SOCIAL SECURITY

The Commissioner

February 14, 2014

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed is the report you requested during the hearing on January 16, 2014. As you requested, the report describes our efforts to detect fraud and support the Office of the Inspector General's (OIG) fraud prevention efforts in the Social Security Disability Insurance and Supplemental Security Income programs. The report also includes recommendations for further study by Congress.

I want to thank you and the Subcommittee for holding oversight hearings on the egregious situations that occurred in Puerto Rico and New York City. Congressional focus on these crimes highlights the diligent and longstanding efforts of the Social Security Administration (SSA), our State and Commonwealth Disability Determination Services (DDS), the OIG, and prosecutors to bring criminals to justice. Our message to the criminals is clear: We will tirelessly seek to find and punish anyone who attempts to defraud American taxpayers.

As I stated during the January 16 hearing, I take my responsibility for detecting any potential fraud very seriously. I share your outrage over the alleged fraud schemes that we have uncovered. Preserving the public trust in our programs is a vital mission for our agency. Consequently, I also share your concern that, while the incidence of fraud in the Social Security disability program is low, the discovery of the fraud schemes may lead to a perception that our programs are vulnerable. I want to assure you that we have zero tolerance for any fraud. I am very proud of our employees for working cooperatively to detect and refer the alleged fraud in Puerto Rico and New York City. Their actions show that our current fraud detection programs are effective. We continue our work to identify new ways of combatting fraud. Working together with the OIG and Congress, I believe we will strengthen our anti-fraud activities and continue to earn the public's trust in our stewardship of our disability program.

The report describes what we are doing and our strategies for enhancing our efforts. You will find more details on these initiatives in the report, but I would like to highlight several activities:

1. With the fiscal year (FY) 2014 appropriations, Congress provided us with funding to significantly increase the number of Continuing Disability Reviews (CDR) that we are able to conduct. While the primary purpose of CDRs is to determine whether a beneficiary is no longer entitled to benefits because his or her condition has medically improved, our ability to significantly increase CDRs may allow us to detect increased numbers of potentially fraudulent or suspicious activities.

2. Working with the OIG, we will expand the number of Cooperative Disability Investigations (CDI) units and expand the capacity of existing units. According to the OIG, CDI units have produced savings of more than $860 million over the last 3 years. As the report shows, we provide most of the funding for these units, and in collaboration with the OIG, we plan to expand the CDI program by seven additional units beginning in 2014. We anticipate these 7 units will be fully operational in 2015, increasing the total number of units from 25 to 32 nationwide. We also will expand the capacity of existing CDI units by increasing the number of law enforcement investigators in a number of current units, including Puerto Rico and New York.

3. All of our frontline employees receive anti-fraud training. We will expand training to all SSA employees during fiscal year FY 2014, with specific focus on lessons learned from Puerto Rico and New York City. SSA and DDS front-line employees remain our best line of defense against those seeking to cheat the system.

4. We initiated a special program to use data analytics to enhance fraud detection. Specifically, we will develop analytical tools based on known cases of fraud and past allegations to determine common characteristics and patterns. We will apply these tools to help us uncover potential fraud or other suspicious behavior when we review initial applications or data on existing beneficiaries. We invited the OIG to participate in this initiative.

5. We are establishing a specialized fraud unit comprised of disability examiners dedicated to reviewing and acting on potential fraud cases. These examiners will be our experts in working disability fraud cases, and we plan to have them compile data from the cases that may help us to develop the analytical tools to identify potential fraud.

6. For many years, our regional offices have successfully collaborated with regional OIG agents and local law enforcement on "Regional Anti-Fraud Committees." We also are going to reinstitute the National Anti-Fraud Committee, which will be co-chaired by the Inspector General and our Deputy Commissioner for Budget, Finance, Quality, and Management. The National Anti-Fraud Committee supports national and regional strategies to combat fraud, waste, and abuse. Support includes providing an open forum for senior executives to collaborate on fraud challenges and opportunities at a strategic level.

