Needed to Address Human Capital Challenges Facing the DDSs*, GAO-04-121 (January 27, 2004), 20 – 22.
[23] 20 CFR §404.1603(13) and §416.1003(13), 2007; SSA, "Professional/Medical Relations Officers In Your Area," *Medical/Professional Relations* website and SSAB supra N. 8, 2:01:08.
[24] Section 221, *Public Law 83-761, Social Security Amendments of 1954*, September 1, 1954, 1081 – 1082.
[25] Section 305, *Public Law 92-603, Social Security Amendments of 1972,* October 30, 1972, 1484 – 1485.

Congress has expanded requirements for SSA to review DDS decision-making, as discussed later in this report).

In the summer of 1956, Congress enacted disability insurance as an additional Social Security benefit. It authorized the same state agencies determining medical eligibility for the freeze to determine medical eligibility for benefits. The statutory framework governing the SSA/DDS relationship has remained largely unchanged since 1954.

SSA's Funding of the DDSs

SSA's administrative budget is largely funded via the Social Security Trust Funds and, for the SSI program, general revenues. DDS personnel expenses, the purchase of medical evidence, and certain indirect and other costs are considered part of SSA's administrative budget.[26] SSA's administrative expenses are subject to annual review and limitations under the jurisdiction of the Appropriations Committees.[27] Due to changing demand (receipts) and workload volumes, SSA allocates resources to the DDSs within the broader context of all agency priorities rather than basing them solely on DDS workload projections. This holds true unless Congress statutorily directs specific allocations to priority areas.[28]

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[26] William R. Morton, "SSA: Trends in the Annual Limitation on Administrative Expenses (LAE) Appropriation Through FY 2021 Figure 3," CRS, May 11, 2022, 12.

[27] The ability of Congress to annually limit SSA's administrative expenditures was disputed immediately after Social Security programs were moved off budget in 1990. The Office of Management and Budget's (OMB's), interpretation of the statute conflicted with the view of the Senate Budget Committee and the Congressional Budget Office. OMB's 1991 decision has been controlling on the treatment of SSA administrative expenses associated with Social Security ever since. Subcommittee on Legislation and National Security, Committee on Government Operations, US House of Representatives, "Testimony of Paul N. Van de Water Chief, Projections Unit Budget Analysis Division, Congressional Budget Office," *Hearing on the Social Security Protection Act of 1991,* July 1991, 4 – 7.

[28] For example, Congressional appropriators recently recommended millions in additional funding be allocated directly to the DDSs, although the "earmark" was not included in the enacted legislation. House Committee on Appropriations, "*House Report 117-403 Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2023*," July 5 2022, 316; Senate Committee on Appropriations, Explanatory Statement for the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2023, July 28 2022, 309.

The SSA/DDS Partnership in Practice

From the beginning, there was (and still is) considerable state variation in DDS organizational approaches and decisional outcomes.[29] Especially following the implementation of the SSI program in 1973 and its additional workloads,[30] policymakers noticed a high variation in disability allowance rates across geographic locations.[31] In 1977, Congress requested an audit of the state/federal relationship, and the now-Government Accountability Office (GAO) reported that:

> *Under the existing federal/state arrangement, [SSA] cannot exercise direct managerial control of the activities of the state agencies. This circumstance, together with Social Security's failure to correct other weaknesses in the disability determination process, provides no assurance that a reasonable degree of uniformity and efficiency will be achieved…*[32]

GAO also reported on SSA's efforts to manage the determination process and assure programmatic consistency through new SSA/DDS agreements. In 1977, SSA proposed language that allowed the agency to set performance and personnel qualification standards for the DDSs, among other changes. At that time, 34 states said they would not sign the revised agreement. SSA then established a task force of agency and DDS representatives to craft a new version. DDSs rejected the negotiated agreement, and SSA abandoned the effort to increase direct management of the DDSs.[33] GAO's ongoing examinations of SSA's disability programs raised questions about the continued medical eligibility of some beneficiaries. These program integrity

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[29] Allowance rates, staff qualifications and pay scales, and other DDS characteristics can vary by state. Berkowitz supra N. 14, 82 – 83; SSAB, *Disability Chartbook: Chapter 7 Variation in DDS Decision Making*, 2017.

[30] Implementation of the SSI program in 1974 corresponded with nearly a 54 percent increase in pending claims at the DDSs. Carolyn Puckett, "Administering Social Security: Challenges Yesterday and Today," *SSB 70*, no. 3 (2010), 52.

[31] In 1976, GAO distributed 221 claims to ten different DDSs (and SSA) and found 78 percent variability between SSA adjudicators and those at the DDSs for at least some disability determination conclusions. The same study cited what was at that time SSA's discretionary and sporadic quality assurance function as one possible cause of the variation. GAO, *The Social Security Administration Should Provide More Management and Leadership in Determining Who Is Eligible for Disability Benefits*, HRD-76-105 (August 1976), (state variation) 5; (ten-state study) 9 – 10; (quality assurance) 20 – 23.

[32] GAO supra N. 18, i.

