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Report to the Honorable Gerald D. Kleczka, House of Representatives

September 1994

SOCIAL SECURITY

Rapid Rise in Children on SSI Disability Rolls Follows New Regulations

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GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-256120

September 9, 1994

The Honorable Gerald D. Kleczka
House of Representatives

Dear Mr. Kleczka:

This report responds to your request for information about the recent growth in the number of children receiving disability benefits under the Supplemental Security Income (SSI) program administered by the Social Security Administration (SSA). From 1989 to 1993, the number of children receiving SSI disability benefits has more than doubled, growing from almost 300,000 to more than 770,000.

Rising numbers of children in poverty and SSA outreach efforts explain part of this growth. This report focuses on two other significant changes, which in concert had a major impact on SSA's criteria for determining whether children are eligible for SSI disability benefits. First, in February 1990, the U.S. Supreme Court mandated in Sullivan v. Zebley that SSA make its disability criteria for children less restrictive by adding to its disability determination process a new basis for awarding benefits to children who previously would have been denied. For those children who do not qualify for benefits on the basis of medical standards alone, the Court required SSA to add an individualized functional assessment (IFA) of how each child's impairment limits his or her ability to act and behave in age-appropriate ways.[1] SSA issued regulations to this effect in February 1991. Second, in December 1990, SSA issued regulations revising and expanding its medical standards for assessing mental impairments in children by incorporating functional criteria into the standards and adding such impairments as attention deficit hyperactivity disorder. These changes were made to reflect advances in medicine and science, in accordance with the Disability Benefits Reform Act of 1984 (DBRA).

Concern has recently focused on the rapid growth in disability awards since the Zebley Supreme Court decision, especially for children with mental impairments. Of particular concern are children awarded benefits because of attention deficit hyperactivity disorder and other disorders that have been broadly characterized as "behavior problems."

[1]The medical standards are divided into two sections: one for adults and one for children. The medical standards for childhood impairments are regulations containing strict medical criteria for physical and mental impairments that, in and of themselves, are comparable in severity to impairments that would prevent adults from engaging in any gainful activity. Children can also qualify for benefits under the adult criteria.

In your June 20, 1994, request, you asked us to address a number of issues related to the growing number of children receiving SSI disability benefits. This report responds to your request that we quantify the growth in awards to children with disabilities since the disability criteria changed, focusing in particular on the growth in awards for mental impairments and the growth in awards based on the new functional assessment process. Subsequent reports will quantify the variation among states in the rate of growth in awards to children and address your concerns about whether the program is adequately meeting the needs of disabled children.

To quantify the growth in awards to children, we compared the results of SSA's disability decisions made on children by type of disability and basis of award 2 years before and 2 years after the criteria changed. The early period covers decisions made from January 1, 1988, through February 20, 1990—the date of the Supreme Court decision. The latter period covers decisions made from February 11, 1991—the first date both changes were in effect—through December 31, 1992. (See app. I for a more detailed discussion of our scope and methodology.)

Results in Brief

The number of children receiving SSI disability benefits has more than doubled in the last 4 years. Many Members of Congress have expressed concern about this growth. While much of the attention has focused on the Sullivan v. Zebley Supreme Court decision as the cause of this growth, our analysis shows a more complicated picture. Although the new functional assessment process established by Zebley added 87,900 children to the disability rolls through 1992 who previously would have been denied benefits, this new process only accounts for about 30 percent of all awards made since it was implemented. In contrast, 70 percent of all awards went to children whose impairments were severe enough to qualify on the basis of SSA's medical standards alone, without the need for a functional assessment. Thus, most of the children who received new awards would have qualified for them even without the functional assessment process mandated by the Zebley decision.

Huge increases in the number of children awarded benefits because of mental impairments—including children with mental retardation and other mental disorders, such as attention deficit hyperactivity disorder—account for more than two-thirds of the growth in awards. After the changes revising the medical standards for mental impairments and adding the functional assessment process, 60 percent of awards based on the medical standards and 82 percent of awards based on the functional assessment

process went to children with mental impairments. Table 1 shows the growth in awards by type of impairment and basis of award.

Table 1: Growth in Awards by Type of Impairment and Basis of Award

	Average monthly awards			
	Based on medical standards		Based on functional assessment	
Type of impairment	Before regulatory changes	After regulatory changes	Before regulatory changes	After regulatory changes
Mental	1,854	5,501	0	3,192
Physical	1,691	3,664	0	683
Unknown	2	18	0	8
Total	3,547	9,183	0	3,883

Source: Analysis of SSA's 831 file.

Most awards to the mentally impaired go to children with mental retardation. While the portion of mental awards to children with "behavior problems," such as attention deficit hyperactivity disorder, personality disorders, and autism and other pervasive developmental disorders is growing, it is still relatively small. From February 11, 1991, through 1993, children with "behavior problems" have received 22 percent of awards made to children with mental impairments.

SSI Program for Children Has Undergone Major Changes

Since 1974, the SSI program has been providing benefits to low-income blind and disabled persons—children and adults—who meet financial eligibility requirements and the Social Security Act's definition of disability.[2]

Each eligible child receives a maximum federal benefit of $446 per month; 27 states also provide a supplemental benefit payment.[3] In 1993, children received a total of $4.35 billion in federally administered SSI benefits.

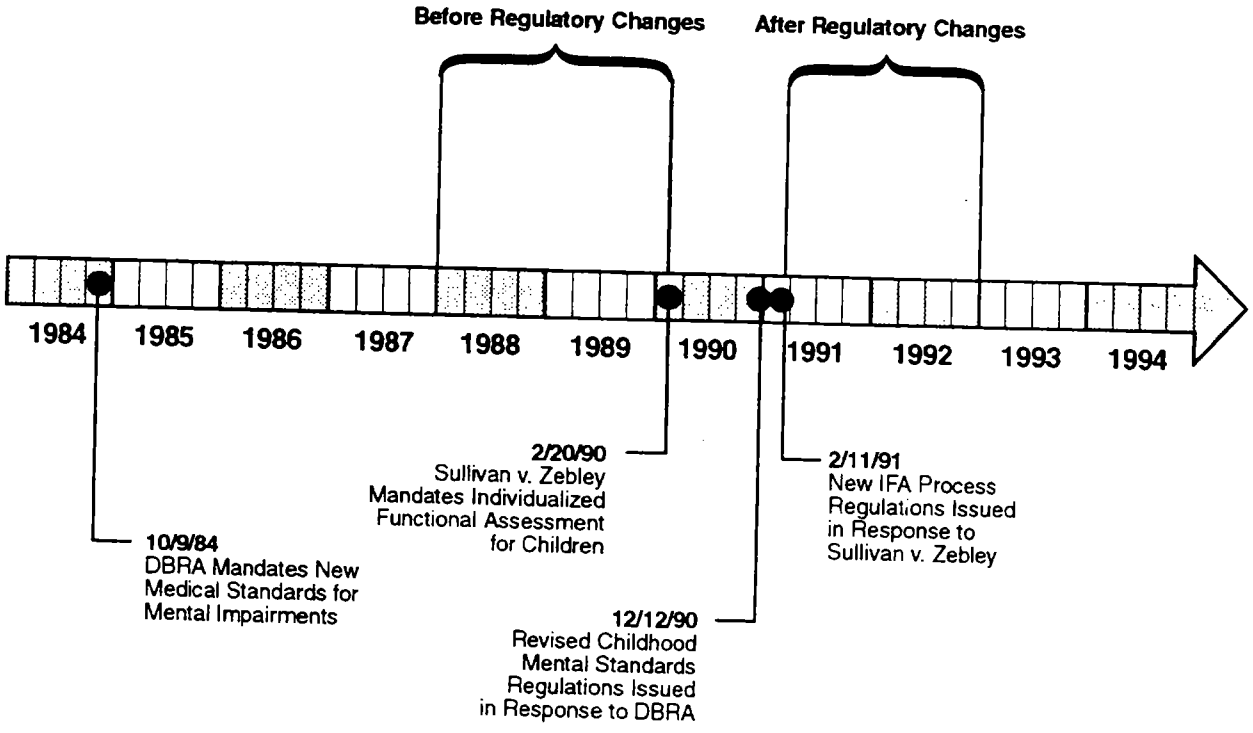
[2]SSA determines applicants' financial eligibility; state disability determination services (DDS) determine their medical eligibility. DDSs are state agencies funded and overseen by SSA.

[3]Five additional states provide supplemental SSI benefit payments only to children who are blind and three states provide supplemental benefits only to children who live in residential care homes.

Changes to SSA's Criteria for Determining Disability in Children

During virtually the same period, SSA issued two sets of regulations that changed the criteria for determining children's eligibility for SSI disability benefits. (See fig. 1.) One set of regulations was issued in response to the Sullivan v. Zebley Supreme Court decision, which required SSA to make its process for determining disability in children analogous to the adult process. The second set of regulations, issued in accordance with DBRA, revised and expanded SSA's medical standards for evaluating mental impairments in children to incorporate recent advances in medicine and science. Both sets of regulations place more emphasis than before on assessing how children's impairments limit their ability to act and behave like unimpaired children of similar age. Both also emphasize the importance of obtaining evidence from nonmedical sources as part of this assessment.

Figure 1: Changes to SSA's Criteria for Evaluating Disability in Children



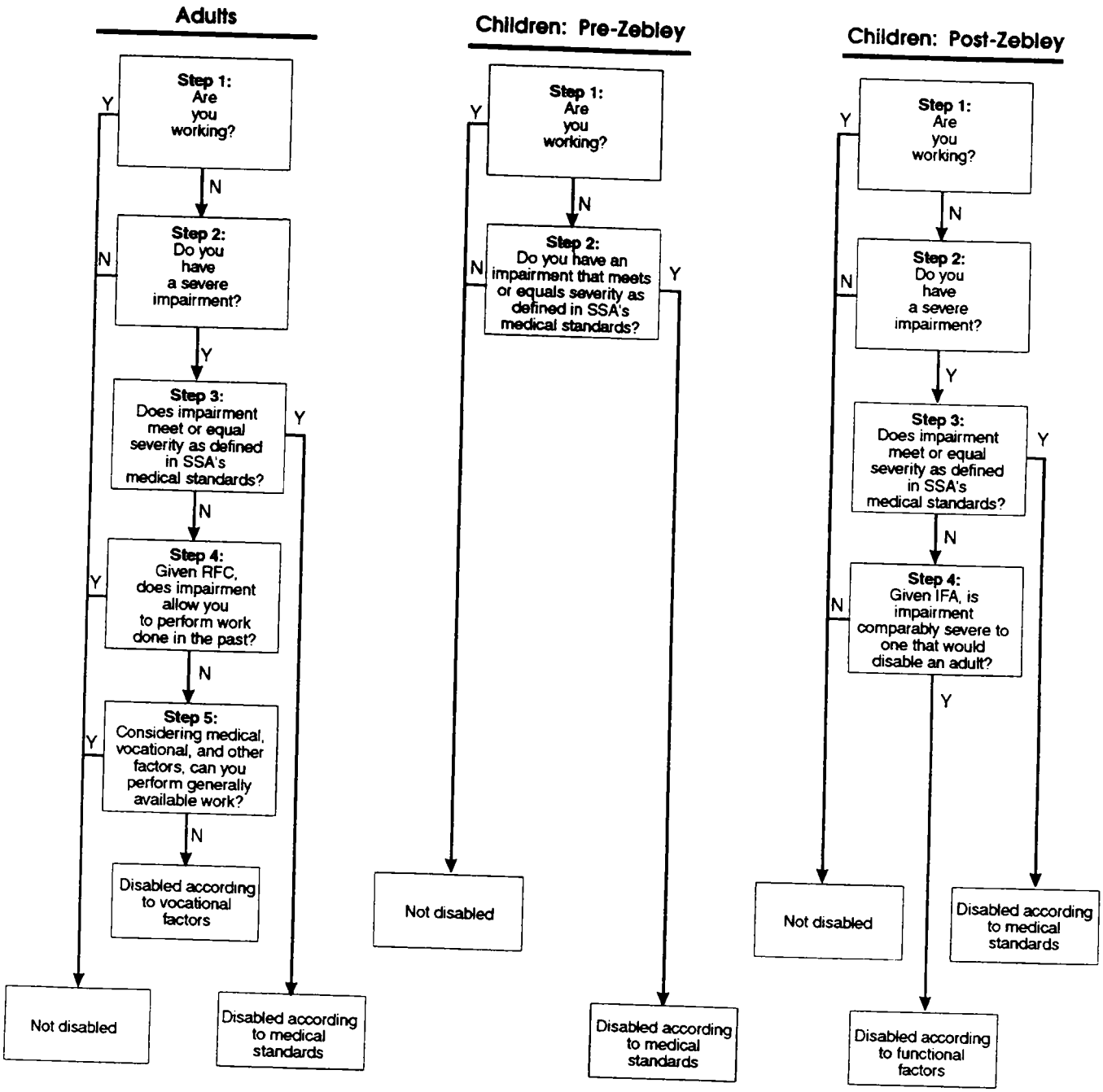
Zebley Regulations Add New Functional Assessment Process

On February 20, 1990, the Supreme Court ruled that SSA's process for determining disability in children under 18 violated the Social Security Act because the process held children to a more restrictive disability standard than it did adults. Under the Social Security Act, a child is entitled to disability benefits if his or her impairment is "of comparable severity" to that of an adult.[4]

To determine adults' eligibility for disability benefits, SSA uses a five-step sequential evaluation process. Before Zebley, it used only a two-step process to determine children's eligibility for benefits. (See fig. 2.) Children were awarded benefits only if their impairments met or equaled the severity criteria in SSA's medical standards. All other children were denied benefits. In contrast, adults who did not qualify under the standards could still be found eligible for benefits if an assessment of their "residual functional capacity" (RFC) showed that they could not engage in substantial work. No analogous assessment of functioning was done for children who did not qualify under the medical standards.

[4]Disability for adults is defined as the inability to engage in substantial gainful activity because of a medically determinable physical or mental impairment that is expected to last at least 12 months or to result in death. Substantial gainful activity is defined as earning more than $500 per month.

Figure 2: Sequential Evaluation Process for Adults Versus Children



To eliminate this disparity, the Court mandated that for those children who do not qualify for benefits under the more restrictive medical standards, SSA must add a less restrictive individualized assessment of how the child's impairment affects his or her ability to function in age-appropriate ways—that is, to act or behave in ways that children of similar ages normally do—before it can decide whether the child is eligible for benefits.

SSA issued regulations implementing the Supreme Court's decision on February 11, 1991.[5] According to these regulations, for the child to be eligible for disability benefits, the functional assessment must show that the child's impairment or combination of impairments limits his or her ability "to function independently, appropriately, and effectively in an age-appropriate manner." Specifically, the impairment must substantially reduce the child's ability to grow, develop, or mature physically, mentally, or emotionally to the extent that it limits his or her ability to (1) attain age-appropriate developmental milestones; or (2) attain age-appropriate daily activities at home, school, play, or work; or (3) acquire the skills needed to assume adult roles.

As a result of these regulations, DDSs now perform an individualized functional assessment to assess the child's social, communication, cognitive, personal and behavioral, and motor skills, as well as his or her responsiveness to stimuli and ability to concentrate, persist at tasks at hand, and keep pace.[6] In addition to information from medical sources, DDSs obtain information about the child's behavior and activities from the

[5]In the wake of the Zebley decision, SSA stopped denying benefits to children whose impairments did not meet or equal the medical standards. It operated under an interim policy for determining disability in children until the regulations went into effect. The interim policy outlined preliminary general criteria for assessing functioning in children.