7. The Department of Justice (DOJ) is responsible for prosecuting defendants who have violated Federal law. However, due in part to a lack of prosecutorial resources, DOJ declines many cases for prosecution. For more than a decade, we have provided SSA attorneys, who serve as Special Assistant United States Attorneys (fraud prosecutors), to several Federal districts to support prosecution efforts. The goal is to increase the number of prosecutions for crimes involving Social Security matters by providing dedicated resources

to focus on Social Security fraud cases. Since FY 2003, our fraud prosecutors have secured over $60 million in restitution and more than 1000 convictions. Given the success of our Fraud Prosecution Project, we plan to hire 12 additional attorneys to serve as Special Assistant U.S. Attorneys.

8. There has been concern that claimants withhold medical evidence that could be unfavorable to their claims. Therefore, we propose to revise our regulations to require claimants to inform us about or submit all evidence known to them that relates to their disability claim—both favorable and unfavorable. This modification would result in expanded case records, which would allow us to make more accurate disability determinations.

You asked about potential policy changes or congressional action that could be considered to combat fraud. We discuss such changes in the report, but clearly, the most important congressional action would be to provide full funding for our program integrity work. Considering that CDRs yield, on average, $9 in lifetime program savings (including savings accruing to Medicare and Medicaid) for every dollar invested, and that CDR funding offers increased opportunities for fraud detection, we ask Congress to provide us full and sustained funding for our program integrity work in FY 2015 and beyond.

Disability insurance benefits are indispensable for so many persons who are suffering from debilitating diseases or incapacitating injuries. We provide about $12 billion in monthly disability insurance benefits to approximately 11 million workers and their families.

Unfortunately, one only has to follow the daily news to know that people will commit bad deeds. We manage the largest disability insurance program in the world. Given the immense scope of the program, we cannot guarantee that we will eliminate 100 percent of the fraud. However, I do guarantee that we will continue to work hard to protect our trust funds from persons who are not eligible for benefits, and we will pursue those who attempt to steal from the American people.

Again, thank you for the opportunity to describe our fraud-fighting efforts and for bringing attention to our work to root out fraud. I hope that you find the information in the enclosed report helpful, and we look forward to working with Congress on this critical issue. If I may be of further assistance, please contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Carolyn W. Colvin

Carolyn W. Colvin
Acting Commissioner

Enclosure

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

The Social Security Administration (SSA) administers the Old-Age, Survivors, and Disability Insurance program, commonly referred to as "Social Security," which protects against loss of earnings due to retirement, death, and disability. Social Security provides a financial safety net for millions of people—few programs touch so many. We also administer the Supplemental Security Income (SSI) program, funded by general revenues, which provides cash assistance to persons who are aged, blind, or disabled, as defined in the Social Security context, with very limited means.

The responsibilities with which we have been entrusted are immense in scope. To illustrate, in fiscal year (FY) 2013 we:

- Paid over $850 billion to almost 63 million beneficiaries, of whom almost 11 million receive disability insurance benefits;
- Handled over 53 million transactions on our National 800 Number Network;
- Received over 68 million calls to field offices nationwide;
- Served about 43 million visitors in over 1,200 field offices nationwide;
- Completed over 8 million claims for benefits and 794,000 hearing dispositions; and
- Completed over 429,000 full medical continuing disability reviews (CDRs).

Given the scope and importance of our responsibilities, we continually strive to preserve the public's trust in our programs. Toward that end, we have zero tolerance for fraud. Historically, we have been successful in this regard; the best available evidence shows that the level of actual disability fraud is less than 1 percent.[1]

Acting Commissioner Carolyn W. Colvin has consistently reinforced her commitment to infuse long-term strategic thinking and planning at SSA, and to implement a more robust approach to performance management and improvement. Of specific relevance here, Acting Commissioner Colvin has impressed upon executives across all functional areas to take strategic measures that position our agency for early detection of, and action on, threats to our program integrity. Our current Agency Strategic Plan (ASP) expressly aims to "Preserve the Public's Trust in Our Programs," with targeted objectives and strategies to find innovative ways to detect fraud. Our updated ASP, which we expect to publish soon, will continue this strong stewardship focus and commitment to fight fraud.