[33] Ibid, 8.

concerns eventually led Congress to change the arrangement and sparked a significant state/federal conflict.[34]

1980 to 1984 – Accuracy Questions Lead to Controversy and a New Relationship Framework

GAO published another report in 1978 that called into question DDS determinations that converted state Aid to the Permanently and Totally Disabled recipients to the new SSI program.[35] In response to these findings and GAO's earlier critique of the SSA/DDS relationship, Congress amended the Act in 1980 to require a more robust process of determining continued SSI and DI eligibility over time, along with other provisions affecting DDSs (Table 1).[36]

Table 1: Select Provisions of the Disability Amendments of 1980 Affecting State Agencies and Subsequent Statutory Changes to Those Provisions

Pre-Effectuation Reviews	Beginning in 1983 SSA must review 65 percent of all claims allowed by the DDSs before awarding benefits. (This number has since been changed to 50 percent).[37] The provision also authorized SSA to reverse a state agency decision to deny a DI claim.
Continuing Disability Reviews (CDRs)	Effective in January 1982, DDSs are required to determine continued medical eligibility at least every three years for beneficiaries initially found not to have permanent disabilities.

[34] Berkowitz supra N. 14, 140.
[35] The report found that 24 percent of sampled recipients converted to SSI (where sufficient documentation existed to make such a determination) were likely not eligible under the federal statutory definition of disability, and 38 percent of converted claims did not include sufficient medical evidence to determine eligibility for SSI. GAO, *Review of the Eligibility of Persons Converted from State Disability Rolls to the Supplemental Security Income Program*, HRD-78-97 (April 1978), 3.
[36] SSA Office of Legislative and Regulatory Policy, "Social Security Disability Amendments of 1980: Legislative History and Summary of Provisions," *SSB 44*, no. 4 (April 1981), 28.
[37] 42 USC §421(c)(3)(A)(i), 1676.

Administrative Structure	The law prescribes a switch from signed agreements with the states to regulations establishing administrative requirements each DDS must follow in conducting disability determinations, including performance measures, fiscal controls, and other requirements. It also outlines circumstances when a DDS could lose or voluntarily cede responsibilities under the Act and requires SSA to have a contingency plan in place if this should happen.

On the heels of the 1980 amendments, GAO published an audit of DI beneficiaries, indicating that up to 20 percent might be medically ineligible. GAO estimated that removing those likely ineligible beneficiaries could yield $2 billion in program savings annually.[38] SSA's leadership sped up and expanded the implementation of the CDR statutory requirement, beginning the reviews a year earlier than Congress required.[39] The agency's CDR approach also required DDS examiners to conduct each review based on current evidence and current criteria, without regard to the initial determination.[40] In addition, reviews were targeted to those beneficiaries and recipients who likely were granted benefits in error (especially in the period immediately following SSI implementation). Also, SSA focused on younger beneficiaries/recipients to prevent long-term benefit receipt for those who did not meet the disability definition.[41]

In the spring of 1981, DDSs received 64,000 claims to review. The savings projections led SSA to make more CDR referrals. By 1984, 1.2 million CDRs had been conducted, 490,000 of which led to benefit termination for affected beneficiaries/recipients.[42] Administrative law judges reinstated benefits in about 200,000 cases.[43] Many CDR terminations were eventually reversed because the initial determinations were found to contain no clear fraud or

[38] GAO, *More Diligent Followup Needed To Weed Out Ineligible SSA Disability Beneficiaries*, HRD 81-48 (March 1981), 7 – 8.
[39] This decision was made, in part, to ease the workload burden on DDSs. Katharine P. Collins and Anne Erfle, "Social Security Disability Benefits Reform Act of 1984: Legislative History and Summary of Provisions," *SSB 48*, no. 4 (April 1985), 12.
[40] John R. Kearney, "Social Security and the 'D' in OASDI: The History of a Federal Program Insuring Earners Against Disability," *SSB 66*, no. 3 (August 2006), 16 –17.
[41] Berkowitz supra N. 14, 127.
[42] Ibid, 127
[43] Kearney supra N. 40, 16.

error. Others were reversed due to no evidence of medical improvement since the initial allowance.[44] Meanwhile, press accounts of people with disabilities harmed by the loss of income support began to concern federal and state officials.[45]

In May 1983, at the direction of its governor, the Massachusetts DDS became the first state agency to decline to conduct CDRs in the manner SSA prescribed. Instead, the DDS applied a medical improvement standard to each CDR. Twenty-two other states took similar actions.[46] Also, in August 1983, the National Governors Association (NGA) passed a resolution supporting federal legislation to set a medical improvement standard for the conduct of CDRs.[47]

SSA took steps to address state concerns, and Congress eventually ended the controversy with the passage of the Disability Benefits Reform Act of 1984, which included the establishment of a medical improvement review standard and other reforms.[48] The period from the enactment of SSI through this CDR refinement showed how statutory change implemented across 50 states in a relatively short timeframe presented risks to program integrity and required consistent policy interpretation across the system. Today, although the legislative landscape for DDSs has remained largely unchanged for decades, DDS managers cite ongoing regulatory/policy changes as a source of adjudicative complexity.[49]

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[44] Ibid, 16.
[45] Members of Congress were moved by stories of beneficiary suicide following termination of benefits. Also, the White House intervened on behalf of a Medal of Honor recipient who was a DI beneficiary but was later found not disabled under the CDR process implemented in 1981. The judiciary became involved as legal aid entities and others filed suit on behalf of affected beneficiaries. Berkowitz supra N. 14, 130 – 133, 137 – 139.
[46] David Koitz, *Social Security: Reexamining Eligibility For Disability Benefits*, CRS, May 1984 (updated), 9.
[47] Subcommittee on Social Security, Committee on Ways and Means, US House of Representatives, "Testimony of John Mudd, Acting Secretary, Executive Office of Human Services, Commonwealth of Massachusetts," *Hearing on the Status of CDRs*, February 1984, 27.
[48] In 1982, Congress authorized temporary benefit continuations for those appealing CDR termination, and when that provision expired, SSA stopped mailing termination notices. These were considered stopgaps until the 1984 amendments. Collins and Erfle supra N. 39, 17, 26.
[49] National Council of Disability Determination Directors (NCDDD), Report on National Trends and Common Issues for DDS Agencies, July 2022, 30.