[6]Social skills, communication skills, cognitive skills, and motor skills are assessed for children of all ages. Personal and behavioral skills are assessed for children aged 1 and older. The ability to concentrate, persist at tasks at hand, and keep pace are assessed for children aged 3 and older; responsiveness to stimuli is assessed in children under age 1.

child's teachers, parents, and others knowledgeable about the child's day-to-day functioning, in order to make these assessments.[7]

As part of the settlement of the Zebley case, SSA also agreed to readjudicate under the new criteria—including the new medical standards for childhood mental impairments—all decisions made from January 1, 1980, through February 11, 1991, to deny or terminate benefits to children. Of the 287,900 children who have had their cases readjudicated through March 1, 1994, 129,700 children have been found eligible under the new criteria—an award rate of 45 percent.[8]

Regulations Substantially Change Criteria for Assessing Children's Mental Impairments

SSA issued new regulations in accordance with DBRA on December 12, 1990, that revised and expanded its medical standards for childhood mental impairments to reflect up-to-date terminology used by mental health professionals and recent advances in knowledge, treatment, and methods of evaluating mental disorders in children.[9]

The new medical standards for mental impairments provide much more detailed and specific guidance on how to evaluate mental disorders in children than the former regulations, which were published in 1977. In particular, the new medical standards place much more emphasis on the importance of assessing how a child's mental impairment limits his or her ability to function in age-appropriate ways. SSA made this change because mental health professionals consider functional factors particularly important in evaluating mental disorders of children.

[7]The regulations issued in response to Zebley also expanded the criteria for determining whether a child qualified for benefits under the medical standards by adding the concept of "functional equivalence." Before Zebley, a child qualified for benefits under the medical standards only if his or her impairment met the severity criteria in the standards or were medically equivalent to the standards.

After Zebley, a child could also qualify for benefits under the medical standards if the functional limitations resulting from his or her impairment were the same as the disabling functional consequences of an impairment listed in the medical standards, as long as there was a direct, medically determinable cause for the functional limitations. The regulations provide 15 examples of conditions—such as the need for a major organ transplant—presumed to be functionally equivalent to the impairments listed in the medical standards.

[8]As of March 1, 1994, SSA had notified almost 452,500 Zebley class members that they could have their cases readjudicated, of which over 321,600 responded affirmatively. Of the 321,600, SSA has readjudicated about 287,900 cases. About 33,700 cases remain to be readjudicated.

[9]DBRA specifically mandates that the Secretary of Health and Human Services (HHS) revise the mental disorders criteria in the medical standards. The mental disorder standards are divided into two parts—one for adults and one for children. The act states that the revised standards should realistically evaluate the ability of a mentally impaired individual to work in a competitive environment. It does not specify how to apply this criterion to children.

The former medical standards for mental impairments emphasized the medical characteristics that must be met to substantiate the existence of the impairment. Specific areas of functioning sometimes were and sometimes were not mentioned as a factor in this determination. In contrast, the new medical standards provide much more detailed guidance on assessing the functional aspects of each impairment. The standard for most impairments is divided into two parts: medical and functional criteria, both of which must be satisfied for the applicant to qualify for a benefit.

The functional criteria are described in terms of the age of the child and the specific areas of functioning—such as social, communication, or cognition skills—that must be assessed. Like the Zebley regulations, the new medical standards emphasize the importance of parents and others as sources of information about a child's day-to-day functioning.

The new medical standards also classify childhood mental disorders into more distinct categories of mental impairments. Previously, there were 4 impairments listed—mental retardation, chronic brain syndrome, psychosis of infancy and childhood, and functional nonpsychotic disorders—now there are 11. Several of the newly listed impairments, such as autism and other pervasive developmental disorders, mood disorders, and personality disorders, describe impairments that were previously evaluated under one or more of the four broader categories of childhood mental impairments. Several other impairments are mentioned for the first time, such as attention deficit hyperactivity disorder and psychoactive substance dependence disorders.

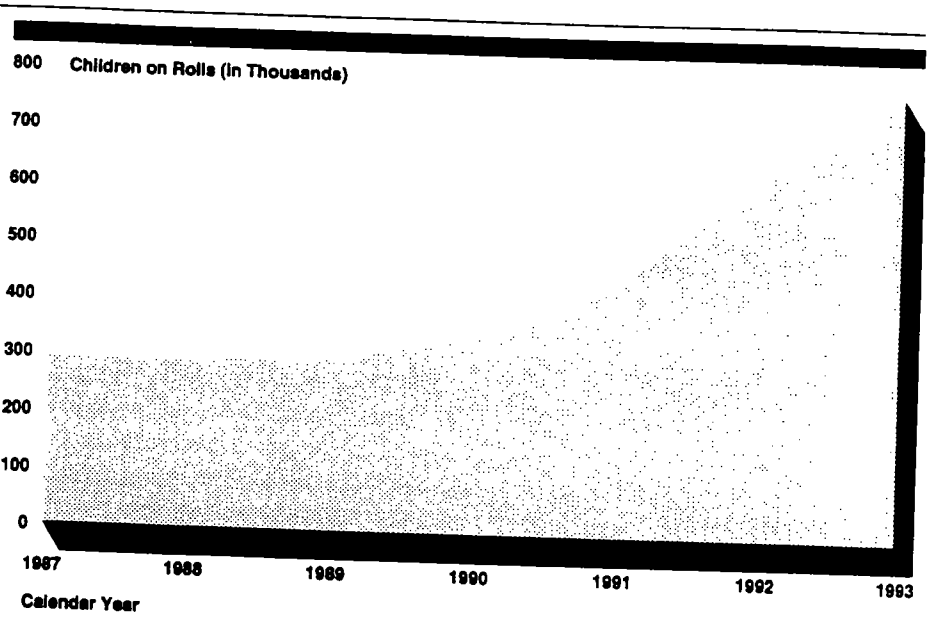
Rapid Growth in Number of Children Receiving SSI

The number of children receiving SSI disability benefits has grown rapidly since the regulatory changes went into effect. The number of children receiving SSI disability benefits rose from 296,300 at the end of 1989—2 months before Zebley—to 770,500 at the end of 1993.[10] (See fig. 3.) Over the same time, children also became a larger portion of the SSI disability rolls—up from 11.5 percent to 19.9 percent.[11]

[10]Figures include children under 22.

[11]The SSI program also provides benefits to low-income persons aged 65 and older. Children represented 6.5 percent of the total SSI population at the end of 1989 and 12.9 percent of the total SSI population at the end of 1993.

Figure 3: an Increasing Number of Children Receive SSI

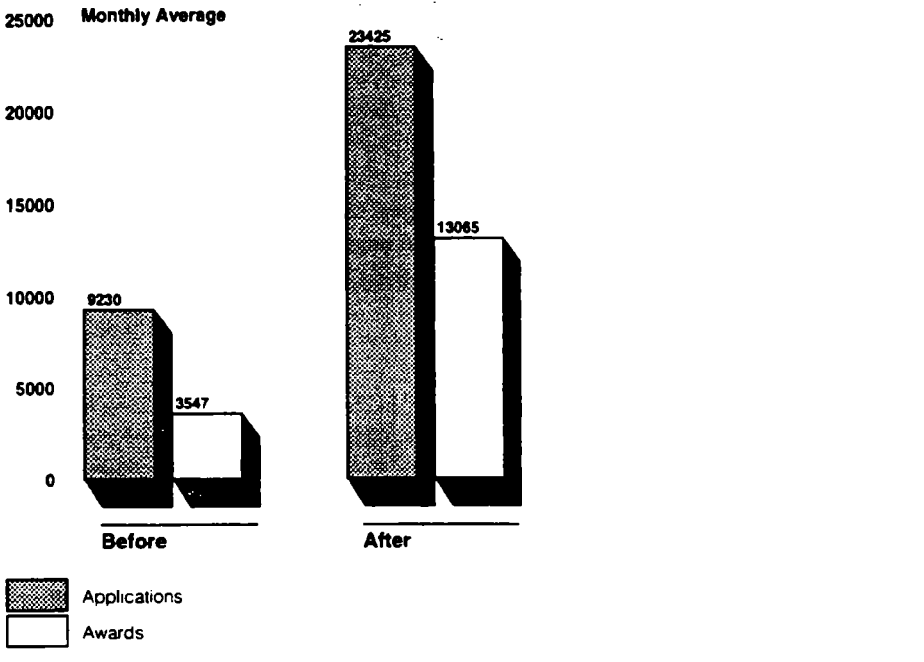


Source: Annual Statistical Supplements to the Social Security Bulletin.

Large Increases in Applications and Awards

The growth in the rolls is the result of huge increases in both applications and awards for children's disability benefits. (See fig. 4.) After both regulatory changes went into effect, DDSs acted on 23,400 applications each month—more than 2-1/2 times the monthly average before the changes. Awards grew even more dramatically than applications. Average monthly awards almost quadrupled, from 3,500 before the regulatory changes to 13,100 afterwards. Awards grew more sharply than applications because the percentage of applications resulting in awards—the award rate—also rose substantially. Before the changes, a little more than a third (38 percent) of the children who applied for disability benefits received awards. After the changes, more than half (56 percent) of the children received awards.

Figure 4: Growth in Applications and Awards



Source: Analysis of SSA's 831 file.

Medical Standards Account for Most of Award Growth

Even after Zebley added the new functional assessment process, 70 percent of the children awarded benefits—a total of 207,900 children—had physical or mental impairments severe enough to qualify for disability benefits under SSA's strict medical standards alone, without the need to perform an IFA.[12] In contrast, 30 percent—a total of 87,900 children—qualified under the less restrictive functional assessment criteria.

Large increases in the number of children qualifying under the medical standards—including those with physical impairments—also account for more than half of the growth in awards. Awards based on the standards more than doubled—increasing from 3,500 per month before the regulations changed to 9,200 per month afterwards—accounting for 59 percent of the growth in awards.

[12]The 207,900 awards based on the medical standards include 15,000 awards to children who qualified under the medical standards' new "functional equivalence" criteria added by the Zebley regulations. These children would have been denied benefits before Zebley. The 15,000 awards—700 per month—represent 5 percent of all awards made after Zebley.

In comparison, the new functional assessment process, which made it possible for children who did not qualify on the basis of the medical standards alone to be eligible for awards, added an average of 3,900 children to the rolls each month, accounting for 41 percent of the growth in awards.

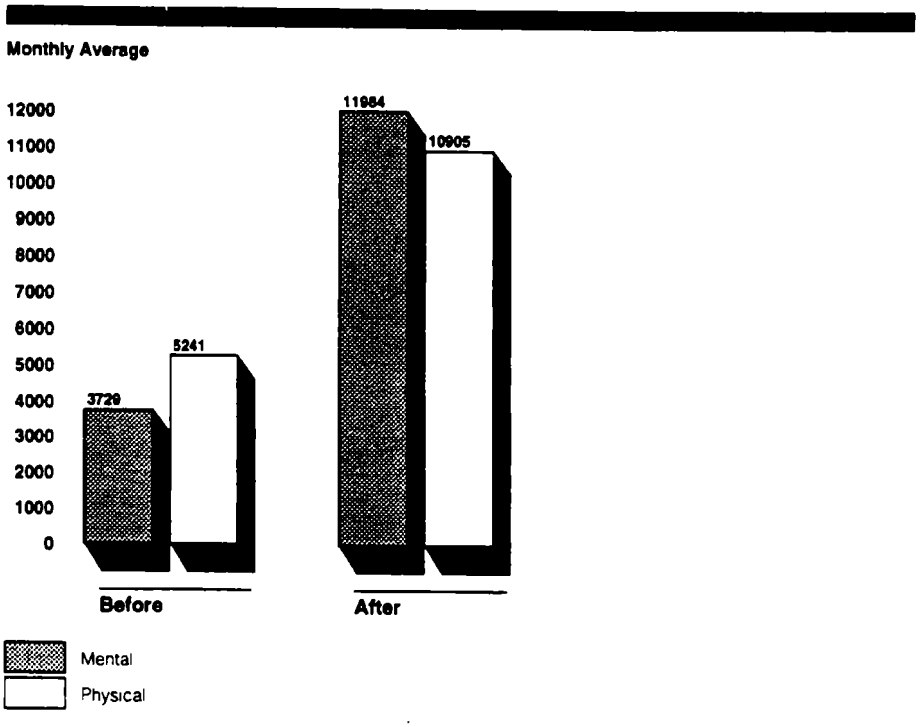
Growth Most Dramatic for Children With Mental Impairments

More than half of the growth in applications and more than two-thirds of the growth in awards is from children with mental impairments, including mental retardation and other mental disorders.

Applications Tripled for Children With Mental Impairments

Applications for children with mental impairments rose faster than applications for children with physical impairments. Applications for children with mental impairments more than tripled, from 3,700 per month before the changes to 12,000 per month afterwards, while applications for children with physical impairments more than doubled, from 5,200 to 10,900 per month. (See fig. 5.) After the changes, 51 percent of the applicants had mental impairments, compared with 40 percent before.

Figure 5: Larger Increase in Applications for Children With Mental Impairments



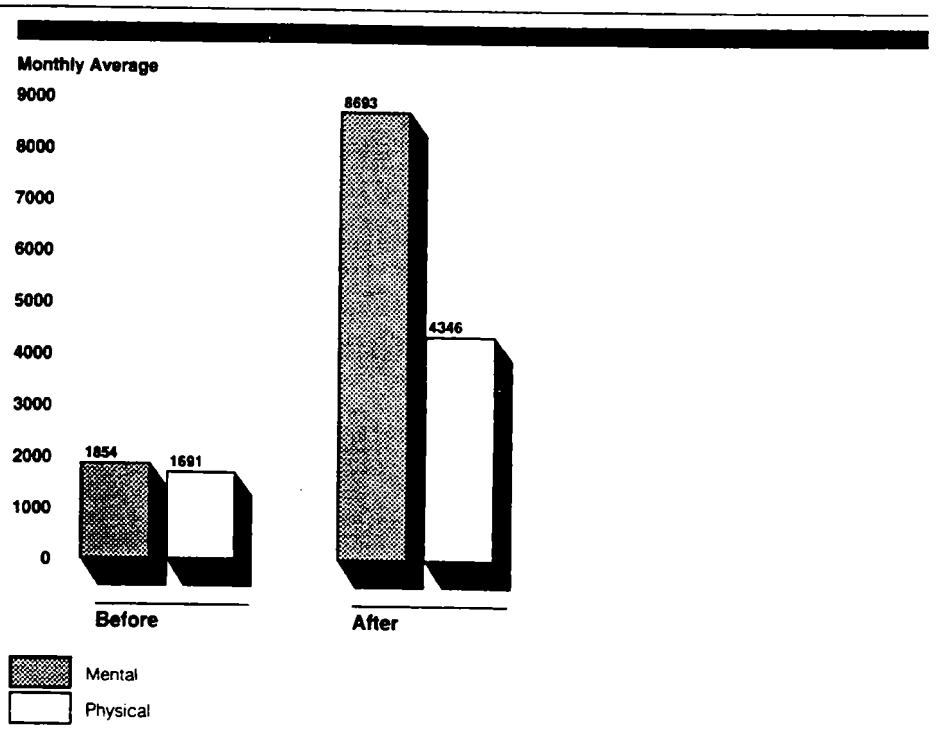
Source: Analysis of SSA's 831 file.

Awards Quadrupled to Children With Mental Impairments

Even more pronounced than the growth in applications for children with mental impairments is the growth in awards. Both awards based on the medical standards and awards based on the new functional assessment process grew more for those with mental impairments than for those with physical impairments.

Total awards to children with mental impairments more than quadrupled after the changes, rising from 1,900 per month to 8,700 per month; at the same time, awards to children with physical impairments rose from 1,700 per month to 4,300 per month. (See fig. 6.) After the changes, children with mental impairments received two-thirds (67 percent) of all awards, compared with about half (52 percent) before.