This report describes our efforts to support fraud prevention, detection, and deterrence; policy and procedural changes that we have made in the wake of recent high profile fraud cases; and planned improvements in our anti-fraud efforts. This report also offers recommendations for congressional action in this area.

[1] *See* OIG, *Overpayments in the Social Security Administration's Disability Programs,* Appendix A, at 6-7 (providing a point-in-time estimate of potential fraud cases out of a sample of over 1,500 cases).

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

I. Background

To place this discussion within its proper context, this report will first briefly distinguish the fraudulent receipt of benefits from other causes of overpayments. Further, the report delineates the responsibilities of SSA and the Office of the Inspector General (OIG) in combatting fraud, waste, and abuse.

Distinction Between Fraud and Other Causes of Overpayments

As described by OIG on its website, fraud, waste, and abuse against Social Security can include actions such as:

- Making false statements on claims for Social Security benefits; and
- Concealing facts or events that affect eligibility for Social Security benefits.[2]

Persons who commit such acts can face prosecution that can result in a fine, imprisonment, or both.[3] Additionally, persons who commit such acts are subject to administrative penalties or to civil monetary penalties (CMP), the latter of which are imposed by the Office of the Counsel to the Inspector General.[4]

While fraud—like what allegedly occurred in Puerto Rico and New York City—achieves notoriety because of its repugnance, the best available evidence indicates that benefits obtained through fraud constitute a small subset of improper payments as a whole. In 2003, then Chairman Charles Grassley of the Senate Finance Committee asked OIG to review improper payments in our disability programs. In its subsequent review, OIG examined a sample of 1,532 cases and found only 5 cases of possible fraud, or less than one-third of 1 percent of the sample.[5] A copy of that report can be found in Appendix A.

Most improper payments, including overpayments, have other causes not related to fraud, such as errors in calculating payments, beneficiaries failing to report in a timely manner an event that affects eligibility, and beneficiaries misunderstanding program rules. We are committed to paying benefits accurately and maintaining a robust program to curb and recover overpayments. In fact, curbing improper payments (including overpayments) is a key objective in our strategic goal to preserve the public's trust in our programs. Although our overall payment accuracy is generally high, we are always trying to eliminate improper payments.

Regardless of the source, SSA pursues collection of any overpaid benefits in a manner consistent with Congress's direction in the law. In FY 2013, we recovered over $3.4 billion in overpayments.

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[2] *See* OIG, *What is Fraud, Waste, and Abuse?*, available at http://oig.ssa.gov/what-abuse-fraud-and-waste (last visited on Feb. 14, 2014).
[3] *See, e.g.*, Social Security Act §§208(a), 811(a), and 1632(a); 42 U.S.C. §§408(a), 1011(a), 1383(a)
[4] *See* OIG, *The Office of the Counsel*, available at http://oig.ssa.gov/about-oig/offices/office-counsel (last visited on Feb. 14, 2014).
[5] *See* note 1.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

Role of SSA and OIG in Fraud Prevention

We are proud of our nearly four decades of assistance to the Inspector General's office in the fight against fraud. This collaboration dates back to 1976, when Congress created the first statutorily mandated Inspector General's office in the Department of Health, Education, and Welfare, or HEW (SSA's former parent agency, which later became the Department of Health and Human Services).[6]

At the time, congressional investigators noted that within HEW there was no "central unit with the overall authority, responsibility, and resources necessary to insure effective action against fraud and abuse."[7] In response, the Chair of the House Government Operations Subcommittee on Intergovernmental Relations, Representative L.H. Fountain, proposed legislation that would "establish in HEW for the first time a high-level official with no program responsibilities who is charged with giving undivided attention to the prevention of fraud and program abuse."[8]