Regulations Replace SSA/DDS Agreements

The regulations called for in the 1980 amendments became the administrative mechanism for managing the SSA/DDS relationship in 1981. Those rules control the relationship today. They outline general requirements for SSA and DDS operations and describe the responsible parties for statutory functions such as:[50]

- **Personnel** – The Act and regulations require that SSA fund DDS staffing, while hiring and qualification requirements are managed by the DDSs under state rules. DDSs may have salaries constrained by how their state governments classify DDS positions within the larger state workforce. This means that SSA-funded salary incentives may not be possible – even in response to high attrition at a DDS.[51]
- **Medical expertise, evidence collection, and cost** – SSA sets policy for how much and what type of evidence is required for disability determination and funds the purchase of that evidence from providers operating in the states.[52] The agency relies on the DDSs to recruit medical professionals who lend medical or, when necessary and available, psychological expertise to the disability determination process. Today, some DDSs struggle to obtain that expertise.[53] Separately, DDS administrators have raised the volume of medical evidence contained in some claims as one cause of workload processing problems. They report that the size of case files has increased markedly in the last decade.[54]
- **Workload management** – The regulations articulate the DDS's responsibility (in most cases) for determining disability in their state and describe the circumstances under which workload transfers may

[50] 20 CFR Part 404 Subpart Q and Part 416 Subpart J.
[51] For example, Delaware, whose DDS had the second-highest attrition rate in the country in 2021 at over 71 percent, commissioned a state government-wide compensation study that found state salaries lagged those paid by the federal government by about 15 percent. NCDDD Table 3 supra N. 49, 12 and The Segal Group, *State of Delaware Comprehensive Study Part I – Total Compensation Study (revised) Table 2*, 2018, 4.
[52] Health information technology (HIT) evidence is the exception to this approach because SSA conducts network/provider recruitment and manages the infrastructure for HIT. SSAB, *Medical Evidence Collection in Adult Social Security Disability Claims*, May 2022, 7.
[53] Lisa Rein, "Social Security offices critical to disability benefits hit breaking point," *The Washington Post*, December 5, 2022.
[54] In a recent survey of DDS directors, increased regulatory and subregulatory requirements for decisional documentation in a claim and the Affordable Care Act were cited as contributors to larger claim files. NCDDD supra N. 49, 5.

occur between a state DDS and SSA. When a DDS cannot process claims timely, it can request a transfer. However, SSA does not possess the authority to order a DDS to give up claims and instead must negotiate to affect transfers.[55]

- **Performance** – The regulations include specific DDS performance levels for processing time and accuracy. For example, the administrative regulation set the minimum performance for the average processing time of DI claims at 49.5 days and 58 days for SSI claims.[56] However, the combined average processing time for DDSs processing DI and SSI claims was about 75 days in the 1980s. Beginning in the early 1990s and continuing now, processing times routinely average over 100 days.[57] Lastly, the regulations refer to steps SSA can take to address a poor-performing DDS. However, while SSA has considered using its statutory authority to assume determinations for a "substantially failing" DDS,[58] the agency has never done so.[59]

The 1990s – Rapid Program Growth Tests the Relationship

Throughout the 1990s, SSA and the DDSs struggled to keep up with increased disability workloads.[60] The agency reported a 69 percent increase in initial disability claims between FY 1990 and 1995. Out of concern for long-term operational integrity in its disability programs, SSA spent the next several years attempting a process redesign with goals of greater consistency and speed, and better customer service across all levels of adjudication.[61]

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[55] SSA's federal DDS conducts disability determinations for claimants living outside the United States (e.g., most U.S. territories), as well as for states that request or agree to workload transfer. SSAB supra N. 8, 2:58:36.
[56] 20 CFR 404.1642 and 416.1042, 1991.
[57] GAO, *Increasing Number of Disability Claims and Deteriorating Service*, HRD-94-113, (November 10, 1993), 3 and SSAB supra N. 52, 16.
[58] U.S.C. 42 §421(b)(1), 1676.
[59] Robert A. Rosenblatt, "US May Seize California State Disability Office," *Los Angeles Times*, May 3, 1991.
[60] Causes for the increases included: SSI eligibility rule changes, "baby boom" generation entry to disability-prone years, and women's workforce participation. GAO supra N. 57, 11 – 12; SSA Office of Retirement and Disability Policy, *Trends in DI Briefing Paper*, No. 2019-01 (2019), 2 – 3.
[61] SSA, "Disability Process Redesign: The Proposal from the SSA Disability Process Reengineering Team," *SSB 57,* no. 2 (April 1994), 51.

A feature of the early redesign was a disability claim manager (DCM) position. DCMs were envisioned as a single point of contact for claimants. DCMs would explain the determination process at the outset, assist with evidence collection, and explain to the claimant the rationale for a denied claim. The agency also planned to streamline some DCM-conducted disability determinations (by eliminating consultation with medical/psychological personnel) in more straightforward cases.[62] The DCM model proved controversial among DDSs because it would have allowed SSA field office employees to conduct DDS-specific functions as described in the Act. Ultimately, SSA abandoned the DCM position[63] (and most redesign initiatives).[64] The DCM episode illustrates statutory limitations on SSA's power to redesign its process.