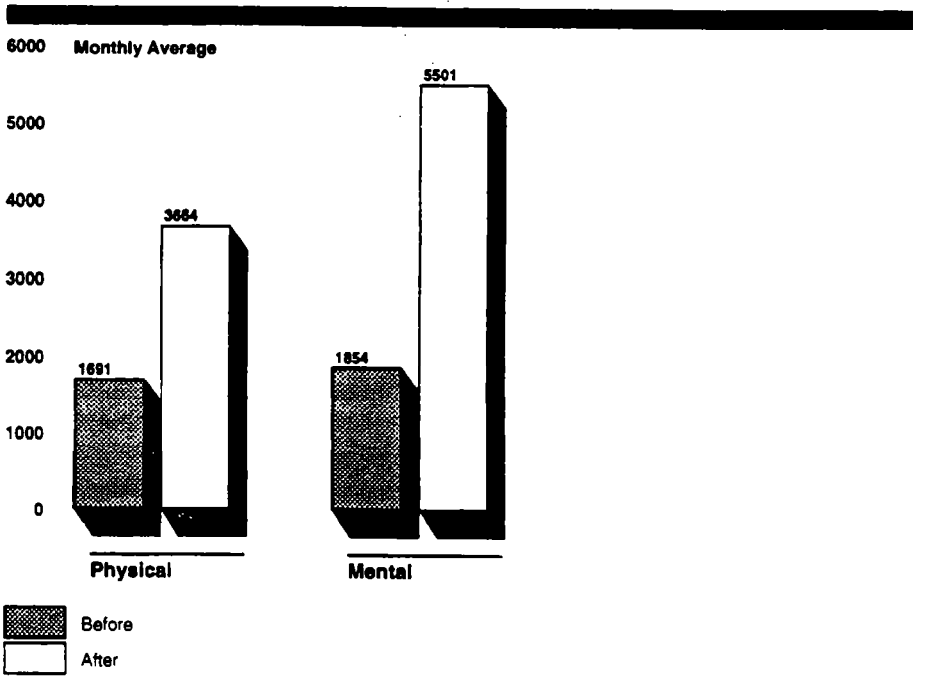
Figure 6: Larger Increase in Awards to Children With Mental Impairments



Source: Analysis of SSA's 831 file.

The effect of the revised and expanded medical standards for childhood mental impairments can be seen in the rapid growth in the number of children with mental impairments awarded disability benefits based on the new medical standards. Awards based on the standards to children with mental impairments almost tripled, from 1,900 per month before the standards changed to 5,500 per month afterwards. Over the same time, awards to children with physical impairments based on the standards more than doubled, from 1,700 per month to 3,700 per month. (See fig. 7.) Before the changes, 52 percent of awards based on the standards went to children with mental impairments; after the changes, 60 percent did. This growth in mental impairment awards based on the medical standards accounts for 53 percent of the total growth in awards to children with mental impairments.

Figure 7: Medical Standards Awards Increased More for Children With Mental Impairments



Source: Analysis of SSA's 831 file.

Children with mental impairments received most of the awards based on the new functional assessment process mandated by Zebley as well. More than four-fifths (82 percent) of all awards based on the new functional assessment process went to children with mental impairments; an average of 3,200 children with mental impairments and 700 children with physical impairments received awards based on functional assessments each month. This new process accounts for 47 percent of the total growth in awards to children with mental impairments.

Award Rate Higher for Children With Mental Impairments

Awards to children with mental impairments grew at a faster rate than awards to children with physical impairments. The award rate for children with mental impairments rose 23 percentage points (from 50 percent before the changes to 73 percent after), while the award rate for children with physical impairments rose 8 percentage points (from 32 percent to 40 percent). Even more significantly, more than half of the children with

mental impairments on whom functional assessments were done (53 percent) received awards compared with less than one-sixth (14 percent) of children with physical impairments.

Most Awards for Mental Impairments Go to Children With Mental Retardation

After the regulatory changes went into effect, a total of 196,800 children—or 8,700 children per month—received awards because of mental impairments. Almost two-thirds of these children—120,300 total, or 5,300 per month—received awards because of mental retardation. This represents 41 percent of all awards. In contrast, one-fifth of these children—39,400 total, or 1,700 per month—received awards because they had diagnoses of attention deficit hyperactivity disorder, personality disorders, or autism and other pervasive developmental disorders—mental disorders that have been broadly characterized as "behavior problems." Children with these diagnoses represented 13.3 percent of all awards.[13]

Because SSA revised its medical standards for childhood mental impairments in December 1990, it is not possible to compare the number and percentage of children receiving benefits because of specific types of mental impairments before and after the standards changed. The new medical standards recategorized the groupings of mental impairments, adding some new categories—such as autism and other pervasive developmental disorders and attention deficit hyperactivity disorder—that were not specifically identified in the former medical standards for childhood mental impairments.

Trend Continuing for 1993

Our data for the period after the regulatory changes cover the results of disability decisions SSA made on children from February 11, 1991, through the end of 1992. Data from SSA for 1993 show that awards to children with mental impairments continued to rise sharply.[14] (See table 2.)

[13]SSA and the HHS Office of the Inspector General have noted problems with the way SSA's computerized record of disability decisions codes mental impairment cases. Some behavioral disorders have been coded as "other" or as "mental retardation" cases. The exact extent of these coding anomalies is unknown.

[14]Our data include the results of initial determinations and reconsideration decisions made by DDSs. They include Zebley classmembers whose cases were readjudicated since February 11, 1991, for whom benefits had been denied or terminated from 1980 to 1987. SSA's data include initial determination decisions made by DDSs on persons applying for the first time.

Table 2: Awards to Children With Mental Impairments, February 11, 1991, Through December 31, 1993

Mental impairment	2/11/91 - 12/31/92 Monthly average	2/11/91 - 12/31/92 Percent of mental impairment awards	1/1/93 - 12/31/93 Monthly average	1/1/93 - 12/31/93 Percent of mental impairment awards
Mental retardation	5,315	61.1	7,081	56.9
Attention deficit hyperactivity disorder	878	10.1	1,690	13.6
Personality disorders	614	7.1	936	7.5
Autism/other developmental disorders	249	2.9	364	2.9
Organic mental disorders	264	3.0	378	3.0
Schizophrenic/other psychotic disorders	84	1.0	131	1.0
Mood disorders	352	4.1	582	4.7
Anxiety disorders	282	3.2	338	2.7
Alcohol dependence disorders	8	0.1	11	0.1
Drug dependence disorders	5	0.1	13	0.1
Somatoform disorders	5	0.1	9	0.1
Eating and tic disorders	21	0.2	23	0.2
Developmental/emotional disorders of infants	211	2.4	381	3.1
Other	404	4.7	504	4.1
Total	**8,693**	**100.0**	**12,441**	**100.0**

Source: Analysis of SSA's 831 file and information from SSA.

About 149,300 children—12,400 per month—received awards in 1993 because of mental impairments. Children with mental retardation received 57 percent of these awards and 39 percent of total awards. This represents a slightly smaller portion of both mental impairment and total awards than through 1992, even though the actual number of such awards grew to 85,000, or 7,100 per month—up from 5,300 awards per month through 1992.

Children with attention deficit hyperactivity disorder, personality disorders, and autism and other pervasive developmental disorders received a larger portion of awards due to mental impairments and total awards in 1993. Such children received a total of 35,900 awards—3,000 per month—or almost one-quarter (24 percent) of all awards to children with mental impairments and almost one-sixth (16 percent) of total awards in

1993. This represents a 72-percent increase in the actual number of awards from 1,700 per month through 1992.

Conclusions

While it is commonly thought that the number of children receiving SSI disability benefits has grown dramatically because of the Zebley decision, our analysis presents a more complicated picture. Clearly, many of the children now on the rolls are receiving benefits because they qualified under the new functional assessment process mandated by Zebley. But the Congress had already mandated that SSA change its criteria for assessing mental impairments, and children qualifying under the resulting regulations constitute a significant portion of new awards. Recent congressional debate and legislative proposals highlight national interest in the SSI program for children. This report analyzes the nature of the newly emerging caseload to aid the Congress in its deliberations on whether the program is meeting its expectations or whether legislative changes are needed.

Agency Comments

We did not request written comments from HHS on a draft of this report. However, we discussed the draft with SSA staff and have incorporated their comments where appropriate.

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

Please contact me on (202) 512-7215 if you have any questions about this report. Other major contributors are Cynthia Bascetta, Barry Tice, Ellen Habenicht, Linda Baker, and Mary Ellen Fleischman.

Sincerely yours,

Jane L. Ross

Jane L. Ross
Associate Director,
Income Security Issues

Contents

Abbreviations

DBRA	Disability Benefits Reform Act of 1984
DDS	disability determination service
IFA	individualized functional assessment
HHS	Health and Human Services
RFC	residual functional capacity
SSA	Social Security Administration
SSI	Supplemental Security Income

Scope and Methodology

To analyze the growth in Supplemental Security Income disability awards to children since the Social Security Administration changed its criteria for determining children's eligibility for disability benefits, we obtained SSA's computerized records on the results of initial determination and reconsideration disability decisions made by disability determination services on children under age 18 from 1988 through 1992. These records exclude the results of disability decisions made by administrative law judges. We compared the results of disability decisions made 2 years before and 2 years after the criteria changed. The first period covers decisions made from January 1, 1988, through February 20, 1990—the date of the Sullivan v. Zebley Supreme Court decision. The latter period covers decisions made from February 11, 1991—the first date both regulatory changes were in effect—through December 31, 1992.

We determined what portion of new awards was due to children qualifying under the new functional assessment process and what portion was due to children qualifying under SSA's medical standards. We also classified children according to their primary diagnosis to determine what portion of the new awards was attributable to children qualifying on the basis of mental versus physical impairments. Among children with mental impairments, we identified the portion of those who qualified on the basis of mental retardation and on the basis of other mental disorders, focusing in particular on awards to children with attention deficit hyperactivity disorder, personality disorders, and autism and other pervasive developmental disorders—mental disorders broadly characterized as "behavior problems." To determine whether awards to children with "behavior problems" are growing, we supplemented our data for the period after the regulatory changes with data for 1993 from SSA. Before the medical standards for childhood mental impairments changed, SSA's computerized records did not separately identify awards made because of the three "behavior problem" categories of mental disorders.

We excluded 139,400 children who had applied during 1988 through February 10, 1991, from our universe of 652,100 children on whom decisions were made from February 11, 1991, through the end of 1992. We did this to minimize the extent to which data from our comparison periods reflect the result of cases readjudicated as part of the settlement in the Zebley class action lawsuit. About 287,900 Zebley classmembers for whom benefits were denied or terminated from January 1, 1980, through February 11, 1991, have had their cases readjudicated as of March 1, 1994. We were not able to identify or exclude Zebley classmembers for whom benefits had been denied or terminated from 1980 through 1987 from

either comparison period. According to SSA, Zebley classmembers are more likely to have physical impairments than the general population of new SSI child applicants. Thus, our data on applications and awards for both periods may include an unusually high number of children with physical impairments. We did, however, obtain information on the results of these cases and report them separately from the results of our comparison.

We supplemented our analysis of SSA's computerized records on awards to children with data from SSA on the total number of children and adults receiving SSI disability benefits. We used these data to determine whether children constitute a growing portion of the SSI rolls.

We did our work at SSA headquarters in Baltimore, Maryland, from August 1993 through April 1994 in accordance with generally accepted government auditing standards.

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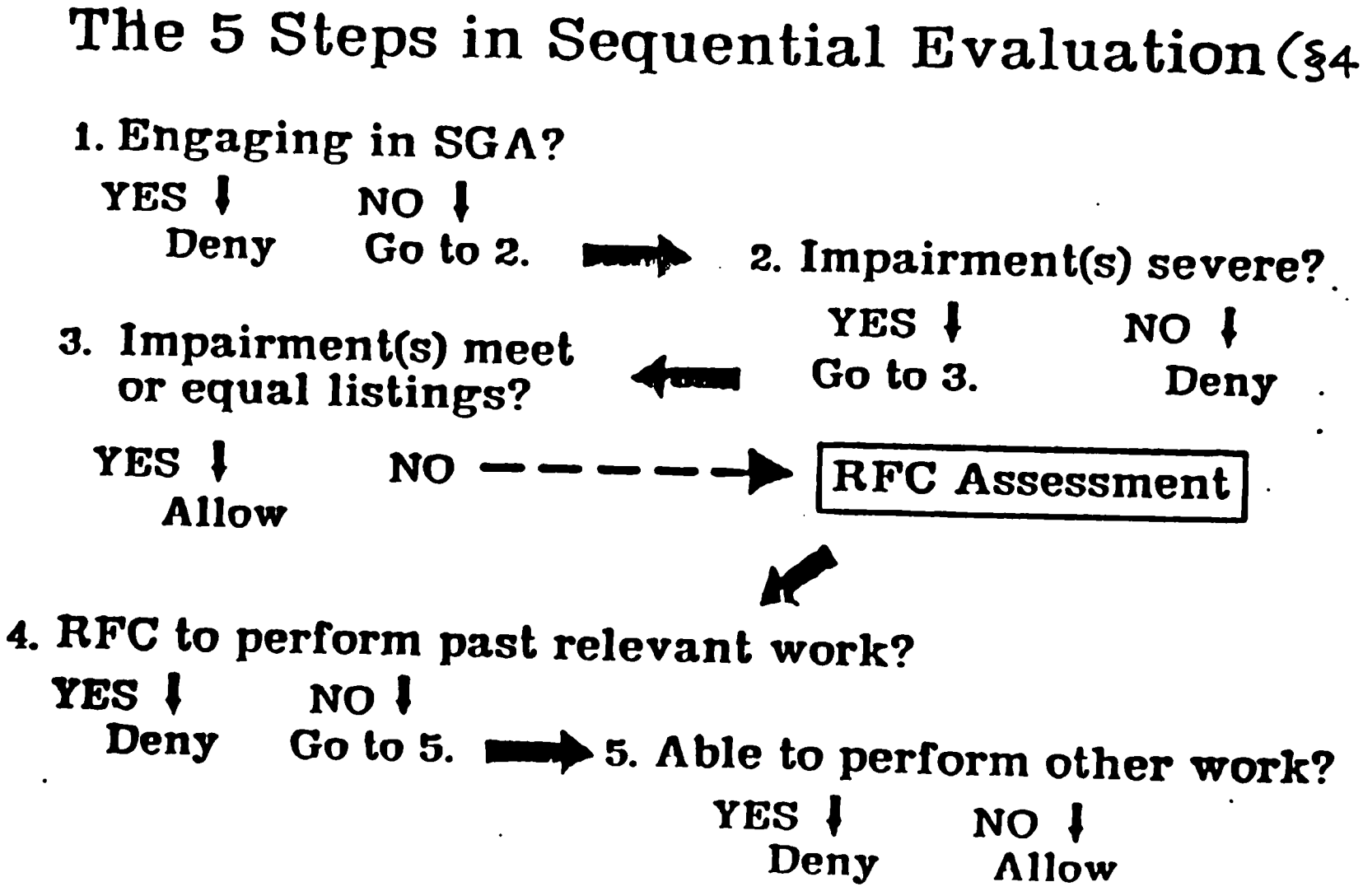
SSA

The 5 Steps in Sequential Evaluation (§416.920)



Initial Sequential Evaluation (§416.924) Process for Children

1. Substantial gainful activity?

YES ↓ Deny

NO ↓ Go to 2.

2. Severe impairment or combination of impairments?

YES ↓ Go to 3.

NO ↓ Deny

3. Meets listing?

YES ↓ Allow

NO ↓ Equals (medical) listing?

YES ↓ Allow

NO ↓ Equals (functional) listing?

YES ↓ Allow

NO ↓ Proceed to IFA

IFA

4. Comparable severity?

YES ↓ Allow

NO ↓ Deny

DOMAINS AND BEHAVIORS BY AGE GROUP (§416.924d(c))

Although some domains are common to all ages, the age-appropriate functions assessed in those domains are different for each age group (e.g., social functioning in a preschool-age child is very different from social functioning in an older adolescent).

All Ages (0-18):

- Cognition
- Communication
- Motor Abilities
- Social Abilities

Newborns and Young Infants (0-1):

- Responsiveness to Stimuli

Older Infants and Toddlers; Children (1-18):

- Personal/Behavioral Patterns

Children (3-18):

- Concentration, Persistence, and Pace in Task Completion

STUDY GOALS AND RESULTS

The goals of the study were to determine:

- What types of evidence were being obtained and whether that evidence, both medical and functional, is sufficient to establish both the existence (or nonexistence) and the severity of the alleged impairment(s).

- The behavioral characteristics exhibited by the children.

- If there is widespread "coaching" or "malingering."

- If children with "mild" impairments are being found disabled.

- If findings of disability and non-disability are being made in accordance with the rules and guidelines contained in the title XVI childhood disability regulations, the Program Operations Manual System (POMS), and other policy issuances.