Two years later, under the Inspector General Act of 1978, Pub. L. 95–452, Congress created additional Inspector General positions modeled after the office it had created in HEW.[9] Over time, Congress amended the law to create more Inspectors General,[10] including the SSA Inspector General, when it passed legislation in 1994 making SSA an independent agency.[11] Congress made the Social Security Inspector General's responsibilities the same as those outlined in the 1978 law,[12] which includes the responsibility to "provide leadership and coordination … to prevent and detect fraud and abuse."[13]

II. SSA's Referral Process, OIG Investigation of Possible Fraud, and Prosecution

OIG utilizes many different sources and methods to fulfill its statutory obligations to prevent and detect fraud and abuse. However, its best fraud leads have always come from SSA and State and Commonwealth Disability Determination Services (DDS) employees. They are highly trained professionals in the administration of the disability program and are in the best position to identify potential fraud and alert OIG to such cases.

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[6] Statement of David Walker, Comptroller General, before the House Government Reform Subcommittee on Government Efficiency and Financial Management, Oct. 8, 2003, available at http://www.gao.gov/assets/120/110419.pdf (app. I) (last visited on Feb. 14, 2014).
[7] *See* Department of Health and Human Services Office of Inspector General, "Protecting Public Health and Human Services Programs: A 30-Year Retrospective," at 7, available at https://oig.hhs.gov/publications/docs/retrospective/AnniversaryPub.pdf (last visited on Feb. 14, 2014).
[8] *Id.*; *see also* S. Rep. 94-1324, 94th Cong., 2nd. Sess. 1976 ("The committee believes a central unit is needed within DHEW to provide leadership for, and coordination of, activities relating to the prevention and detection of fraud and abuse ….").
[9] *See* S. Rep. 95-1071, 95th Cong., 2nd Sess. 1978.
[10] *See* Inspector General Act Amendments of 1988, Pub. L. 100-504.
[11] *See* Social Security Independence and Program Improvements Act of 1994, Pub. L. 103-296, § 102.
[12] *Id.*
[13] *See* Inspector General Act of 1978, Pub. L. 95–452, § 2.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

Social Security and DDS employees are an indispensable part of OIG's fraud investigations. They provide the majority of fraud referrals to OIG. Furthermore, OIG typically relies on them to analyze and interpret disability case files. Following an OIG finding of fraud or similar fault, Social Security employees coordinate with OIG to suspend or terminate benefits or impose administrative penalties.

SSA's Referral Process

Our field office and DDS employees are our first and best line of defense against fraud. They are highly trained professionals who understand our complex disability program rules and are dedicated to protecting the program from abuse. Their knowledge and experience in administering our programs allow them to identify situations that may indicate potential fraud. OIG relies heavily on their expertise—the majority of fraud referrals come from our front-line employees. In FY 2013, we made over 22,500 disability fraud referrals to OIG, of which OIG opened about 5,300 cases and, of those, referred over 100 to the United States Attorney's Office for criminal prosecution. In fact, in both Puerto Rico and New York City, front-line employees in a DDS alerted OIG to the possible fraud.

Combating fraud starts with vigilance. In the course of serving the public, our employees look out for indications of potential fraud. These signs can include contradictory statements from applicants, suspicious documents, and tips from the local community.

When field office employees suspect that fraud may be involved in a case, they gather additional evidence. This information gathering can involve obtaining and verifying information through third parties and interviews with the sources of the information.[14] Employees then refer the cases of potential fraud to OIG.

OIG Investigation of Possible Fraud Cases

OIG analyzes referrals made by SSA and from other sources, and determines whether to investigate further. During OIG's investigation, our employees provide support by providing expert analysis and gathering additional information, as needed. For additional information, see OIG's website regarding the function of its Office of Investigation.[15]

Prosecution

If, after investigating, OIG believes that fraud or other criminal activity may have occurred, they may refer the case to the local United States Attorney for consideration of civil or criminal prosecution. If the United States Attorney's Office declines to take further action on the case, OIG may seek to refer the case to a State or local prosecutor. (For a discussion of CMPs, administrative sanctions, and a discussion of SSA's Fraud Prosecution Project, see section III.)