9/11 and Hurricane Katrina – Examples of Regional Disruptions and an Evolving Process

Occasionally, the system is stressed by events occurring regionally instead of nationally. Two examples of this were the tri-state area of New York, New Jersey, and Connecticut in the fall of 2001 and the Gulf Coast in 2005. In November 2001, SSA reported to Congress that the New York DDS had to retrieve and decontaminate 15,000 paper-based disability claims from the office near the World Trade Center site after the terrorist attack.[65]

By contrast, four years later, in the aftermath of Hurricane Katrina, 1,500 case files from the DDS in New Orleans were electronic and could be digitally transferred to other locations for processing.[66] Today, nearly all disability claims are processed electronically.[67] The development of the electronic claim folder made workload transfers much easier and has

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[62] Ibid, 53.
[63] Although the agency abandoned DCM, it maintained the pilot to allow experienced DDS examiners in 20 states to make certain decisions without a medical/psychological consultant. Data from the single decision maker (SDM) pilot indicated faster decisions and slightly higher allowance rates on affected claims. SDM was popular among the DDSs, and SSA continued it until Congress ended the initiative with the passage of the Bipartisan Budget Act of 2015. SSAB, *The SDM Pilot: A 16 Year Flight and Still No Clear Landing*, 2015, 3 and 5.
[64] GAO, *Social Security Disability: Disappointing Results From SSA's Efforts to Improve the Disability Claims Process Warrant Immediate Attention*, GAO-02-332 (February 27, 2002), 3.
[65] House Subcommittee on Social Security, "Statement of Larry G. Massanari," *Hearing on the SSA's Response to the September 11 Terrorist Attacks*, November 1, 2001, 23.
[66] SSA Office of Disability and Income Security Policy, "Addressing the Challenges Facing SSA's Disability Programs, Note #5," *SSB 66*, no. 3, August 2006, 39.
[67] SSA, *POMS* DI 81010.030, August 2022.

allowed the agency to develop other helpful tools, such as natural language processing.[68]

The Great Recession – Backlogs and State Furloughs

Around 2009, the housing market collapsed, and the Great Recession precipitated a significant drop in state revenues.[69] As a result, some states furloughed their workforces, including DDS employees.[70] Governors cited labor union agreements and overall fairness to state employees, among other reasons, for including DDS employees in the furloughs.[71] These furloughs came at a difficult time for SSA, which was facing a sharp increase in claims.[72]

Michael Astrue, then Commissioner of Social Security, and then-Vice President Joseph R. Biden, wrote to the NGA requesting that states leave DDSs out of furlough plans. SSA also proposed emergency legislation to address the issue.[73] Congress did not change the law, and, all told, about 13 states furloughed or took other personnel actions affecting DDSs in 2009 and 2010.[74] State-level furloughs remain a potential threat to system capacity that SSA (and the DDSs themselves) cannot control.

The Pandemic Period – Systemic Weaknesses Come to the Fore

The onset of COVID-19 forced office closures and created multiple operational difficulties for SSA and the DDSs. At the pandemic's start, some DDSs did not have the necessary equipment and were sent home without

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[68] Commissioner Joanne Barnhardt oversaw the development of the electronic folder starting in the early 2000s. She sought the input of DDSs in designing the electronic process. SSA, *News Release: Commissioner Barnhart Presents Her Approach to Improving the Disability Determination Process*, September 25, 2003.
[69] Tracy Gordon, "State and Local Budgets and the Great Recession, Figure 2," Brookings Institution, 2012.
[70] This step came despite SSA fully funding the positions and most operating costs of each DDS. However, state governments reported that exempting DDS employees would be unfair and, for some, administratively complex. Scott Szymendera and [redacted], *State Furloughs of DDS Employees*, CRS, October 2009, 4.
[71] Editorial Board, "Furloughing U.S.-paid employees could end up costing Ohio money: editorial," *The Cleveland Plain Dealer*, February 15, 2010.
[72] Szymendera supra N. 70, 7.
[73] Ibid, 6 and Senate Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia, "Statement of Michael J. Astrue," *Hearing on Improving DI Claim Processing in Ohio*, November 2010, 7.
[74] Szymendera supra N. 70, 4.

the means to conduct remote work. For those that had not received laptops from the agency, SSA permitted DDS employees to work from home using the desktop computers they had at the office and flip-style mobile phones. The DDSs have requested but still have not received voice-over-internet protocol software.[75] These technological barriers may have contributed to early operational struggles.[76]

As shown in Figure 1, workload processing delays that emerged before the pandemic in FY 2019 are ongoing.[77] The Board has analyzed publicly available budget documentation and DDS workload data from the late 2000s through FY 2022. Figure 1 shows that, until FY 2019, trends in the volume of initial claims pending at the DDSs and those of initial claims received (receipts) were similar.[78] Recently, however, the number of initial claims pending has increased markedly (alongside average processing/wait time) while claim receipts have declined.