The study determined that:

- There was a wide range of evidence in file that supported the decisions reached. Where evidentiary problems were cited, it was not because there was an absence of evidence, rather because the evidence in file was not sufficiently detailed or timely.

  In general, denials in this group of targeted impairments were better documented than allowances. Additional information should have been obtained in 27.7% of the allowances, but only 1.4% of the denials. Most of these cases required clarification of general descriptions of the child's behavior. Although all cases in which the child's behavior was germane to the decision contained some description, they did not always provide sufficient information to determine whether, and the extent to which, a child's behavior was outside the range of "normal."

- Children in this group exhibited a wide array of inappropriate behaviors.

- There was no evidence of widespread "coaching" or "malingering."
  The reviewers identified only 13 cases, 3 allowances and 10 denials, in which there was possible coaching or malingering. All of the allowances were based on other evidence and were appropriate decisions.

- In general the rules and guidelines were being applied correctly and correct decisions were reached. However, a small number of children with "mild" impairments were found disabled due to various kinds of misapplications or misunderstandings about the rules and guidelines. The reviewers disagreed with 28 of the 325 allowances. The review indicated that 8.6% of the allowances--approximately 2% of the universe of childhood claims--should have been denied.

Allegations of Coaching

- Of great concern to SSA are the allegations and anecdotal information we have received from members of the educational community and others that children with "mild" impairments were being coached by their parents to act abnormally to qualify for SSI payments.

- As a result of these allegations, SSA conducted a study in 1993 (with results reported in May 1994) of 617 childhood disability cases involving children with conduct and learning disorders.

- The study focused on claims involving conduct and learning disorders because these impairments seem the most likely to be susceptible to coaching. Also, they are the ones most often cited by those who allege that children with "mild" impairments are being improperly granted disability.

- First of all, SSA found no evidence of widespread coaching. Even when coaching or malingering was an issue (13 cases), the cases were generally denied (10 cases) or the allowances were based on factors not affected by the suspected malingering.

- We also learned that the disability rules and guidelines were, generally, being applied correctly and that proper decisions were being reached. However, a number of issues were identified which necessitated clarification. To address these issues, we issued a series of 13 technical reminders (Disability Digest articles) to all adjudicators as the issues arose. In addition, national training was conducted in June 1994 on the results of the study and the issues that were identified.

- However, because SSA continues to receive these allegations, and because there are allegations that coaching/malingering situations are not being reported, we have instituted the following actions:

  -- We provided the State disability determination services with instructions for identifying, developing and evaluating cases in which coaching may be a factor. Such cases are referred for a special review.

  -- 800-numbers were established to permit teachers and other school personnel to make confidential reports to SSA on an individual basis. Instructions were issued so that allegations from the general public will also be directed into the same investigative process as allegations from teachers.

-- We issued a communique to all SSA employees that informs them of their role in detecting when coaching has occurred. The communique informs employees of the 800-numbers that are available for use by school personnel and the procedures to follow when reports or other indications of coaching are received.

-- Two open letters - one to parents and another to teachers - have been developed. These letters inform the readers about the SSI program and their role in providing the information used in deciding a child's claim. Both letters refer to the allegations of coaching.

  - Parents are told that children are expected to put forth their best effort on any testing and that, in this regard, we can deny a claim for failure to cooperate and that any parent who coaches a child to do otherwise is breaking the law.

  - The letter to teachers informs them of the 800-numbers that can be used to confidentially report incidents of coaching.

-- A brochure for school professionals that describes SSI childhood disability benefits has been published which reminds teachers to notify SSA if they have any knowledge that the child has been coached to function poorly. A similar brochure for health professionals asks that lack of effort on testing be reported.

-- Operating instructions have been issued requiring that requests for information from teachers and other school personnel specifically ask whether the source has personal knowledge that a child has been coached.

- Additional instructional transmittals added new coding provisions which will help better identify specific categories of childhood cases (learning disorders, conduct disorders, etc.) for further study.

- A followup study is planned to review the same kinds of cases on which the 600-case study focused in order to test the effects of our remedial actions (technical clarifications, national training) on adjudicative accuracy nationwide.

- Unconnected with allegations of coaching or the 600-case study, we are about to begin a study of childhood claims involving physical impairments. The study will focus on congressional and other groups' concerns that children with physical impairments are not treated as fairly under our evaluation process as are children with mental impairments.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

OCT 13 1994

Memorandum

Date

From June Gibbs Brown
Inspector General

Subject Concerns About the Participation of Children With Disabilities in the Supplemental Security Income Program (A-03-94-02602)

To

Shirley S. Chater
Commissioner of Social Security

Attached is our final report presenting the results of our review of concerns about participation of children in the Supplemental Security Income (SSI) program. These concerns were reported to our office by members of Congress and others.

The results of this review indicated confusion with the intent of the SSI disability program for children. If Congress intended that the SSI program provide only cash assistance to children with mental impairments, then the program is successful. About $4.5 billion in SSI payments were made to, or on behalf of, children in 1993. However, if Congress intended that the SSI program should help children overcome their disabilities, and grow into adults capable of engaging in substantial gainful activity, changes are needed.

Our report contains recommendations concerning the participation of children with disabilities in the SSI program which need to be addressed. The Social Security Administration agreed with our recommendations.

If you wish to discuss this report, please call me or have your staff contact Daniel W. Blades, Assistant Inspector General for Social Security Audits, Office of Audit Services at (410) 965-9700. We would appreciate receiving a status report within 60 days from the date of this memorandum on the progress made in implementing our recommendations. A copy of this report is being sent to other interested departmental officials and members of Congress.

To facilitate identification, please refer to Common Identification Number A-03-94-02602 in all correspondence relating to this report.

Attachment

cc:
Bruce C. Vladeck
Administrator
Health Care Financing Administration

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CONCERNS ABOUT THE PARTICIPATION OF CHILDREN WITH DISABILITIES IN THE SUPPLEMENTAL SECURITY INCOME PROGRAM

JUNE GIBBS BROWN
Inspector General

OCTOBER 1994
A-03-94-02602

EXECUTIVE SUMMARY

BACKGROUND

Title XVI of the 1972 Amendments (Public Law (P.L.) 92-603) to the Social Security Act established the Supplemental Security Income (SSI) program. The SSI program was implemented in 1974, replacing three State and/or county administered assistance programs. The Social Security Administration (SSA) administers the SSI program, and is assisted by States' Disability Determination Services (DDS).

The purpose of the program, as defined in P.L. 92-603 (hereafter referred to as the SSI statute), is to provide supplemental security income to the aged, the blind, and individuals with disabilities who have been determined eligible on the basis of income and resources. A purpose of the SSI program, as described in House Report No. 92-231, is that children with disabilities from low-income families are deserving of special assistance to help them become self-supporting members of our society.

Under the SSI statute, an individual is considered disabled "*...if he is unable 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 twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).*"

The Supreme Court decision in *Sullivan v. Zebley* (hereafter referred to as the *Zebley* decision) of February 20, 1990, found that the Department of Health and Human Services' (Department) approach to child disability was not comparable to its approach to adult disability and was, therefore, "*manifestly contrary to statute.*" In response, SSA established an individualized functional assessment of children which was based on a child's ability to function in an age-appropriate manner.

OBJECTIVES

The Office of Inspector General (OIG) was requested by a Member of Congress to review a number of concerns about child participation in the SSI program which were reported to his office by several of his State's residents--primarily teachers, psychologists, and school administrators. Subsequent to receiving this request for audit, OIG received similar reports from other members of Congress and other sources in such States as Michigan, Pennsylvania, Iowa, and Arkansas. The concerns were that:

- the *Zebley* decision resulted in a significant number of children being determined eligible for SSI benefits;

- children with impairments, such as a learning disability or an emotional problem, which might interfere to some degree with school functioning but will

not prevent them from earning a living as adults, are being determined eligible for SSI benefits;

- children are being determined eligible for SSI benefits without regard to actual financial needs created by their disabilities; and

- the SSI payments are not being used for special needs of children with disabilities so that they can engage in substantial gainful activity[1] as adults.

The Member of Congress, who made the initial audit request, expressed concern that SSA had interpreted the SSI statute to mean that a child is disabled if an impairment substantially reduces his or her ability to function independently and effectively in an age-appropriate manner. He stated that a child's inability to function in an age-appropriate manner hardly seems "comparable in severity" to a physical or mental impairment that would prevent an adult from engaging in substantial gainful activity.

In addressing the four concerns mentioned above, we used the results of our statistical sample of children in three selected diagnostic categories: (1) mental retardation; (2) attention deficit hyperactivity disorder; and (3) "other," as categorized in SSA's automated records. The statistical sample was taken in eight States. Two other States were also included in our review. Our audit universe consisted of a total of 124,639 children who enrolled in the SSI program during Calendar Year (CY) 1992 in the 3 selected diagnostic categories. All of our statistical sampling projections are based on this audit universe of 124,639 with the exceptions of those projections related to the Food Stamp program. There were a total of about 269,300 children with disabilities who enrolled in the SSI program during CY 1992.

RESULTS OF AUDIT

The results of our review indicated confusion with the intent of the SSI disability program for children. Under the statute, the "intent" of the program is to provide cash assistance to children with disabilities. Our review found that the program basically achieves that purpose. About $4.5 billion in SSI payments were made to, or on behalf of, children in 1993.

Congressional intent in passing the legislation was less clear in that the House Ways and Means Committee believed poor children with disabilities "...are deserving of special assistance in order to help them become self-supporting members of our society." Other than to generally provide children access to the Medicaid program (our review showed that 78 percent of the children in our audit universe were enrolled in the Medicaid program at the time of their SSI enrollment) and to the Maternal and Child Health Services Block Grant program, the SSI program is not oriented towards assisting children to become "self-supporting members of our

[1] Substantial gainful activity means the performance of significant physical and/or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit. Since January 1, 1991, substantial gainful activity has been set at $500 per month or more.

society." The SSI program does not evaluate a child's potential to engage in substantial gainful activity; does not identify a financial need created by a child's impairments; and does not require that the SSI payments be used to treat impairments. Our review has shown that:

Prior to the passage of the SSI statute, there was controversy in the Congress regarding the appropriateness of providing SSI payments for children with disabilities.

- ✓ The House Ways and Means Committee stated that children living in low-income households are among the most disadvantaged of all Americans and are deserving of special assistance in order to help them become self-supporting members of our society. The Committee believed that poor children with disabilities should be eligible for SSI benefits because their needs are often greater than those of nondisabled children.

- ✓ The Senate's Finance Committee contended that the needs of children with disabilities were generally greater than nondisabled children only in the area of medical treatment, and that the Medicaid program was available to meet most of those needs. The Committee's position was that children with disabilities should not be included in the SSI program.

- ✓ The legislation that was passed after conference included child participation in the SSI program.

The Zebley decision, which called for modified eligibility criteria for children with disabilities, has had a significant impact on the growth of the SSI program.

- ✓ About 83,000 children, or 31 percent of the children who enrolled in the SSI program during 1992, were determined eligible on the basis of an individualized functional assessment of their ability to act in an age-appropriate manner, a process required by the *Zebley* decision.

- ✓ The use of individualized functional assessments when applied to children with certain mental impairment diagnoses is inherently complex, and has contributed to errors found by SSA in a special review[2] of childhood disability claims, the majority of which were decided using an individualized functional assessment.

  The SSA:

  - ☛ concluded that 8.6 percent of the allowance cases reviewed should have been denied, and that an additional 27.7 percent of the allowance cases should not have been decided until further information supporting the allowance was obtained;

[2] The results of this special study are not representative of the SSI child population as SSA focused on specific diagnoses where it suspected that coaching of the child could occur most frequently.

- concluded that 1.4 percent of the denied cases should have been allowed, and another 1.4 percent should not have been decided until further information supporting the denial was obtained; and

- took actions to prevent similar errors in the future.

Neither the SSI statute nor the regulations require an assessment of a child's potential to engage in substantial gainful activity as a condition of program eligibility.

✓ The SSA must evaluate a child's current functioning, including, if appropriate, the child's current ability to function in an age-appropriate manner.

- Predicting whether children have the potential to engage in substantial gainful activity may be difficult because of variables including parental roles, the nature and timeliness of treatment, and age. The average age of the children in our audit universe was about 9 years old.

- One indication of a child's potential to engage in substantial gainful activity is the degree of permanency of the impairment. We estimate that 104,713 of the 124,639 children included in our audit universe were determined to have nonpermanent impairments by DDS personnel, and improvement is either possible or expected.

✓ Continuing disability reviews (CDR), designed to ensure that SSI beneficiaries remain eligible for SSI benefits after enrollment, were generally not conducted on SSI beneficiaries, including children with disabilities. Unlike the Title II Disability Insurance program which mandates CDRs, the SSI statute does not mandate that CDRs be conducted on SSI beneficiaries.

- The SSA has planned to increase the number of CDRs conducted on SSI beneficiaries, including children, in Fiscal Year (FY) 1995.

- The Social Security Independence and Program Improvements Act of 1994 requires SSA to conduct CDRs on children receiving SSI benefits after they reach 18 years of age.

Neither the SSI statute nor the regulations require an identification of a financial need created by a disability as a condition of program eligibility.

✓ The SSA is required to ensure that SSI beneficiaries, including children, meet financial eligibility requirements for low income and assets levels. There is no consideration of the added cost to the family or guardian created by an impairment.

✓ Needs of the children were being addressed, at least in part, by other assistance programs at the time of their SSI application.

- ☞ We estimate that 94 percent of the children in our sample were enrolled in at least one other assistance program at the time of their SSI application.

- ☞ We estimate that 96,602 children in our audit universe were enrolled in the Medicaid program at the time of their SSI application, and thus had access to many types of free medical services.

- ☞ We estimate that 81,892 children in our audit universe were enrolled in special education programs at the time of their SSI application. Special education programs may provide not only educational-oriented services but also psychological services and other forms of counseling.

- ☞ We estimate that 71,737 children in our audit universe were enrolled in the Aid to Families With Dependent Children (AFDC) program at the time of their SSI application. The AFDC program is a cash assistance program for low-income families.

- ☞ We estimate that 68,186 children in our audit universe were enrolled in the Food Stamp program at the time of their SSI application. The Food Stamp program is designed to afford a nutritionally adequate low-cost diet to eligible low-income families.

Neither the SSI statute nor the regulations require that SSI payments be used solely for any special needs of children with disabilities.

- ✓ How SSI funds are used is unclear since representative payees, who generally receive the SSI payments on behalf of children with disabilities, self-report usage. This reporting mechanism is not totally effective in that:

  - ☞ it may deter, but cannot readily detect, misuse of SSI cash payments by representative payees; and

  - ☞ representative payees did not always submit required annual reports specifying how SSI payments were spent.

Conclusions and Recommendations

The concerns addressed in this report focus on the intent of SSI payments made on behalf of children with disabilities, and the manner in which some of the children are determined eligible, that is the individualized functional assessment of their ability to act in an age-appropriate manner.

We believe that the intent of the SSI program for children with disabilities, and the manner in which some children are determined eligible by individualized functional assessments need to be revisited by Congress.

- ✓ If Congress intends the program to help children with disabilities become adults capable of engaging in substantial gainful activity, changes are needed to ensure that the children receive the assistance they need for them to meet this objective.

- ✓ If Congress does not want children to be determined eligible for SSI benefits on the basis of an individualized functional assessment of their ability to act in an age-appropriate manner, changes are needed. The SSA did not interpret the SSI statute in this manner. The *Zebley* decision required SSA to begin the individualized functional assessments.

Needed changes to the SSI program may result from the Social Security Independence and Program Improvements Act of 1994. One provision of this Act requires the establishment of a Commission on the "Evaluation of Disability in Children." The Commission is tasked with studying several aspects of the SSI program for children with disabilities.

One of the tasks is for the Commission to consider the appropriateness of an alternative definition of disability for children under the age of 18. Another task is to consider methods to increase the extent to which SSI benefits are used to help children achieve independence, and engage in substantial gainful activity.