[14] Similarly, when hearing office employees suspect fraud, they refer it immediately to OIG.
[15] *See* http://oig.ssa.gov/about-oig/offices/office-investigations (last visited on Feb. 14, 2014).

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

III. Other SSA Anti-Fraud Efforts, and Other Stewardship Activities

Properly preventing, detecting, and deterring fraud requires a multi-faceted approach. This section of the report will focus on some of the other tools we use. These include comprehensive training, the Cooperative Disability Investigation (CDI) program, program integrity activities, a fraud prosecution program, quality reviews, CMPs, and administrative sanctions.

Comprehensive Training

We have maintained our focus and high expertise on fraud identification and referral through comprehensive training. All front-line employees receive extensive training on fraud during their initial training. This training includes identifying common fraud scenarios—including "middleman fraud" such as what allegedly occurred in Puerto Rico and New York City. We supplement initial training with continuing education consisting of detailed policy manual instruction,[16] mandatory annual security reminders, videos on demand, and office visits by executives from SSA and OIG.

Our regional offices and Headquarters components provide ongoing support to our front-line employees in the fight against fraud. Our regional offices alert their employees about potential fraud trends and share recent success stories of fraud prosecution. They solicit feedback from front-line employees on policies and procedures that may be vulnerable to fraud, analyze this information, and work jointly with Headquarters components on necessary policy or procedural changes. Finally, each Regional Commissioner collaborates with his or her regional OIG counterpart to co-chair regional anti-fraud committees. These committees analyze trends and develop regional strategies to combat waste, fraud, and abuse. Later in this report, we discuss how we are replicating this model with the National Anti-Fraud Committee.

Cooperative Disability Investigation Program

The premier disability fraud investigation and prevention tool is the CDI program, which has developed a close partnership among SSA, DDSs, OIG, and local law enforcement. Each CDI Unit consists of an OIG Special Agent who serves as the Team Leader, State DDS and SSA employees who act as programmatic experts, and State or local law enforcement officers. CDI units investigate individual disability applications to identify applicants, beneficiaries, attorneys, doctors, translators, and other third parties (including non-attorney representatives) who facilitate disability fraud. CDI units may present the results of these investigations to Federal and State prosecutors for criminal prosecution or civil action, as well as to the Office of the Counsel to OIG for the imposition of CMPs. We may also impose sanctions on claimant representatives who violate our standards of representative conduct. Appendix C includes a chart that provides the locations for CDI units and costs.

[16] For an example of our fraud instructions, see DI 023025.000 Fraud or Similar Fault at https://secure.ssa.gov/apps10/poms.nsf/lnx/0423025000.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

There are currently 25 CDI units operating throughout the United States with the most recent one established in Puerto Rico. The value of these units is clear. According to OIG, since the program's inception in FY 1998 through FY 2012, CDI efforts nationwide have resulted in $2.2 billion in projected savings to our disability programs and over $1.4 billion in projected savings to non-Social Security programs, such as Medicare and Medicaid. These savings are the result of CDI units opening about 40,000 cases and developing evidence to support about 30,000 actions, resulting in a denial, suspension, or termination of benefits. If not for the New York CDI unit, which was among the first five units established in 1998, it may have been much more difficult to connect individual fraud referrals from the New York DDS to a possible criminal conspiracy.

Program Integrity Activities

Our program integrity work helps ensure that only those persons eligible for benefits continue to receive them. There is a long-standing adage in the agency—the right check to the right person at the right time. Delivering on this statement is our goal because we know that when we accomplish it, we demonstrate our stewardship and preserve the public's trust in our programs.