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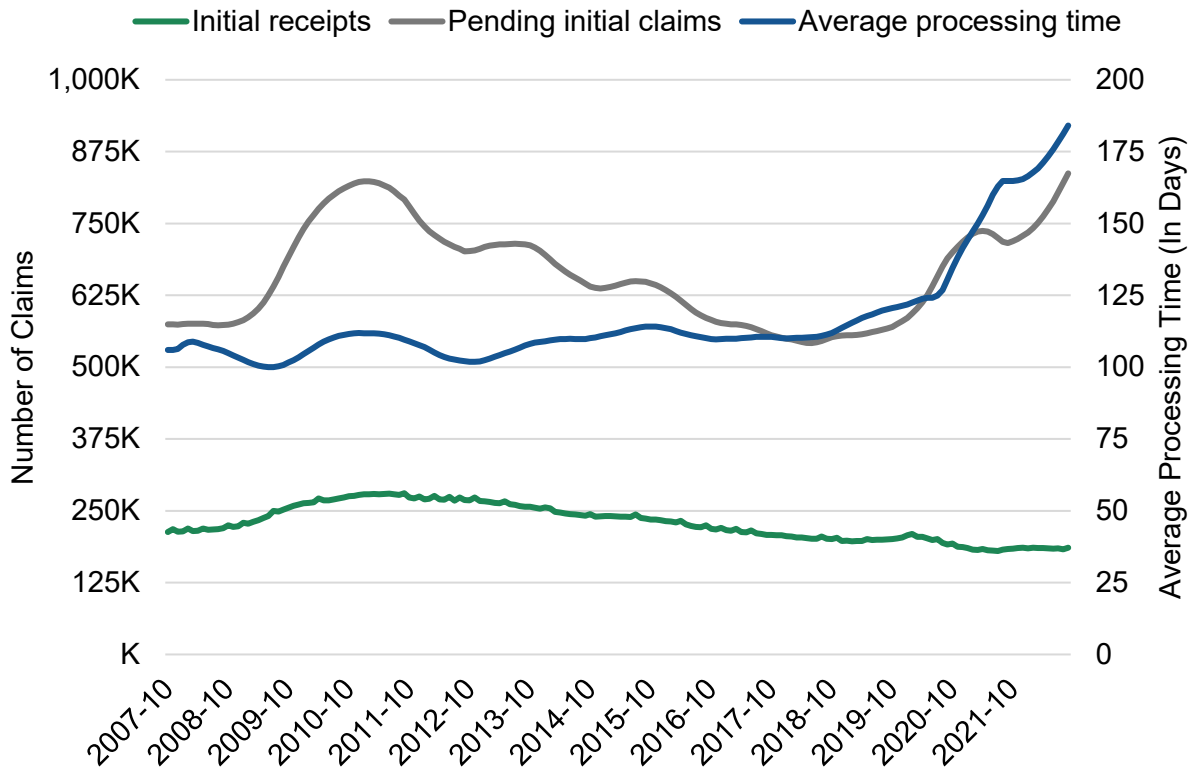
[75] Voice-over-internet protocol is a software that allows for computer-based telephone calls and would have negated the need for DDS personnel to use personal or SSA-provided flip phones to call claimants. Calling from personal phones is problematic for two reasons. First, if DDS employees do not block their numbers, claimants will have those employees' personal contact information. Second, claimants will be even less likely to pick up a call they receive from a blocked or otherwise unrecognizable phone number. Rein supra N. 53; NCDDD supra N. 49, 38.

[76] OIG, "Fiscal Year 2020 Statement on SSA's Major Management and Performance Challenges," *SSA's FY 2020 Agency Financial Report*, November 2020, 144.

[77] SSA has established working groups to address DDS staffing and initial claim challenges. Kilolo Kijakazi, Acting Commissioner, SSA, "*Executive Personnel Announcements*," August 22, 2022, as reported by Charles T. Hall, *Social Security News* blog. August 23, 2022.

[78] Data for receipts, pending claims, and average processing times are 12-month rolling averages computed per month per FY shown in the chart. Initial claims include the number of initial DI-only (Title II), SSI-only (Title XVI), and concurrent claims received monthly then averaged over 12 months using prior monthly data. Pending claims includes all initial claims for DI-only, SSI-only, and concurrent pending at the end of the month, averaged over the last 12 months. Processing time is defined as the cumulative number of elapsed days (including processing time for transit, technical determinations, medical determinations, and quality review) from the date of filing through the date payment is made or the denial notice is issued for all initial DI and SSI claims that require a medical determination. SSA, *State Agency Monthly Workload* dataset, All Initial Claims, Receipts, Closing Pending, and Determinations, October 2007 to September 2022; SSA, *Monthly Data for Combined Title II Disability and Title XVI Blind and Disabled Average Processing Time*, October 2007 to September 2022.

Figure 1. Average DDS Receipts, Pending Initial Claims, and Combined DI and SSI Average Processing Time, FYs 2008 – 2022



Sources: SSA, State Agency Monthly Workload Data (receipts and pending initial claims) and Monthly Combined Title II and Title XVI Blind and Disabled Average Processing Time.