We believe that the establishment of this Commission provides SSA with an opportunity to clarify the issues that have been raised by Members of Congress, teachers, school administrators, psychologists, DDS employees, and others regarding the intent of SSI payments to children, and the rules used to determine their eligibility.

We, therefore, recommended that SSA:

1. Work with the Commission to develop recommendations to Congress regarding:

   a. the intent of SSI payments for children with disabilities, and to make any necessary changes to program operations and regulations based on actions taken by Congress; and

   b. whether the current practice of basing SSI eligibility in part on a child's ability to function in an age-appropriate manner--a practice directed by the *Zebley* decision--should be modified.

2. Develop a CDR profile of SSI beneficiaries, including children, whose disabling impairments are most likely to improve, and conduct CDRs on the basis of this profile (these CDRs would be in addition to those mandated by the Social Security Independence and Program Improvements Act of 1994).

The SSA agreed with our recommendations. Appendix C of this report includes a copy of SSA's comments on our draft report.

CONTENTS

CONTENTS

INTRODUCTION

BACKGROUND

The SSI program was established by Title XVI of the 1972 Amendments (P.L. 92-603) to the Social Security Act, and is administered by SSA. Implemented in 1974, the SSI program replaced three State and/or county administered assistance programs--Old Age Assistance, Aid to the Blind which included blind children under the age of 18, and Aid to the Totally and Permanently Disabled which did not include children with disabilities under the age of 18. These three assistance programs are commonly known as the "adult programs." The SSI program provides cash assistance to children.

According to the SSI statute, the primary purpose of the SSI program is to assure a minimum income for aged, blind, and disabled persons who have low income and assets. The House Report No. 92-231 adds that children with disabilities from low-income families are deserving of special assistance to help them become self-supporting members of society.

The SSA establishes eligibility for the SSI program, assisted by States' DDS which determine whether applicants are disabled. According to the SSI statute, adults are disabled if they are unable "*...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 a continuous period of not less than twelve months.*" A child (under the age of 18) is disabled "*...if he suffers from any medically determinable physical or mental impairment of comparable severity....*" to that which would make an adult disabled.

As of December 1993, there were about 6 million aged, blind, and disabled individuals enrolled in the SSI program at a cost of about $24 billion. About 770,000 of these individuals were children with disabilities who received payments totaling about $4.5 billion. According to SSA's automated records, about 411,500 of the children had mental impairments.

SCOPE OF AUDIT

Our audit was made in accordance with generally accepted government auditing standards. It was in response to various concerns about the SSI program for children with disabilities which were reported to the OIG by members of Congress and others. The objectives of our review were to:

- develop information relevant to various concerns that were reported to our office which focused on the intent of SSI benefits for children;

- determine the adequacy of SSA guidelines provided to the States' DDS, which determine whether SSI applicants are disabled, and of DDS' compliance with the guidelines when making eligibility determination decisions during CY 1992; and

- determine the nature and extent of the medical treatment received under the Medicaid program by children with disabilities enrolled in the SSI program during CY 1992.

This report presents the results of our first objective, and includes our response to four major concerns about the SSI program for children with disabilities. The OIG was initially requested by a Member of Congress to review these concerns which were reported to his office by several of his State's residents--primarily teachers, psychologists, and school administrators. After receipt of this request, we were notified of similar concerns by other Members of Congress and other sources. The four major concerns are:

- The *Zebley* decision of February 20, 1990 is responsible for an extraordinary number of children being determined eligible for SSI benefits.

- Children with impairments, such as a learning disability or an emotional problem, which might interfere to some degree with school functioning but will not prevent them from earning a living as adults, are being determined eligible for SSI benefits.

- Children are being determined eligible for SSI benefits without regard to actual financial needs created by their disabilities.

- The SSI payments are not being used for special needs of children with disabilities so that they can engage in substantial gainful activity as adults. This is defined as the performance of significant physical and/or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit. Since January 1, 1991, substantial gainful activity has been set at $500 per month or more.

In the near future, we will issue two other reports containing the results of our reviews of: (1) the adequacy of SSA guidance to State DDS for determining the eligibility of children for SSI payments, and DDS compliance with this guidance; and (2) the medical treatment received under the Medicaid program by children enrolled in the SSI program.

As part of this audit, we reviewed the SSI statute and the legislative history surrounding its enactment. We also reviewed the *Zebley* decision, and SSA's response to it, including regulations published in February 1991, and revised in September 1993.

We statistically selected a sample of 300 children who were enrolled in the SSI program in 10 States in CY 1992. We also selected for review 270 children nationwide who were denied SSI enrollment in CY 1992. The primary purpose of our review of both the children enrolled and the children denied was to determine if States were complying with SSA guidelines for SSI medical eligibility. We were unable to conduct testing to identify fraud or abuse in the program. The Family

Educational Rights and the Privacy Act of 1974 prevented us from obtaining third party information to independently verify the child's condition and determine whether or not parent coaching or child malingering occurred.

In this report, we are using information gathered from our review in 10 States to address the concerns raised about child participation in the SSI program. Our sampling design is based upon a two-stage unrestricted sampling technique. The first stage consisted of a random selection of 8 entities from a population of 50 States,[3] Puerto Rico, and the District of Columbia. The second stage consisted of a random selection of 30 children from each of the selected States' population of children with disabilities who enrolled in the SSI program during CY 1992, and whose diagnostic category was: (1) mental retardation (MR); (2) attention deficit hyperactivity disorder (ADHD); or (3) "other," as categorized in SSA's automated records. A summary of the statistical methodology is contained in Appendix B.

In our audit universe, there were 124,639 children who enrolled in the SSI program in CY 1992 in the 3 selected diagnostic categories. In total, there were about 269,300 children with disabilities who enrolled in the SSI program during CY 1992. Thus, our audit universe represents about 46 percent of the total number of children who enrolled in the SSI program during the year.

The eight States selected were: Connecticut, Illinois, Kentucky, New York, North Carolina, North Dakota, South Dakota, and Vermont. In addition to the eight States, Pennsylvania was selected as a pilot State to conduct our audit survey, and Wisconsin was selected because of concerns expressed about the SSI program in that State.

We selected the three diagnostic categories because: (1) MR was the largest single diagnostic category for mentally impaired children; and (2) the other two diagnostic categories were, in our opinion, among the categories which were the focus of the concerns reported to our office (learning and behavior disorders were not specifically identified in SSA's computer system, and were being included under existing diagnostic categories, including the three we selected).

A summary of the selected children by State and by diagnostic category follows.

---

[3] Three entities--Pennsylvania, Wisconsin, and Puerto Rico--were excluded from the universe for nationwide projection purposes because we had judgmentally selected the two States for survey, and Puerto Rico is not included in the SSI program.

SUMMARY OF SAMPLE SELECTIONS				
STATES	DIAGNOSTIC CATEGORY OF THE CHILDREN			
	MR	ADHD	OTHER	TOTAL
CONNECTICUT	26	3	1	30
ILLINOIS	23	5	2	30
KENTUCKY	26	4	0	30
NEW YORK	23	4	3	30
NORTH CAROLINA	24	4	2	30
NORTH DAKOTA	24	6	0	30
PENNSYLVANIA	25	2	3	30
SOUTH DAKOTA	24	4	2	30
VERMONT	18	2	10	30
WISCONSIN	16	7	5	28
TOTAL	229	41	28	298

Pennsylvania and Wisconsin were not included in our eight State statistical sample as mentioned previously. We selected the 30 children in each State randomly following the second stage methodology used in the other States. See Appendix B for details on how we appraised the results of our sample.

Case files for two of the children in Wisconsin were not furnished. Since Wisconsin was not included in our statistical sample, we limited our review there to 28 cases, for a total of 298 children in the 10 States. We obtained the case files on the 298 selected children from SSA, and evaluated the evidence contained therein. We also visited the DDS in the 10 States to survey their Quality Assurance programs, to obtain their opinions on the guidance received from SSA and other issues involving the children determined eligible, and to evaluate their compliance with SSA guidelines. We obtained information from various State agencies concerning the children's enrollment in other assistance programs.

We reviewed the Supplemental Security Income Display (SSID) maintained by SSA to determine if the children in our sample underwent CDRs when scheduled, and if the representative payees submitted an annual Representative Payee Report (Form SSA-623) used to account for SSI payments, when required. We also reviewed a report prepared by SSA showing the results of a study of 617 children who had applied for SSI benefits.

Our audit included discussions with officials at SSA headquarters in Baltimore, Maryland, and at various field and regional offices nationwide. Our audit work was performed between September 1993 and July 1994.

FINDINGS AND RECOMMENDATIONS

The issues in this report address concerns of teachers, school administrators, psychologists, and others which were brought to our attention by Members of Congress as well as other sources. The concerns focus primarily on: (1) the congressional intent of SSI payments made on behalf of children with disabilities; and (2) the manner in which some children are determined eligible for the SSI program. Our review showed that:

- ✓ Prior to the passage of the SSI statute, the Senate Committee on Finance at first opposed the participation of children in the SSI program, questioning the purpose of the SSI payments.

- ✓ The *Zebley* decision resulted in SSA starting individualized functional assessments of a child's ability to function in an age-appropriate manner. These assessments contributed to a significant increase in the number of children enrolled in the SSI program, and to errors in medical determination decisions detected by the SSI study.

- ✓ There were an estimated 104,713 children, of the 124,639 children in our audit universe, judged to have nonpermanent impairments by DDS. Since improvements were either expected or possible, it is possible that some of these children have potential to engage in substantial gainful activity as adults. The SSA did not generally conduct CDRs on these children, although SSA plans to increase the number of CDRs conducted on SSI beneficiaries.

- ✓ About 94 percent of the children in our sample were enrolled in one or more other assistance programs at the time of their SSI application, indicating that at least some of their special needs were being addressed prior to SSI enrollment.

- ✓ The SSI statute does not require that SSI payments be used for treatment of a child's impairments. It is unclear how the payments are used since representative payees, who receive the payments for most children, self-report usage.

On August 15, 1994, the Social Security Independence and Program Improvements Act of 1994 was signed into law. One provision of this Act requires the establishment of a Commission on the "Evaluation of Disability in Children." The Commission, in consultation with the National Academy of Sciences, is tasked with studying several aspects of the SSI program for children with disabilities. Some of its tasks relate to the issues discussed in this report.

We believe that SSA should work with this Commission to revisit the purpose of SSI payments made on behalf of children with disabilities, and the method of determining

their eligibility for the program. We also believe that SSA should conduct CDRs on children receiving SSI benefits.

LEGISLATIVE HISTORY OF CHILD PARTICIPATION IN SSI PROGRAM

The concerns brought to our attention by Members of Congress and others focus primarily on the intent of child participation in the SSI program, that is, the purpose of SSI payments made to representative payees on behalf of children with disabilities. Questions concerning the purpose of child participation in the SSI program are not new. In fact, debate on this issue was going on prior to the passage of the SSI statute.

The OIG issued an inspection report[4] in 1992 on the origins of the SSI program. The report concluded that the Administration and Congress originally did not intend to create a new disability program. Rather, the Administration's 1969 proposal called for sweeping changes in family welfare. The Aid to Families with Dependent Children (AFDC) program was to be replaced with a Federal program called the Family Assistance Plan (FAP). The proposal would have continued the State "adult programs" but would have: (1) established nationally uniform minimum benefits; (2) eliminated some State eligibility restrictions; (3) increased the Federal share of funding; and (4) given States the option of contracting with the Federal Government for administration.

Although both the House and Senate passed versions of the proposal that included the "adult program" reforms, the House refused to go to conference to consider a Senate bill that did not include the FAP. At the time the Administration and Congress were content to continue the State "adult programs." Senate Finance Committee Chairman Russell Long remarked, "There is no pressing need to completely throw out present programs for the aged, blind and disabled and start a new program. These programs, on the whole, have been working well."

Following the defeat of the 1969 proposal, the House Ways and Means Committee submitted a new bill in June 1971. This bill included the FAP and called for the replacement of the State "adult programs" with a new Federal program that included children with disabilities. According to House Report No. 92-231, it was the Committee's belief:

> "...that disabled children who live in low-income households are certainly among the most disadvantaged of all Americans and that they are deserving of special assistance in order to help them become self-supporting members of our society. Making it possible for disabled children to get benefits under this program, if it is to their advantage, rather than under the program for families with children, would be appropriate because their needs are often greater than those of

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[4] Office of Inspector General, SSI OVERVIEW: Program Origins 1969-1973, (OEI-09-91-01330) March 1992.

> nondisabled children. The bill, accordingly, would include disabled children under the new program."

In September 1972, the Senate Committee on Finance agreed to the House bill for "adult programs" with one major difference--the eligibility of children for disability payments. According to the Committee report (Senate Report 92-1230, dated September 26, 1972):

> "The House justified its inclusion of disabled children under age 18 under aid to the disabled, if it is to their advantage, rather than under the program for families with children, on the grounds that their needs are often greater than those of nondisabled children. The needs of disabled children, however, are generally greater only in the area of health care expenses. In all but the two States that do not have Medicaid programs, children now eligible for cash assistance are covered under existing State medical assistance programs. Disabled children's needs for food, clothing, and shelter are usually no greater than the needs of nondisabled children."

The Senate Committee on Finance, therefore, opposed the inclusion of children with disabilities in the SSI program on the basis that the needs of these children, other than medical, were usually no greater than the needs of nondisabled children. The Committee also continued to reject the FAP. On October 6, 1972, the full Senate passed the legislation with only minor changes from the Senate Finance Committee's bill. On October 17, 1972, the House and Senate passed legislation which included the SSI program and other Social Security Act amendments but without the FAP. The SSI program included coverage for children with disabilities under 18 years of age. There was nothing mentioned in the legislative history as to how the Senate Finance Committee's initial opposition to child participation was resolved.

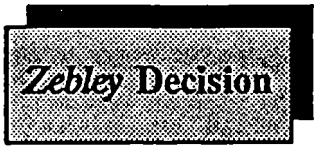
IMPACT OF *ZEBLEY* DECISION ON SSI PROGRAM

The 1990 Supreme Court *Zebley* decision required SSA to revise its method of determining SSI eligibility for children with disabilities by requiring individualized functional assessments of children who would have previously been denied SSI benefits. This revision has had a significant impact on the number of children found eligible for the SSI program, and, to a lesser degree, on the number of errors made in making medical determination decisions.

Pre *Zebley* Decision

In initially implementing the SSI program, SSA established two different sequential evaluation processes for determining disability in adults and children. Both processes began with a determination of whether the claimant was involved in substantial gainful activity, but then the processes differed. Essentially, adult eligibility was determined on the basis of: (1) a medical listing of impairments; and (2) a residual functional capacity assessment of an adult's capacity to work, if the adult's impairment was not on or equal to the impairment listing.

On the premise that children could not be expected to have a capacity to work, child eligibility was determined solely on the basis of a medical listing of impairments. If a child's impairment was not on or equal to the listing, the child was determined to be not disabled. Children were not given the opportunity for an individualized functional assessment.



The difference in the eligibility determination process for adults and children, namely the lack of an individualized functional assessment for children, became the focus of the *Zebley* Supreme Court decision of February 20, 1990. Brian Zebley, a child who had been denied SSI benefits, challenged SSA's child-disability regulations in court alleging that the Department had:

> "...promulgated regulations and issued instructions...whereby children have their entitlements to SSI disability benefits based solely on the grounds that they have a listed impairment or the medical equivalent of a listed impairment...in contravention of the Act's requirement that a child be considered disabled if he suffers from any medically determinable physical or mental impairment of comparable severity to that which disables an adult under the program."

The Department did not seriously dispute the disparity in the approach to child and adult disability determinations. Rather the Department argued that the listings-only approach was the only practical way to determine whether a child's impairment is "comparable" to one that would disable an adult. The Department's position was that an individualized functional assessment for children was not feasible since children do not work, and there was no available measure of their functional abilities analogous to an adult's ability to work. The only way to measure "comparable severity" was to compare a child's medical evidence with the standard of severity set by the listings.