An important part of our program integrity activities are periodic medical re-evaluations, which we use to determine if beneficiaries are still disabled. With the recent appropriations legislation, Congress provided us with funding to increase significantly the number of continuing disability reviews (CDRs) that we are able to complete. While the primary purpose of CDRs is determining whether a beneficiary is no longer entitled because his or her condition has medically improved, we expect that our ability to perform significantly more CDRs will allow us to detect increased numbers of potentially fraudulent or suspicious activities. The CDR process affords us another opportunity to review and secure new information about the beneficiary's medical condition. Reflecting on the case as a whole at a later time can bring to light unusual or suspicious patterns that may not have been obvious at an earlier point in time.

SSA's Fraud Prosecution Project

The Department of Justice (DOJ) is the Federal agency responsible for prosecuting defendants who have violated Federal law. However, due in part to a lack of prosecutorial resources, DOJ declines many cases for prosecution. For more than a decade, SSA's Office of the General Counsel (OGC) has worked with OIG to develop the SSA Fraud Prosecution Project. The goal of this initiative is to increase the number of prosecutions for crimes involving Social Security matters. To support this project, OGC has provided attorneys who serve as Special Assistant United States Attorneys (fraud prosecutors) in many of the Federal districts where we have regional offices and at Headquarters. We currently have 12 attorneys serving as fraud prosecutors. From FYs 2003 through 2012, our fraud prosecutors secured over $52.3 million in restitution orders and 921 convictions. In FY 2013, they secured over $8.9 million in restitution and obtained 139 convictions. Additionally, their prosecutions have resulted in the unquantifiable financial benefit of stopping ongoing fraudulent schemes as well as dissuading would-be criminals from attempting to defraud Social Security.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

In those districts where we have an SSA fraud prosecutor, there has been an increase in the prosecutions of Federal program fraud and the imposition of restitution orders. It is worth noting that a beneficiary's eligibility for SSI is frequently used by other social service agencies to determine that person's eligibility for other Federal benefits, such as Supplemental Nutrition Assistance Program (SNAP) benefits, Medicaid, and Temporary Assistance to Needy Families (TANF). Therefore, these Federal prosecutions often result in recoveries of fraud losses suffered by other Federal programs and agencies in addition to the recoveries of SSA-administered benefits.

Moreover, there are collateral benefits of the program such as providing a deterrent effect and punishing those who undermine the public's trust in our agency's stewardship of the trust funds by stealing from our benefit programs.

Quality Reviews

The quality of our benefit decisions is a paramount concern for the agency. We take decisional accuracy seriously, and have set up quality review processes for DDS determinations and hearing decisions. We have recently taken steps to strengthen the quality of field office adjudication. We have established a new review process called the Continuous Quality Area Director Review Process. This review will help ensure the accuracy of work completed by field office technicians. One of the primary areas for review is the front-end disability accuracy in field offices, with a concentration on the accuracy of how we determine the applicant's disability onset date. We intend to use the results of these focused reviews to identify systemic issues; recommend training, policy, and systems enhancements; and provide direct feedback to employees regarding their compliance with existing policy. This process provides us with yet another opportunity for identifying unusual patterns or inconsistent information provided during the application process.

While the primary purpose of quality reviews is to ensure a high level of decisional accuracy, they can also detect potential fraud. For example, the Division of Quality (DQ) selects a random sample of unappealed hearing decisions for possible own-motion review by our Appeals Council. These reviews address concerns in particular claims and support our ability to ensure consistent, legally sufficient, and policy-compliant decision making throughout the disability adjudication process. At the same time, the DQ's work uncovered anomalies in the Huntington, West Virginia hearing office, and we conveyed that information to OIG.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

Civil Monetary Penalties

A person who engages in fraudulent activity may be subject to a civil monetary penalty (CMP). Under section 1129 of the Social Security Act (Act), we may impose CMPs against individuals who make certain material false statements or omissions to receive initial or continuing benefits under the Act. Section 1129 gives us the authority to impose a CMP against those who:

- make false statements or representations in connection with obtaining or retaining benefits or payments under Social Security;
- wrongfully convert Social Security payments made; or
- knowingly withhold a material fact from SSA.