Several factors may influence the increases in claims pending and the average processing time (concurrent with a decline in production per work year [PPWY]), including:

- Difficulty in obtaining needed medical evidence during the pandemic[79]
- An unplanned transition to telework and longer-term closure of some DDSs offices and not others[80]
- Insufficient technology to communicate with claimants and for workload processing[81]
- Limitation on administrative expenses (LAE) (and DDS allocations) that sometimes lag behind workload volume increases, eventually

[79] SSAB supra N. 52, 14 – 15.
[80] SSAB supra N. 8, 2:31:59.
[81] SSAB, *Summary of Disability Process Improvement Roundtables*, October 2020, 5.

leading to backlog. In other words, there are instances when demand exceeds DDS capacity (Figure 2)[82]
- Fluctuating staffing levels (Figure 2)
- The length of time needed for new DDS staff to gain proficiency[83]
- Higher DDS attrition rates[84]

Alongside these workload struggles, a recent survey of DDS administrators found very low morale and historically high caseloads. Administrators blamed the situation on resource challenges and limitations with the new Disability Case Processing System (DCPS) which SSA built to replace piecemeal DDS-level legacy systems. In the same survey, administrators also mentioned increased program complexity as a cause of strain on the system; this point has also been raised by disability examiners as long ago as 2002.[85]

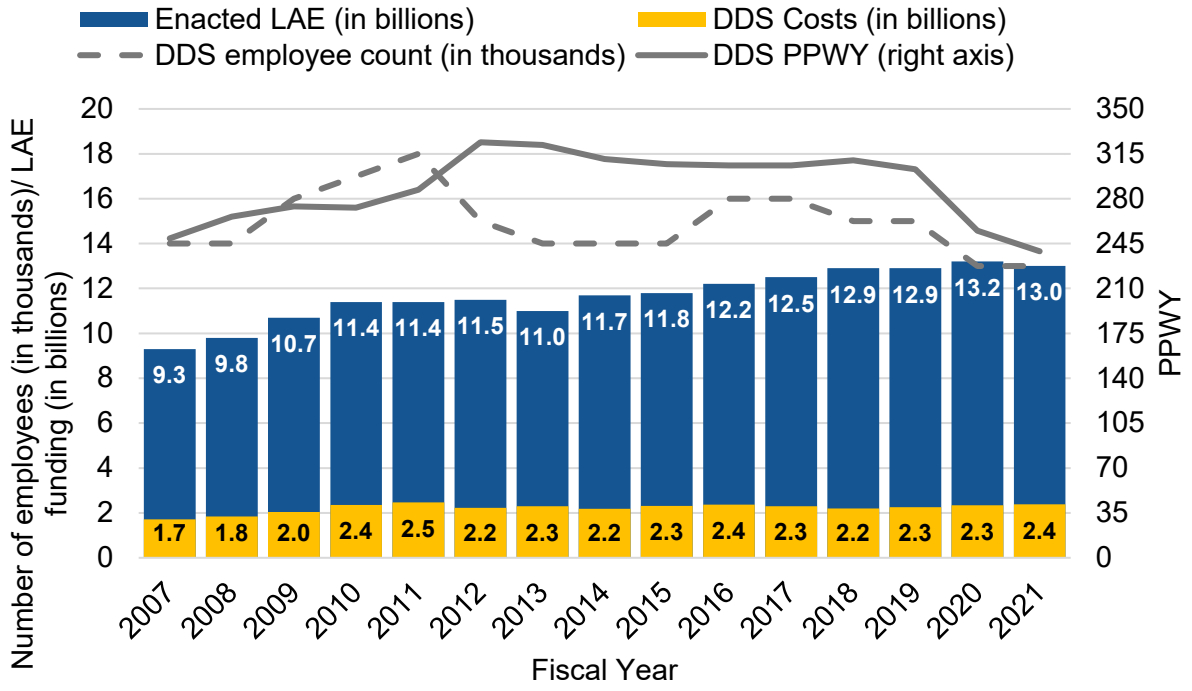
[82] Before FY 2020, SSA reported state DDS employees in approximate thousands, so the Board has recorded all staffing data in that format. DDS PPWY is an expression of overall productivity calculated by first establishing the number of days that one full-time DDS employee works per year (minus weekends, leave, and holidays) and dividing that number by the projected workload (defined as the number of cases to be disposed of in a particular timeframe.) SSA, *POMS*, DI 39503.230, July 30, 1996; SSA, *Justification of Estimates to the Appropriations Committees, FYs 2008 onward* (enacted LAE, DDS costs, DDS employee counts minus FY 2019, and PPWY); SSA, *Annual Performance Report FYs 2019–2021*, February 2020, 5 (FY 2019 DDS employee count).

[83] SSAB supra N. 8, 1:49:22

[84] House Subcommittee on Social Security, "Testimony of Grace Kim, Deputy Commissioner for Operations," *Hearing on Strengthening Social Security's Customer Servic*e, May 17, 2022.

[85] According to a survey of DDS directors, SSA has required more documentation of decisions through its quality review process and greater adjudicative complexity through regulatory revisions to the Listing of Impairments and other subregulatory changes such as those made to collateral estoppel. NCDDD supra N. 49, 1 – 3 (DDS director feedback); National Association of Disability Examiners (as quoted in recent comments regarding SSA's revisions to the musculoskeletal listings). Barbara Silverstone, *Letter of Comment Re: Notice of Proposed Rulemaking on Revised Medical Criteria for Evaluating Musculoskeletal Impairments*, 2018, 3; *The Advocate Newsletter, Winter Edition 37*, no. 1 (February 2021), 5 (collateral estoppel workload increases).

Figure 2. SSA LAE, DDS Costs, Employee Count, and PPWY, FYs 2007 – 2021



Source: SSA Justifications of Estimates to the Appropriations Committees, FYs 2008 through 2022, and for DDS staffing in FY 2019, SSA Annual Performance Report FYs 2019 – 2021.