The Supreme Court was unconvinced by this argument. The Court concluded that because a vocational analysis used for adults is inapplicable to children it does not mean that a functional analysis cannot be applied to them. An inquiry into the impact of an impairment on the normal daily activities of a child such as speaking, walking, washing, dressing, feeding oneself, going to school, playing, etc., is no more unmanageable than an inquiry into the impact of an adult's impairment on his ability to perform substantial gainful work.

In a seven to two decision, the Supreme Court found that the Department's regulations and rulings implementing the child disability statute did not carry out the statutory requirement that SSI benefits be provided to children with "*...any...impairment of comparable severity....*" to an impairment that would make an adult "*...unable to engage in any substantial gainful activity.*" The Supreme Court thus held that the Department's approach to child disability is "*...manifestly contrary to the statute.*"

The dissenting opinion pointed out the different purposes underlying the SSI program for adults and children. According to this opinion, Congress provided disability benefits for adults to ensure "*...the basic means of replacing earnings that have been lost as a result of...disability...*" for those who "*...are not able to support themselves through work.*" By contrast, Congress provided disability benefits to children because "*...their needs are often greater than those of nondisabled children.*" In other words, Congress' aim in providing benefits to children was not to replace lost income, but to provide for their special needs, such as home health care costs arising out of the child's medical disability.

The dissenting Supreme Court Justices, therefore, concluded that it was consistent with this distinct purpose to focus consideration on the severity of the child's impairment from a medical perspective alone, without individualized consideration of vocational or similar factors or the child's residual functional capacity.

Post *Zebley* Decision

In response to the *Zebley* decision, SSA, in March 1990, announced the establishment of a child expert group to assist in revising the SSI regulations. The experts represented a wide range of experience in the assessment of child disability, such as, general pediatrics, developmental pediatrics, infant development, child psychology, learning disorders, and early and adolescent childhood education.

The child expert group met during the months of April, May, and June 1990, to help SSA devise new regulations in response to the *Zebley* decision. The group focused on:

- ✓ the definition of the standard to be used to establish that a child has an impairment of comparable severity to one which would render an adult disabled;
- ✓ age-appropriate functional criteria required by the *Zebley* decision; and
- ✓ the method of incorporating the results of the individualized functional assessments into the disability determination process.

The SSA also sought assistance from other childhood experts, and advocacy groups which included Community Legal Services in Philadelphia, Association for Retarded Citizens of the United States, the Mental Health Law Project, and the National Senior Citizens Law Center. Within the SSA community, SSA solicited comments and advice from its regional offices and the States' DDS.

Based on the *Zebley* decision and input from the child expert group, SSA concluded that the functional assessment had to be done not only in terms of specific age-appropriate activities and developmental milestones, but in the broader context of developmental domains which include motor functioning, communicative skills, cognition, socialization, and behavior.

On May 3, 1990, while SSA was meeting with the experts and developing new rules, a stipulation and court order was issued which established an interim standard to be applied to all pending and new child disability claims until the publication of new regulations governing the adjudication of such claims. The interim standard provided for a determination of a child's claim based on an individualized functional assessment whenever the impairment did not meet or equal an impairment on the medical listing.

The interim standard was replaced by the new regulations in February 1991, which made the eligibility determination process for children comparable to the process for adults. According to SSA, the child expert group had significant input into the regulations. As shown below, the revised regulations added additional steps to the eligibility determination process.

SEQUENTIAL EVALUATION PROCESS	ADULT	CHILD *ZEBLEY* DECISION	
		PRE	POST
Doing substantial gainful activity	✓✓	✓✓	✓✓
Impairment(s) severe	✓✓		✓✓
Impairment(s) meets or equals a listed impairment	✓✓	✓✓	✓✓
Individual retains capacity to do past relevant work	✓✓		
Individual retains capacity to do other work	✓✓		
Impairment(s) limits child's ability to function in an age-appropriate manner			✓✓

If an adult's severe impairment is not on the listing of medical impairments or equal to an impairment on the listing, a functional assessment is performed relevant to his or her ability to work. If a child's severe impairment is not on the listing of physical or mental impairments or equal to an impairment that is on the listing, SSA must determine if the impairment "*...so limits the child's ability to function in an age-appropriate manner that the limitations are comparable in severity to those that would disable an adult.*" To make this determination, SSA established an individualized functional assessment for children whose impairments were not on the list of medical impairments.

In making this individualized functional assessment of a child, consideration is given to the child's age, ability to be tested given the age, ability to perform age-appropriate daily activities, and other relevant factors. The child is assessed as to the extent that he or she is able to function independently, appropriately, and effectively in an age-appropriate manner in the following domains:

- **Cognition**--The ability to learn through perception, reasoning, or intuition, and to retain, use, and manifest acquired knowledge in action or communication. Applied to children up to age 18.

- **Communication**--With respect to language, refers to the ability to receive, comprehend, and express messages using age-appropriate communication skills in order to meet one's needs or to obtain or convey information. With respect to speech, refers to audibility, intelligibility, and efficiency of speech production. Applied to children up to age 18.

- **Motor Abilities**--The ability to use one's body and extremities in gross and fine motions in order to relate to the physical environment and serve one's own or others' physical needs or purposes; the ability to perform age-appropriate physical activities such as play, physical education, and sports. Applied to children up to age 18.

- **Social Abilities**--The ability to form, develop, and sustain relationships with other people on a personal and social basis in an age-appropriate manner to respond appropriately within one's own social role or to the social role of others, and to conduct oneself according to the manners and mores of one's own social group. Applied to children up to age 18.

- **Responsiveness to Stimuli**--Means physical and emotional behaviors in reaction to visual, auditory, or tactile stimulation, manifesting an infant's sensitivity to stimuli within a range of normal, hypersensitive, or hyposensitive. Applied to children up to age 1.

- **Personal/Behavior Patterns**--Means age-appropriate activities and behaviors in self-help, self-regulation, self-improvement, self-protection and self-control. Applied to children between the ages of 1 and 18.

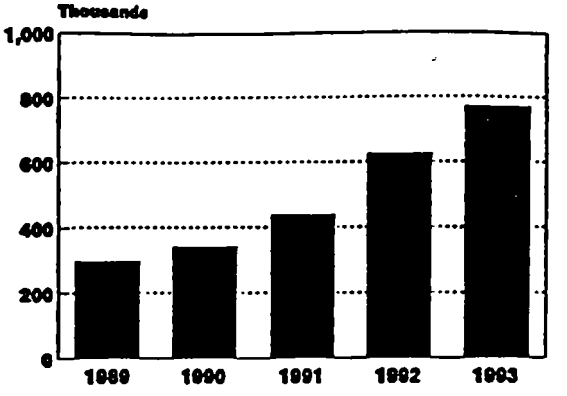
- **Concentration, Persistence, and Pace**--The ability to sustain focus on and attention to an activity or task, such as dressing, playing, reading, studying, or practicing a sport, and to perform the activity or complete the task at a reasonable (age-appropriate) pace. Applied to children between the ages of 3 and 18.

SSI Program Growth

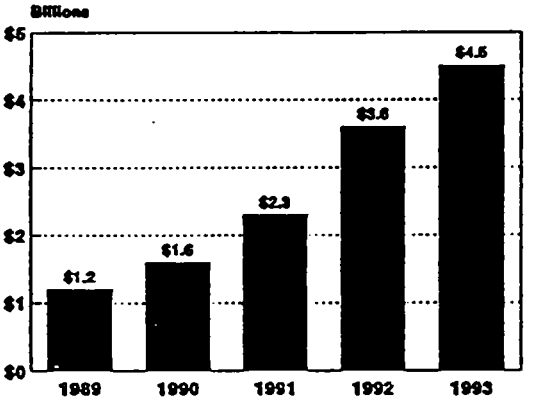
The *Zebley* decision and SSA's response to it have had a major impact on the growth of child participation in the SSI program, but it is not entirely responsible for the significant increase in the number of children participating in the program.

The number of individuals with disabilities enrolled in SSI rose from about 4.6 million in 1989, the year prior to the decision, to over 5.9 million in 1993, for an increase of 28 percent. During that same 5-year period, the number of children receiving payments in SSI rose from about 296,000 in 1989, the year prior to the decision, to over 770,000 in 1993, for an increase of 160 percent. The cost of the SSI program for children rose from about $1.2 billion in 1989 to about $4.5 billion in 1993.

Number of Children With Disabilities Receiving SSI Payments



SSI Payments for Children With Disabilities

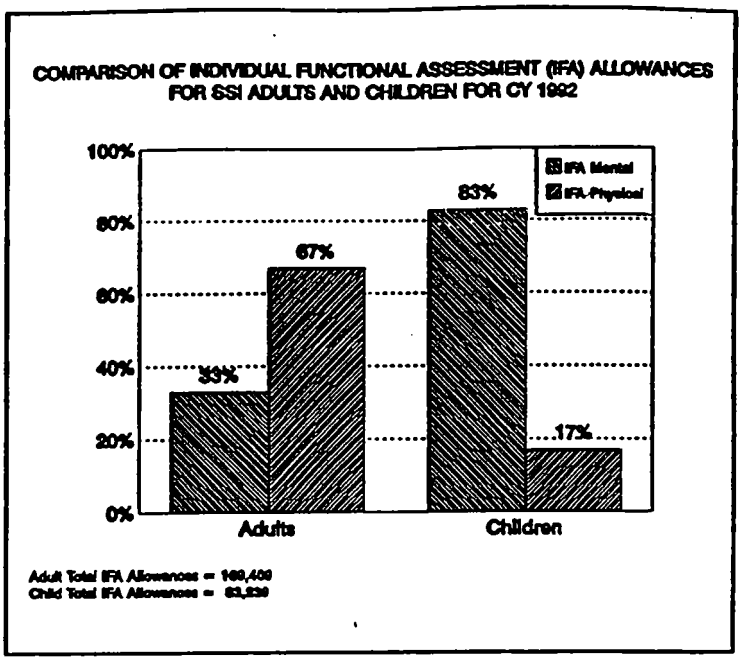


Some of this growth was due to reasons other than the *Zebley* decision. For example, Congress has required an expanded outreach effort since 1990. Also in December 1990, SSA published revised childhood mental listings. These listings, which were under development for several years and had no connection with the *Zebley* decision, increased the number of categories of mental impairments explicitly listed, including such previously unlisted impairments as ADHD and eating and tic disorders.

We believe though that a significant portion of the growth in the number of participating children can be attributed to the *Zebley* decision. For example, in 1992, the year of our review, over 83,200 children, or 31 percent of the 269,300 children who enrolled in the SSI program, were found eligible on the basis of an individualized functional assessment, something that did not exist prior to the *Zebley* decision.

We found that the extent to which allowances were based on functional assessments rather than on the listing of impairments was similar for both adults and children. For example, eligibility for 35 percent of the adults enrolled in the SSI program during CY 1992 was based on residual functional capacity assessments. During the same year, eligibility for 31 percent of the children was based on individualized functional assessments.

A major difference, however, as shown in the adjacent chart, was with the type of impairments involved with the assessments.



For adults, 67 percent of the residual functional capacity assessments resulting in allowances involved physical impairments, while 33 percent involved mental impairments. For children, the opposite was true. Eighty-three percent of the individualized functional assessments resulting in allowances involved mental impairments, while only 17 percent involved physical impairments.

SSA Study Finds Errors

In 1993, SSA conducted a targeted study of 617 childhood disability claims based on behavioral disorders and learning disabilities. These are the impairments most often cited by critics of the SSI program who assert that children with "mild" impairments are being found disabled or are being "coached" to feign disability. The SSA believes that these impairments are also the most difficult to evaluate and, therefore, are more error-prone than claims based on other impairments. The SSA estimated that these kinds of impairments represent about 20 percent of the universe of SSI childhood disability claims, and cautioned that the study findings were not representative of the entire universe of childhood disability claims.

The majority of the study cases were decided using an individualized functional assessment, and about half were allowances and half denials. Within this targeted group, SSA found that 8.6 percent of the allowance cases (cases in which the child was enrolled in the SSI program) were in error. The cases should have been denied based on the evidence in the case files. The SSA also found that an additional 27.7 percent of the allowance cases should not have been approved based on the evidence in the case files. Rather, additional evidence should have been gathered by DDS before any eligibility determination was made. Based on the evidence in the case files, SSA could not determine if these cases should have been approved or denied.

There were few errors found in SSA's review of denied claims. The SSA determined that 1.4 percent of the denied claims should have been approved by DDS, and it could not make any determination of an additional 1.4 percent of the denied cases

due to lack of evidence in the case files. The SSA determined that DDS should not have denied these claims without first obtaining additional evidence.

We agree that, because of SSA's case selection methodology, the results of the study are not representative of the entire SSI child population. We believe, however, that the use of individualized functional assessments and the age-appropriate manner concept that the assessments are based on contributed to the errors detected by SSA. The SSA has taken action aimed at preventing similar errors in the future (we will describe these actions in a separate report).

POTENTIAL FOR CHILDREN TO ENGAGE IN SUBSTANTIAL GAINFUL ACTIVITY

Neither the SSI statute nor the regulations require that a child's potential to engage in substantial gainful activity be considered as a condition of eligibility for SSI benefits. The factors that are considered in the eligibility determination process, other than income and assets, are whether a child's impairment(s) are on or equal to an impairment on the medical impairment listings, and, if necessary, whether a child's current ability to function in an age-appropriate manner is substantially reduced.

Despite the fact that adults with disabilities participate in the American work force, it would be difficult for SSA to predict at the time of SSI application every child's potential to engage in substantial gainful activity as individual outcomes are based on several variables. One variable is the parent or guardian's role with regard to the child. Another variable, related to the first, is the nature and timeliness of the treatment that the child receives for his or her impairment. Since undergoing treatment is not a condition of SSI eligibility, treatment lies mainly with the parent or guardian, and there is no built-in program incentive for the parent to ensure that the required treatment is provided timely. The age of a child could also inhibit accurate predictions of his or her potential ability to engage in substantial gainful activity. The average child in our sample was only 9 years of age at the time of the SSI application.

DDS Evaluations

There is one indication, however, that the condition of many of these children may improve, and that is the number of children judged to have nonpermanent disabilities by DDS at the time of their SSI application.

The DDS evaluate the permanency of a child's impairment during the eligibility process. Unlike the Title II Disability Insurance program, the SSI statute does not require SSA to conduct CDRs of SSI beneficiaries, adults and children alike. Nevertheless, since CDRs are an important safeguard to ensure that only eligible persons continue to receive benefits, SSA has established procedures whereby DDS are required to evaluate the permanency of a child's disability at the time of application and, based on the results of this evaluation, to schedule a CDR for sometime in the future. The CDR is to be scheduled, or diaried, as follows:

- If medical improvement is expected, the disability is determined to be nonpermanent, and a CDR will usually be scheduled within 18 months or less.

- If medical improvement is possible, the disability is determined to be nonpermanent and medical improvement cannot be predicted based on current experience. The facts also do not support the level of severity expected of a permanent disability. A CDR will be scheduled at least once every 3 years.

- If medical improvement is not expected, the disability is determined to be permanent and a CDR will be scheduled once every 7 years but no more frequently than once every 5 years.

We analyzed the CDR scheduling for the 298 children included in our review. We determined that 255 (86 percent) of them were determined by DDS to have nonpermanent disabilities as shown below.

DDS' EVALUATIONS OF CHILD IMPAIRMENTS			
STATE	18 months	19 Months to 3 Years	More than 3 Years
CONNECTICUT	1	22	7
ILLINOIS	0	22	8
KENTUCKY	1	28	1
NEW YORK	1	25	4
NORTH CAROLINA	0	27	3
NORTH DAKOTA	1	24	5
PENNSYLVANIA	0	28	2
SOUTH DAKOTA	0	29	1
VERMONT	3	24	3
WISCONSIN	1	18	9
TOTAL	8	247	43
PERCENTAGES	3%	83%	14%

Projecting these results to the audit universe of 124,639 children with disabilities (see Scope section of this report for details), we estimate that 104,713 of the children were judged to have nonpermanent impairments. Since the impairments of these children were evaluated as being nonpermanent, and improvement was judged to be either expected or possible, it is possible that these children have potential to engage in substantial gainful activity when they become adults.