DDSs Confront Shifting Priorities and Increasing Workloads

Throughout the history of the SSA/DDS relationship, policymakers' priorities and available resources have informed the operational approach to disability determination. Over time, Congress focused on the need for timely processing of the disability workload and program integrity concerns.[86] Recently, SSA's focus has also included modernization and standardization of the IT used by DDSs.[87] These priorities have inherent benefits but also represent additional operational requirements and workloads placed on the state agencies. For example:

[86] Since the mid-1990s, Congress has periodically provided additional funding for CDRs and oversight of the agency on workload processing speed and accuracy. SSA Office of Policy, *Trends In Social Security and SSI Disability Programs*, 2006, 8 – 9, and 54; House Subcommittee on Energy Policy, Health Care and Entitlements, "Testimony of Patrick O'Carroll, Inspector General, SSA," *Hearing on Examining Ways the Social Security Administration Can Improve the Disability Review Process*, April 2014, 71 – 72.

[87] SSA Office of the Inspector General (OIG), *SSA's Disability Case Processing System*, A-14-15-15016 (November 13, 2014), 1.

- **Timeliness** – As noted previously, although the 1981 regulations set the maximum allowable DDS processing time at less than 60 days, those levels have not reflected actual performance since the regulation was published. In the intervening years, processing time has increased dramatically.[88] Since the 1990s, DDS leadership has reported challenges with hiring and retaining experienced staff [89] Most recently, a professional organization representing DDS leadership has raised the vocational aspects of disability determination, i.e., work history and transferable skill evaluations as significant impediments to both timeliness and program integrity.[90]
- **Program integrity** – Particularly since the creation of the SSI program, Congress and SSA have focused heavily on the need to ensure the policy compliance of disability determinations. Until the 1980 amendments, Congress allowed SSA to design and manage its program integrity approach. GAO and others criticized SSA's effort as insufficient to ensure only eligible claimants were granted benefits.[91] Now, CDRs and one type of quality review are required in the Act as program integrity tools. DDSs report that some quality reviews can be confusing and inconsistent between reviewers. They also told the Board at a July 2021 roundtable that they consider the requisite additional steps to correct errors, even errors not affecting the final determination, onerous.[92]
- **IT** – Until the 2010s, each DDS could choose its own IT system for workload management.[93] As SSA has modernized its internal IT infrastructure, it has also built what it hopes will be a unified, standardized system for use across all DDSs.[94] Unfortunately, the SSA-built DCPS is still missing needed functionality, and some

[88] SSA supra N. 61, 52 and SSAB supra N. 52, 16.
[89] GAO supra N. 22, 4.
[90] In both a Washington Post article in late 2022 and a meeting with Board staff in early 2023, NCDDD leadership raised vocational evaluation as an area in need of reform and indicated a desire for Congress to craft legislation to require process improvement. Lisa Rein, "Senate investigators to probe tumult in Social Security watchdog division," *The Washington Post*, December 29, 2022; SSAB staff communication with NCDDD Board, January 11, 2023.
[91] GAO supra N. 18, 15 – 16.
[92] SSAB supra N. 8, 3:42:46 and *POMS* DI 30005.232, July 6, 2022.
[93] SSA OIG, *Identifying Requirements for the DCPS Based on Findings from Prior Audits*, A-44-10-20101 (November 2010), 1.
[94] SSA, *Annual Performance Plan for FY 2010 and Revised Final Annual Performance Plan for FY 2009*, May 2009, 18.

DDSs report frustrating workarounds and that DCPS insufficiently addresses legacy and state-level workloads.[95]

The administrative regulations promulgated in 1981 are a natural place to codify SSA's priorities in its relationship with DDSs. However, those rules have remained largely unchanged for over 30 years. They do not include some of the commonplace features of today's relationship, such as workload transfers between state DDSs, as well as IT requirements.[96] The lack of specificity in the regulations may allow for flexibility in addressing state/local conditions facing each DDS,[97] as well as challenges unforeseen in the 1980s. Still, the Board heard from former SSA executives that the current rules also reinforce some of the limitations of the original SSA/DDS agreements such as SSA's authority to set DDS performance expectations.[98]

SSA/DDS Communication and Support Structures

As SSA adapts policy, IT, workload and performance expectations, and budgets, it must communicate those developments to DDS management, and DDS management must inform or train staff accordingly. SSA's regional offices represent the primary conduit for information from SSA to the DDSs and vice versa. For example, SSA's regional offices communicate operational changes and requirements and incorporate the feedback of individual DDSs to plan for and fund new hires across the system.[99] However, the regional offices do not set the overall budget, productivity, and policy priorities for the DDSs; three different components undertake those functions at SSA headquarters.

DDS workload processing and overall performance is monitored by the Office of Disability Determinations within the Office of the Deputy Commissioner, Operations.[100] SSA's Office of Disability Policy (ODP) within

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[95] SSA claims that DDSs perceive "workarounds" in DCPS and that any additional steps necessary to perform functions are features of the system. SSAB staff communication with SSA management, February 9, 2023; SSAB supra N. 8, 2:55:49.
[96] IT requirements have emerged as a significant tension since SSA decided to centralize DDS IT systems via DCPS. NCDDD supra N. 49, 22 – 26.
[97] SSAB supra N. 8, 1:46:36.
[98] GAO supra N. 31, v and Ibid, 53:43.
[99] SSA, *Organizational Manual: Chapter S2 – The Office of Operations, Subchapter S2D – Office of the Regional Commissioner, The Office of the Assistant Regional Commissioner for Management and Operations Support*, 2022.
[100] SSA, *Organizational Manual (OM): Chapter S2 – The Office of Operations, Subchapter S2T – Office of Disability Determinations*, 2022.

the Office of the Deputy Commissioner, Retirement and Disability Policy develops the regulations and policy governing the disability determination process.[101] The Office of Quality Review within the Office of Analytics, Review, and Oversight assesses DDSs' compliance with ODP policy and regulation and articulates those findings as an overall "accuracy" rate for the state DDSs.[102] Meanwhile, SSA's Office of Budget within the Office of the Deputy Commissioner for Budget, Finance, and Management decides each DDS's total number of hires allowed (in concert with other operational components.) These complicated interactions occur between SSA and more than 50 separate agencies of state government.[103]

SSA's diffuse organizational structure affects the SSA/DDS relationship. For example, SSA's Office of the Deputy Commissioner, Systems' approach to DCPS began as a collaborative agile development with the states, but eventually, some DDSs were required to move entirely to DCPS (in their view prematurely) by September 30, 2020.[104] This timing was particularly problematic as it was at the height of the pandemic. In addition to a perceived lack of a partnership posture between SSA and the DDSs, it can also be difficult to discern which component within SSA is ultimately responsible for elevating the needs of DDSs to SSA's leadership. During a July 2021 roundtable on the SSA/DDS relationship, the Board heard concerns from DDS directors that, as SSA has moved to centralize functions like IT and performance expectation/quality review, DDSs lack the means to provide their perspectives directly to decision-makers and have their needs reflected in SSA's approach.[105] In response to the pending claims and other issues at the DDSs, the agency has taken steps in recent months to address those challenges by working more directly with the DDS administrators.[106] The Board hopes this collaborative approach will be sustained.

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[101] SSA, *OM: Chapter TM – The Office of Retirement and Disability Policy, Subchapter TMR – Office of Disability Policy*, 2022.
[102] SSA, *OM: Chapter TQ – The Office of Analytics, Review, and Oversight, Subchapter TQG – Office of Quality Review*, 2022 and *POMS* DI 30005.001(B)(6), February 9, 2011.
[103] SSA's processes also require considerable workload coordination (but not supervision or oversight) between each DDS and the nation's hearing and field offices.
[104] OIG, *SSA's Cost and Schedule Estimates for the Disability Case Processing System,* A-14-18-50742 (December 2019), 1 and SSAB supra N. 8, 1:40:46.
[105] SSAB supra N. 8, 1:51:27.
[106] Kijakazi supra N. 77.

Conclusion

The precise effects of the pandemic on DDS personnel and performance are difficult to reconcile with decades-long trends in funding, staffing, and the size and complexity of DDS workloads. However, key performance metrics (like those represented in Figures 1 and 2 of this document) indicate that DDSs are struggling to keep up in the current environment. The Board is encouraged by Congressional interest in these challenges.[107] Still, the Board believes long-standing frictions between SSA, state governments, and the DDSs call for ongoing review of how SSA and the DDSs work together and how the agency incorporates DDS needs into its overall strategic, performance, workforce, and contingency plans.[108]

In developing this and other work, the Board has heard suggestions for specific ways to bolster the state-federal partnership. The Board will continue to engage with SSA and the DDSs to assess the overall effectiveness of the relationship, as well as how each partner approaches important features of the disability determination process, including:

- Personnel challenges at the DDS level
- The effect of DCPS, HIT, machine learning, and other IT applications (or lack thereof) on workload processing[109]
- Productivity trends and the effectiveness of SSA's quality review mechanisms

[107] House and Senate Committees on Appropriations supra N. 28.
[108] GAO supra N. 22, 5.
[109] DDSs report inefficiencies caused by prohibitions on the use of text and email to communicate with claimants. SSAB supra N. 81, 9. As noted earlier, they also cite increasing volumes of medical evidence of record as a cause of processing delays.

As this work continues, the Board looks forward to learning more about recent efforts SSA has undertaken through work groups designed to resolve ongoing DDS staffing and workload processing challenges.

Bob Joondeph

Bob Joondeph, Chair

Nancy J. Altman

Nancy J. Altman

Jagadeesh Gokhale

Jagadeesh Gokhale

Amy Shuart

Amy Shuart

Appendix A: Acronyms and Abbreviations

Acronym	Term
"Act"	Social Security Act
"Board"	Social Security Advisory Board
CDR	Continuing Disability Review
CFR	Code of Federal Regulations
CRS	Congressional Research Service
DCM	Disability Claim Manager
DCPS	Disability Case Processing System
DDS	Disability Determination Services
DI	Disability Insurance
FY	Fiscal Year
GAO	General Accounting Office / Government Accountability Office
HIT	Health Information Technology
IT	Information Technology
LAE	Limitation on Administrative Expenses
NCDDD	National Council of Disability Determination Directors
NGA	National Governors Association
ODP	Office of Disability Policy
OMB	Office of Management and Budget
POMS	Program Operations Manual System
PPWY	Production Per Work Year
SDM	Single Decision Maker
SSA	Social Security Administration
SSAB	Social Security Advisory Board
SSB	Social Security Bulletin
SSI	Supplemental Security Income
USC	United States Code
VR	Vocational Rehabilitation

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Social Security Advisory Board
400 Virginia Avenue SW, Suite 625
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@ssabgov www.ssab.gov