CDRs Not Performed

Since our review was limited to CY 1992 enrollments, only 16 of the above children should have had their CDRs conducted at the time of this review, according to the diary information developed at the time of application. None of the CDRs were performed, and SSA has informed us that CDRs are not usually conducted on SSI beneficiaries, unless they report a certain level of earned income.

The United States General Accounting Office (GAO) has previously reported problems with CDRs. In July 1993, GAO reported that about $1.4 billion in unnecessary benefits would be paid through 1997 to ineligible beneficiaries in the Title II Disability Insurance program. Data was not available to make similar estimates for the SSI program, but GAO expressed concern that this program may be similarly impacted by the lack of CDRs.

In March 1994 testimony before the Subcommittee on Social Security, Committee of Ways and Means, House of Representatives, a GAO representative acknowledged SSA's recent actions taken to improve the CDR process, primarily for the Title II Disability Insurance program. The GAO representative suggested that SSA should focus future efforts on beneficiaries who most likely have improved sufficiently to no longer be disabled, and should provide increased attention to SSI beneficiaries.

The SSA representatives have informed us that SSA will conduct CDRs on 5,000 children with disabilities in 1995, as a starting point. The SSA is currently developing a methodology to be used in this effort.

The Social Security Independence and Program Improvements Act of 1994 signed into law on August 15, 1994, requires SSA to conduct CDRs for a minimum of one-third of the children reaching age 18 in each of FYs 1996, 1997, and 1998. We believe that SSA also needs to proceed with its plan to develop a methodology to conduct CDRs of other SSI beneficiaries. The methodology should be based on a profile of SSI beneficiaries, including children, whose disabilities are most likely to improve.

FINANCIAL NEEDS CREATED BY IMPAIRMENT

The SSA is required by the SSI statute and regulations to ensure that a child's deemed income and resources remain below specific levels. The SSA, however, is not required by either statute or regulation to identify a financial need created by a child's disabilities as a condition of eligibility.

Some of the concerns that were referred to us for review implied that the special needs of children with disabilities, including financial needs that may have been created by their disabilities, were being addressed by other assistance programs. We, therefore, attempted to identify the assistance programs that the children were enrolled in at the time of their SSI application.

Because our review was limited to a case file review and contact with State agencies for Medicaid, AFDC, and the Food Stamp program, our results are limited to those programs and special education (information obtained in case files). We determined that 94 percent of the 298 children in our sample were enrolled in at least one assistance program at the time that they applied for SSI benefits, as shown below.

PERCENT OF DISABLED CHILDREN ENROLLED IN ASSISTANCE PROGRAMS				
STATES	MEDICAID	SPECIAL EDUCATION	FOOD STAMPS	AFDC
CONNECTICUT	87	77	77	57
ILLINOIS	87	67	67	57
KENTUCKY	93	60	N/R	90
NEW YORK	67	67	N/R	57
NORTH CAROLINA	67	57	N/R	47
NORTH DAKOTA	63	57	43	27
PENNSYLVANIA	87	77	73	60
SOUTH DAKOTA	40	80	33	23
VERMONT	93	77	53	33
WISCONSIN	100	75	N/R	29
WEIGHTED AVERAGE	78%	66%	66%	58%
N/R = Not Reported				

Medicaid Program

With the exception of 12 States,[5] commonly referred to as "209 b" States, enrollment in the SSI program automatically qualifies children for the Medicaid program. We found, however, that 78 percent of the children included in our sample were already enrolled in the Medicaid program at the time of their SSI application. Projecting this result to our audit universe of 124,639 children with disabilities, we estimate that 96,602 of the children were enrolled in Medicaid at the time of their SSI enrollment.

[5] The 12 States are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia.

The Medicaid program is a Federal/State program that provides medical assistance to low-income families. States have some discretion in determining the eligibility for the Medicaid program, and the services that are provided under it, as shown below.

SERVICES	MANDATORY	OPTIONAL	
		SERVICES	STATES
Inpatient Hospital	✓✓		
Outpatient Hospital	✓✓		
Physician	✓✓		
Laboratory/ X-Ray	✓✓		
Pediatric Nurse Practitioner	✓✓		
Early and Periodic Screening, Diagnosis and Treatment	✓✓		
Family Planning	✓✓		
Rural Health Clinics	✓✓		
Nurse/Midwife	✓✓		
Rehabilitative		✓✓	47
Physical Therapy		✓✓	40
Clinic		✓✓	49
Psychologist		✓✓	31
Speech Hearing and Language Disorder		✓✓	39
Diagnostic		✓✓	29
Inpatient Psychiatric Services - Under 21 Years		✓✓	41
Medical/Social Worker Service		✓✓	7

The above chart shows that while most States cover optional services, some do not cover such vital services to children with disabilities. For example, 20 States do not provide psychological services to children, and 12 States do not provide services for speech, hearing, and language disorders.

It is clear, therefore, that not all the medical needs of children with disabilities can be met in full by the Medicaid program as currently operated. However, children determined to be eligible for SSI are referred by DDS to an applicable State agency

responsible for administering the Title V Maternal and Child Health Services Block Grant program.

Title V of the Social Security Act consolidated several categorical programs into a single Maternal and Child Health Services Block Grant program. The Title V statute establishes two major goals directly related to the provision of services and assistance to children with disabilities. One, it requires that States provide rehabilitation services for SSI blind children and children with disabilities under the age of 16 to the extent medical assistance for such services is not provided under the Medicaid program. Two, it requires that States provide services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. While the SSI program makes these referrals, it does not require the child to obtain services provided under the Block Grant.

Special Education Programs

We found that 66 percent of the children included in our sample were enrolled in special education programs at the time of their SSI application. Projecting this result to our audit universe of 124,639 children, we estimate that 81,892 of the children were enrolled in special education at the time of their SSI application.

The rights of children with disabilities to public education are protected by the Education for All Handicapped Children Act of 1975 (P.L. 94-142). This Act requires States to assure that all children with disabilities have available to them a free appropriate public education which emphasizes special education and related services designed to meet their unique needs. In 1991, P.L. 101-476 was enacted. This law changed the name of the legislation previously referred to as the "Education for All Handicapped Children Act" to the "Individuals with Disabilities Education Act." The P.L. 101-476 also strengthened and coordinated pre-existing Federal programs and requirements for children and youth with disabilities.

The term "special education" means specially designed instruction, at no cost to parents or guardians, to meet the unique needs of a child with disabilities, including classroom instruction. The term "related services" means transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a disabled child to benefit from special education.

It is clear from this legislation that education of children with disabilities is a responsibility of the State and not the SSI program. It is also clear that most children with disabilities are being enrolled in special education classes furnished by the school districts in which they attend, and that the educational needs of these children are being met, at least in part, by their own schools.

There were, however, 92 children in our sample who, according to the information in the case files, were not enrolled in special education classes. Thirty-eight of these children were less than 6 years of age and 1 was over 18 years of age which may account for the lack of special education. We could not determine why the remaining 53 children were not enrolled, however.

AFDC Program

We found that 58 percent of the children included in our sample were enrolled in the AFDC program at the time of their SSI application. Projecting this result to our audit universe of 124,639 children, we estimate that 71,737 of the children were receiving AFDC benefits at the time of their SSI application.

Under Title IV-A of the Social Security Act, AFDC Federal funds are available to all States for the purpose of maintaining and strengthening family life by providing financial assistance and care to needy dependent children in their own homes or in the homes of responsible caretaker relatives.

Cash payments are made directly to eligible needy families with dependent children. These payments are to cover costs for food, shelter, clothing and other daily living needs recognized as necessary by each State's program. Payments in the form of cash or vendor payments assist needy families or individuals with monthly income maintenance and child care or, for certain families with children in emergency or crisis situations, to prevent destitution.

To receive Federal funds, a State must submit, and have approved by the Secretary of the Department, a plan describing the system under which it proposes to operate these programs. States define "need," set their own benefit levels, establish (within Federal limitations) income and resource limits, and administer the program and supervise its administration. On average, Federal funds pay about 55 percent of AFDC benefit costs and 50 percent of administrative costs.

In 1993, the nationwide median maximum AFDC benefit for a one person AFDC household was $214 a month. The regular Federal benefit for SSI for an individual for 1993 was $434 a month. Most States supplement the regular SSI benefit. With the exception of North Dakota, all States in our sample provide some form of State supplementation. Since a person cannot concurrently receive SSI payments and participate in the AFDC program, the parent or guardian of an SSI eligible child enrolled in the AFDC program (as was the case with 58 percent of our sample) must decide which grant to choose. Since the AFDC payment is usually much smaller than the SSI payment, the choice is an obvious one.

Food Stamp Program

We found that 66 percent of the children in six of the States included in our sample (information on four States was not readily available) were enrolled in the Food Stamp program at the time of their SSI application.

Projecting this result to our audit universe of 103,600[6] children, we estimate that 68,186 of the children were enrolled in the Food Stamp program at the time of their SSI application.

The Food Stamp program, which is administered at the Federal level by the Department of Agriculture's Food and Nutrition Service and funded primarily by the Federal Government, is designed to afford a nutritionally adequate low-cost diet to eligible low-income households. While SSI benefits are based on an individual unit, Food Stamp benefits are based on a household unit. Food stamps are issued in the form of coupon booklets. The amount of the Food Stamp benefits depends on the size of the household and its location. Unlike AFDC payments which cannot be received simultaneously with SSI payments, Food Stamp benefits may be received by SSI beneficiaries if their household meets the net Food Stamp eligibility standard for the households size. Beneficiaries of SSI are not eligible to participate in the Food Stamp program in California where a State-financed adjustment to SSI benefits has replaced the program. The table below illustrates the maximum monthly Food Stamp allotments effective for the period October 1992 through September 1993.

HOUSEHOLD SIZE	48 STATES AND THE DISTRICT OF COLUMBIA	ALASKA	HAWAII
1 Person	$111	$143	$182
2 Persons	203	262	335
3 Persons	292	376	480
4 Persons	370	477	609
5 Persons	440	567	724
6 Persons	528	680	868
7 Persons	584	752	960
8 Persons	667	859	1,097
Each Additional Person	83	107	137

USE OF SSI PAYMENTS

Neither the SSI statute nor regulations require that SSI payments be used to meet the special needs of children with disabilities. The SSA requires representative payees--they receive SSI payments on behalf of most of the children enrolled in the SSI program--to spend the funds on food, clothing, shelter, medical care and personal

[6] Four states did not report food stamp data. Therefore, these states were excluded from the universe and the sample data was projected to a universe of 103,600 not 124,639.

comfort items for the child. How these funds are actually used, however, is not entirely clear since representative payees self-report usage. Furthermore, as mentioned earlier in this report, the medical needs of the children are met, at least in part by Medicaid, and possibly by the Title V Maternal and Child Health Block Grant to which SSI-enrolled children are referred.

Of the 298 children included in our review, 288 had their SSI payments controlled by representative payees at the time of their enrollment. A parent was designated representative payee for 246 of these children while some other relative or institution was the representative payee for 42 children.

Annual Reporting Mechanism

The SSA requires representative payees (other than agencies and institutions) to report annually on how the SSI payments were spent through submission of a Representative Payee Report (Form SSA-623 for SSI). This report requires the representative payees to provide information about: (1) changes in either the custody or living arrangements of the SSI beneficiary; (2) felony crime convictions of the representative payee; (3) the representative payee turning payments over to another person; and (4) the total dollar amount of SSI payments used for the beneficiary during the entire 12-month period. The report requires the representative payee to specify the amount spent for:

- ✓ food and shelter;
- ✓ clothing, education, recreation, personal items, or medical and dental expenses; and
- ✓ savings.

The OIG issued a report[7] on SSA's monitoring representative payee performance. As part of this review, OIG staff interviewed personnel in SSA's processing centers and 20 field offices. A total of 81 individuals were interviewed and their comments analyzed. The analysis showed that SSA staff believed that the annual accounting requirement of how payments are used may deter the misuse of benefits by representative payees. The SSA staff, however, also believed that the current process cannot be relied upon to detect misuse by or questionable performance of representative payees because data on the annual reports are self-reported by the representative payees. The SSA staff reported that they often learn of alleged misuse of payments not through the annual reports submitted by the representative payees, but from complaints from beneficiaries, relatives or others who are concerned about the funds. An SSA study shows that although a more labor-intensive process may be needed to detect misuse, the administrative costs would far outweigh the results.

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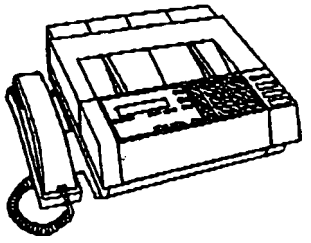
[7] Office of Inspector General, Monitoring Representative Payee Performance Effectiveness and Efficiency of the Accounting Review Process (OEI 09-92-00851), June 1994.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SOCIAL SECURITY AUDITS

FACSIMILE TRANSMISSION COVER MEMORANDUM



ADDRESSEE

NAME: Judy Girard

LOCATION/ORGANIZATION: OI

VOICE TELEPHONE NO.:

FAX TELEPHONE NO.:

DATE:

FROM

NAME: Mike Kowac

VOICE TELEPHONE NO.: (410) 965-9702

Office of Audit Services
Office of Inspector General
Office of Social Security Audits

FAX Telephone No.

410 965-1232

Total pages (including this cover): 3

NOTE: PLEASE CALL 410 965-9701 IMMEDIATELY, IF RETRANSMISSION IS NECESSARY.

SPECIAL INSTRUCTIONS

Subj Memo

Ms. Jean Soliz
Secretary
State of Washington
Department of Social and Health Services
Olympia, Washington 98504-0095

Dear Ms. Soliz:

This is in response to your request for our review of your proposed Program Integrity/Appropriate Benefits Issuance Project. We applaud your commitment to strengthening the integrity and the payment accuracy in your benefit programs. We believe this project has potential for national implementation in the disability determination process of the Social Security Administration's (SSA) Supplemental Security Income (SSI) program. Therefore, we believe SSA should be invited to participate in the design and development of this project. ↑ We have provided a copy of your proposal to Leona Carlson, ~~SSA~~ Director, Division of Field Disability Operations, SSA, (410) 965-5[illegible]

LEONA CARLSON TITLE PHONE #

The SSA has developed a fraud action plan which corresponds to the general steps in your project. In addition, national legislation was enacted to address nationwide problems related to interpreters, middlemen and the potentially erroneous entitlement to Federal benefits. The recent enactment includes the requirement that third-party interpreters certify, under a penalty clause, the accuracy of their translations. The legislation also provides for felony and civil monetary penalties to be imposed against beneficiaries, middlemen, and medical professionals who engage in fraudulent schemes to enroll ineligible individuals in SSA disability programs.

Our experience with investigations of fraudulent mental impairment cases has shown that it is difficult to prove retroactively that an applicant was not disabled. We have also found prosecutors reluctant to accept these cases. Therefore, we support all efforts that prevent individuals from fraudulently obtaining entitlement to benefits. We believe the use of a matrix in the disability determination process at the Disability Determination Service could provide this preventative approach.

As you know, we are involved in numerous investigations of alleged fraud in the SSI program. In addition, our Office of Audit Services is auditing various aspects of the SSI program. These audits involve the use of interpreters in SSI disability claims, SSI benefits for children with mental disabilities, SSI work incentives called Plans for Achieving Self-Support, ~~and profiling SSI disability cases for a possible large scale SSI coaching fraud case~~.

We appreciate the opportunity to review and comment on your proposal and look forward to receiving periodic reports of your progress. If we can be of further assistance, please contact Investigative Operations Branch Chief Olive B. Franklin at (202) 619-2838.

Sincerely,

June Gibbs Brown
Inspector General

bcc:
Exec. Sec.
Larry D. Morey
Daniel Blades
Judy Girard
Michael Kowal
LEORE CARLSON

OIG:OI:CID:Girard/Kowal:CMDay:10/14/94:SOLIZ.3

Annual reports submitted by representative payees may act as a deterrent against misuse of SSI payments by representative payees. We noted, however, that some representative payee reports were not submitted timely. According to SSA's SSIDs, 249 representative payee reports should have been submitted for the children included in our sample. The SSA had not recorded receipt of 110 of these reports as of the time we completed our audit field work.

CONCLUSIONS AND RECOMMENDATIONS

The concerns brought to our attention by Members of Congress and others indicate that there is a perception, particularly among educational professionals, that the SSI program is making payments on behalf of a significant number of children who are being labeled as mentally impaired because they do not act in an age-appropriate manner. We determined that about 83,200, or 31 percent of the 269,300 children who enrolled in the SSI program sometime during CY 1992, were found eligible on the basis of an individualized functional assessment of their ability to function in an age-appropriate manner. Of the 83,200 children enrolled on this basis, 69,245, or 83 percent, were evaluated as having mental impairments. We also determined that the use of the individualized assessments did not result from SSA's interpretation of the SSI statute, but from requirements imposed by the *Zebley* decision.

There is also concern that SSI payments are being made without regard to a child's potential to engage in substantial gainful activities as an adult, and to a financial need created by an impairment, and without adequate assurance that the payments will be used to meet the special needs of the children. We determined that the SSI statute does not require SSA to make any of these determinations as conditions of eligibility.

In some respects, these concerns are similar to the concerns raised by the Senate Finance Committee during the legislative process. The Committee questioned the need for the participation of children with disabilities in the SSI program, concluding that their needs for food, clothing, and shelter are usually no greater than the needs of nondisabled children. Only in the area of health care expenses did the Committee agree that the needs of children with disabilities are greater than nondisabled children. Even here, the Committee pointed out that States have Medicaid programs that can provide medical assistance. The legislation was passed after conference allowing for child participation in the SSI program.

We believe the intent of the SSI program for children with disabilities, and the manner in which some children are determined eligible by individualized functional assessments need to be revisited by Congress. If the purpose of the SSI program is simply to provide cash assistance to children with disabilities, and at a level greater than that available under the AFDC program, the program is, for the most part, successfully meeting this goal. If the purpose of the SSI program is to help children with disabilities engage in substantial gainful activities upon reaching adulthood, then changes in the statute are required.

Further modifications may be required if Congress does not want children to be determined eligible for SSI benefits on the basis of an individualized functional assessment of their abilities to act in an age-appropriate manner. In our opinion, the use of the individualized functional assessments contributed to the errors detected by the SSA study.

Needed changes to the SSI program may result from the Social Security Independence and Program Improvements Act of 1994 signed into law on August 15, 1994. One provision of this Act requires the establishment of a Commission on the "Evaluation of Disability in Children." The Commission, in consultation with the National Academy of Sciences, is tasked with studying several aspects of the SSI program for children with disabilities. Some of its tasks relate to the issues discussed in this report as shown below.

> *"The Commission will conduct a study on the effect of the current SSI definition of disability as it applies to children under the age of 18, and their receipt of services, including the appropriateness of an alternative definition."*

Our review has shown that thousands of children are determined eligible for SSI benefits on the basis of an individualized functional assessment of their ability to function in an age-appropriate manner. The use of this assessment appears to be the focal point of the concerns about the SSI program for children with disabilities, and its modification should be considered in the study of an alternative definition of disability.

> *"The Commission will determine whether the need by families for assistance in meeting the high costs of medical care for children with serious physical or mental impairments might appropriately be met through expansion of Federal health assistance programs."*

Our review has shown that there is no determination as to the added costs to the family of medical care for the children that are not being covered by Medicaid or other assistance programs. The Medicaid program, as it currently operates, does not mandate all the services that would likely be required by children with disabilities. Services provided under the Maternal and Child Health Service Block Grant may fill part of this service gap.

> *"The Commission will examine the feasibility of providing benefits to children through non-cash means, including vouchers, debit cards, and electronic benefits transfer systems."*

Providing benefits to children through noncash implies that the intent of the program is more than just a cash assistance program, and would require an examination of congressional intent of the SSI program for disabled children. Our review has shown that SSI payments are currently made to representative payees for the most part. How they use the benefits is not entirely clear since they self-report usage.

"The Commission will review methods to increase the extent to which benefits are used to help children achieve independence, and engage in substantial gainful activity."

Our review has shown that the SSI program is not specifically geared toward helping children achieve independence, and engage in substantial gainful activity as an adult. The SSI program does provide access to the Medicaid program for children who are not already enrolled in it and to the Title V Maternal and Child Health Block Grant services. The SSI program, however, does not require that children undergo treatment aimed at making them independent and able to engage in substantial gainful activity.

In our opinion, resolution of these issues should result in a greater assurance that the needs of children with disabilities are being met. It should also increase public confidence in the SSI program.

We recommend that SSA:

1. Work with the Commission to develop recommendations to Congress regarding:

   a. the intent of SSI payments for children with disabilities; and to make any necessary changes to program operations and regulations based on actions taken by Congress; and

   b. whether the current practice of basing SSI eligibility in part on a child's ability to function in an age-appropriate manner--a practice directed by the *Zebley* decision--should be modified.

   SSA Comment

   The SSA agreed and will work with the Commission to address the issue.

2. Develop a CDR profile of SSI beneficiaries, including children, whose disabling impairments are most likely to improve, and conduct CDRs on the basis of this profile (these CDRs would be in addition to those mandated by the Social Security Independence and Program Improvements Act of 1994).

   SSA Comment

   The SSA agreed and plans to conduct 10,000 SSI CDRs (5,000 adults and 5,000 children) in FY 1995. The results of these CDRs will be used by SSA to better profile and target cases for future reviews. The 5,000 childhood cases will help develop the base of knowledge necessary for the sophisticated targeting of childhood CDRs.

ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
AFDC	Aid to Families With Dependent Children
CDR	Continuing Disability Review
CY	Calendar Year
DDS	Disability Determination Services
FAP	Family Assistance Plan
FY	Fiscal Year
GAO	United States General Accounting Office
MR	Mental Retardation
OIG	Office of Inspector General
P.L.	Public Law
SSA	Social Security Administration
SSI	Supplemental Security Income
SSID	Supplemental Security Income Display

SUMMARY OF STATISTICAL METHODOLOGY

Attribute Appraisal
Non-Permanent Impairments

Two-Stage Attribute Sampling Results:

PRIMARY UNIT	UNIVERSE	SAMPLE SIZE	SAMPLE ITEMS WITH CHARACTERISTIC(S)	RATIO	PROJECTED
Connecticut	465	30	23	76.67%	357
Illinois	9,133	30	22	73.33%	6,698
Kentucky	3,200	30	29	96.67%	3,093
New York	10,575	30	26	86.67%	9,165
North Carolina	4,078	30	27	90.00%	3,670
North Dakota	163	30	25	83.33%	136
South Dakota	354	30	29	96.67%	342
Vermont	227	30	27	90.00%	204
TOTALS	28,195	240	208		

Primary Sampling Universe - 47 Entities

Secondary Sampling Universe - 114,907 Children

Overall Ratio - 83.93%

Projected Number of children - 96,441

Standard Error - +/- 4.15%

Precision at the 90% Confidence Level - +/- 6.82%

Single-Stage Attribute Sampling Results:

PRIMARY UNIT	UNIVERSE	SAMPLE SIZE	SAMPLE ITEMS WITH CHARACTERISTIC(S)	RATIO	PROJECTED
Pennsylvania	6,546	30	28	93.33%	6,110
Wisconsin	3,186	28	19	67.86%	2,162

Confidence Limits:

	Pennsylvania	Wisconsin
Lower limit at the 90% Confidence Level	5,269	1,614
Upper Limit at the 90% Confidence Level	6,468	2,614

Total Number of Children Projected - 104,713

SUMMARY OF STATISTICAL METHODOLOGY

Attribute Appraisal
Medicaid

Two-Stage Attribute Sampling Results:

PRIMARY UNIT	UNIVERSE	SAMPLE SIZE	SAMPLE ITEMS WITH CHARACTERISTIC(S)	RATIO	PROJECTED
Connecticut	465	30	26	86.67%	403
Illinois	9,133	30	26	86.67%	7,915
Kentucky	3,200	30	28	93.33%	2,987
New York	10,575	30	20	66.67%	7,050
North Carolina	4,078	30	20	66.67%	2,719
North Dakota	163	30	19	63.33%	103
South Dakota	354	30	12	40.00%	142
Vermont	227	30	28	93.33%	212
TOTALS	28,195	240	179		

Primary Sampling Universe - 47 Entities

Secondary Sampling Universe - 114,907 Children

Overall Ratio - 76.36%

Projected Number of children - 87,743

Standard Error - +/- 5.62%

Precision at the 90% Confidence Level - +/- 9.25%

Single-Stage Attribute Sampling Results:

PRIMARY UNIT	UNIVERSE	SAMPLE SIZE	SAMPLE ITEMS WITH CHARACTERISTIC(S)	RATIO	PROJECTED
Pennsylvania	6,546	30	26	86.67%	5,673
Wisconsin	3,186	28	28	100%	3,186

Confidence Limits:

	Pennsylvania	Wisconsin
Lower Limit at the 90% Confidence Level	4,717	2,935
Upper Limit at the 90% Confidence Level	6,239	*

*Since all sample items contained the desired characteristic(s), the program has calculated only the minimum number of items in the universe that contain the desired characteristic(s).

Total Number of Children Projected - 96,602

SUMMARY OF STATISTICAL METHODOLOGY

Attribute Appraisal
Special Education

Two-Stage Attribute Sampling Results:

PRIMARY UNIT	UNIVERSE	SAMPLE SIZE	SAMPLE ITEMS WITH CHARACTERISTIC(S)	RATIO	PROJECTED
Connecticut	465	30	23	76.67%	357
Illinois	9,133	30	20	66.67%	6,089
Kentucky	3,200	30	18	60.00%	1,920
New York	10,575	30	20	66.67%	7,050
North Carolina	4,078	30	17	56.67%	2,311
North Dakota	163	30	17	56.67%	92
South Dakota	354	30	24	80.00%	283
Vermont	227	30	23	76.67%	174
TOTALS	28,195	240	162		

Primary Sampling Universe - 47 Entities

Secondary Sampling Universe - 114,907 Children

Overall Ratio - 64.82%

Projected Number of children - 74,483

Standard Error - +/- 2.48%

Precision at the 90% Confidence Level - +/- 4.08%

Single-Stage Attribute Sampling Results:

UNIT	UNIVERSE	PRIMARY SAMPLE SIZE	CHARACTERISTIC(S)	RATIO	SAMPLE ITEMS WITH PROJECTED
Pennsylvania	6,546	30	23	76.67%	5,019
Wisconsin	3,186	28	21	75.00%	2,390

Confidence Limits:

	Pennsylvania	Wisconsin
Lower limit at the 90% Confidence Level	3,969	1,854
Upper Limit at the 90% Confidence Level	5,792	2,791

Total Number of Children Projected - 81,892

SUMMARY OF STATISTICAL METHODOLOGY

Attribute Appraisal
AFDC

Two-Stage Attribute Sampling Results:

PRIMARY UNIT	UNIVERSE	SAMPLE SIZE	SAMPLE ITEMS WITH CHARACTERISTIC(S)	RATIO	PROJECTED
Connecticut	465	30	17	56.67%	264
Illinois	9,133	30	17	56.67%	5,175
Kentucky	3,200	30	27	90.00%	2,880
New York	10,575	30	17	56.67%	5,993
North Carolina	4,078	30	14	46.67%	1,903
North Dakota	163	30	8	26.67%	43
South Dakota	354	30	7	23.33%	83
Vermont	227	30	10	33.33%	76
TOTALS	28,195	240	117		

Primary Sampling Universe - 47 Entities

Secondary Sampling Universe - 114,907 Children

Overall Ratio - 58.22 %

Projected Number of children - 66,899

Standard Error - +/- 4.44%

Precision at the 90% Confidence Level - +/- 7.30%

Single-Stage Attribute Sampling Results:

PRIMARY UNIT	UNIVERSE	SAMPLE SIZE	SAMPLE ITEMS WITH CHARACTERISTIC(S)	RATIO	PROJECTED
Pennsylvania	6,546	30	18	60.00%	3,928
Wisconsin	3,186	28	8	28.57%	910

Confidence Limits:

	Pennsylvania	Wisconsin
Lower limit at the 90% Confidence Level	2,842	482
Upper Limit at the 90% Confidence Level	4,911	1,453

Total Number of Children Projected - 71,737

SUMMARY OF STATISTICAL METHODOLOGY

Attribute Appraisal
Food Stamps

Two-Stage Attribute Sampling Results:

PRIMARY UNIT	UNIVERSE	SAMPLE SIZE	SAMPLE ITEMS WITH CHARACTERISTIC(S)	RATIO	PROJECTED
Connecticut	465	30	23	76.67%	357
Illinois	9,133	30	20	66.67%	6,089
Kentucky			Not Reported		
New York			Not Reported		
North Carolina			Not Reported		
North Dakota	163	30	13	43.33%	71
South Dakota	354	30	10	33.33%	118
Vermont	227	30	16	53.33%	121
TOTALS	10,342	150	82		

Primary Sampling Universe - 44 Entities (3 Entities did not report)

Secondary Sampling Universe - 97,054 Children

Overall Ratio - 65.31%

Projected Number of children - 63,386

Standard Error - +/- 3.19%

Precision at the 90% Confidence Level - +/- 5.25%

Single-Stage Attribute Sampling Results:

PRIMARY UNIT	UNIVERSE	SAMPLE SIZE	SAMPLE ITEMS WITH CHARACTERISTIC(S)	RATIO	PROJECTED
Pennsylvania	6,546	30	22	73.33%	4,800
Wisconsin			Not Reported		

Confidence Limits:

	Pennsylvania
Lower limit at the 90% Confidence Level	3,733
Upper Limit at the 90% Confidence Level	5,627

Total Number of Children Projected - 68,186

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Memorandum

Refer to:

Date: SEP 30 1994

From: Shirley S. Chater
Commissioner of Social Security

Subject: Office of Inspector General Draft Report, "Concerns About the Participation of Children with Disabilities in the Supplemental Security Income Program" (A-03-94-02602)

To: June Gibbs Brown
Inspector General

Attached are our comments to this draft report. Please let us know if we may be of further assistance.

Attachment:
SSA Comments

COMMENTS OF THE SOCIAL SECURITY ADMINISTRATION ON THE OFFICE OF INSPECTOR GENERAL DRAFT REPORT, "CONCERNS ABOUT THE PARTICIPATION OF CHILDREN WITH DISABILITIES IN THE SUPPLEMENTAL SECURITY INCOME PROGRAM" (A-03-94-02602)

We appreciate the efforts of the Office of Inspector General (OIG) in reviewing this important area. We believe that OIG's input will be particularly valuable in the coming months as the Social Security Administration (SSA) moves forward with the initiatives mentioned in our comments below.

OIG Recommendation

That SSA work with the Commission to develop recommendations to Congress regarding:

a. The intent of supplemental security income (SSI) payments for children with disabilities and to make any necessary changes to program operations and regulations based on actions taken by Congress; and

b. Whether the current practice of basing SSI eligibility in part on a child's ability to function in an age-appropriate manner--a practice directed by the Zebley decision--should be modified.

SSA Comment

We agree. A provision of the Social Security Independence and Program Improvement Act of 1994 is that a Commission will be established to evaluate disability in children. SSA will be working with the Commission to address this major issue.

OIG Recommendation

That SSA develop a continuing disability review (CDR) profile of SSI beneficiaries, including children, whose disabling impairments are most likely to improve, and conduct CDRs on the basis of this profile (these CDRs would be in addition to those mandated by the Social Security Independence and Program Improvement Act of 1994).

SSA Comment

We agree. SSA plans to conduct 10,000 SSI CDRs (5,000 adults and 5,000 children) in fiscal year 1995. We believe this will enable us to conduct the CDRs required by the new law in the most efficient manner. We will use the 5,000 adult cases to develop a statistical profile for SSI-only adult cases and then assess whether the current title II worker profiles are effective with SSI-only cases by: (1) Evaluating a cohort of SSI-only cases using the formulas used to profile title II workers, and

(2) conducting full medical CDRs on the cases predicted to be continuances and cessations. The 5,000 childhood cases will help us to begin developing the base of knowledge necessary for the sophisticated targeting of childhood CDRs.