The responsibility for the CMP program is delegated to OIG. The Act allows us (and by extension, OIG) to impose penalties (after consultation with the Department of Justice) of up to $5,000 for each false statement, representation, conversion, or omission. A person may also be subject to an assessment, in lieu of damages, of up to twice the amount of any resulting overpayment.

After a comprehensive evaluation of the program by OIG in 2011, several changes were instituted to make the program more efficient and effective. As a result, OIG has imposed more CMPs in the past 28 months than in the previous 15 years combined. In FY 2012, OIG tripled the amount from the previous year, and last year it successfully resolved over 300 cases, imposing CMPs exceeding $15 million. We believe this streamlined program deters potential fraudsters.

Administrative Sanctions

Our employees can impose administrative sanctions on individuals who give false or misleading information or who fail to report material information. A sanction bars an individual from receiving benefits for 6 months for the first offense, 12 months for the second, and 24 months for the third. Last September, we strengthened our administrative sanctions process, in collaboration with OIG. We implemented a new, streamlined process for imposing administrative sanctions that will facilitate national consistency and focus agency resources on the most egregious cases that OIG is unable to pursue for a fraud conviction or CMP.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

IV. Policy/Procedural Changes Made Because of Recent Fraud Cases

As discussed earlier, the best available evidence indicates that we have a low level of fraud. We strive to have no cases of fraud. However, bad people will commit bad acts. When we become aware of fraud, we take steps to address it and prevent it from happening again. This report next describes recent changes that we have made.

Puerto Rico

Initial Response

We responded aggressively to allegations of fraud in the Commonwealth of Puerto Rico, beginning with reporting the possible fraud to OIG in 2009.[17] Following the arrests in Puerto Rico on August 21, 2013, we instituted a number of organizational and procedural changes to improve our ability to detect fraudulent activity and to recover fraudulently obtained benefits.

We immediately suspended benefits to the indicted beneficiaries and initiated reviews (redeterminations) of thousands of other beneficiaries whose cases included tainted information from the indicted medical providers. Immediately after the arrests, we added additional staff to the Federal Northeastern Program Center Disability Processing Branch (NEPSC DPB) and the New Jersey DDS to conduct these reviews. During these reviews, our staff disregards medical evidence in the case record received from an indicted or discredited source. If the remaining evidence does not support the original allowance, we provide the beneficiary the opportunity to submit additional medical evidence before making a final determination regarding whether to terminate benefits. Over the past few months, our staff has been reviewing approximately 7,400 cases in which the indicted doctors supplied medical evidence. We are monitoring these cases to ensure accurate and consistent processing.[18]

[17] For details, see Appendix B, Statement of New York Regional Commissioner Bea Disman before the House Committee on Ways and Means, Social Security Subcommittee, Sept. 19, 2013 (also at www.ssa.gov/legislation/testimony_091913.html).

[18] Under sections 205(u) and 1631(e)(7)(A)(i) of the Act, we must redetermine an individual's entitlement or eligibility to benefits if there is reason to believe that fraud or similar fault was involved in that person's application for benefits. In conducting these redeterminations, we review the case record and disregard any evidence if there is reason to believe that fraud or similar fault was involved in providing that evidence. If the remaining evidence does not support the original allowance, we provide the beneficiary the opportunity to submit additional medical evidence before making a final determination. Beneficiaries will receive notification and appeal rights if we ultimately terminate their benefits and assess an overpayment.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

Organizational Changes

Since the initial 2009 report of fraud in Puerto Rico, SSA has increased the resources committed to fraud prevention. These efforts include the establishment of new units, including a Disability Processing Unit and a CDI unit in Puerto Rico. In addition, SSA significantly expanded the NEPSC DPB, located in Jamaica, New York. Finally, in February 2014, SSA's OGC provided a staff attorney to the United States Attorney's Office in Puerto Rico to assist in the criminal prosecutions.

Investigative Support

We also have provided ongoing investigative support to OIG since the initial fraud referral in 2009. This support has included a continuous flow of new fraud referrals. We have provided funding and staff for the recently established CDI unit and for new fraud referral hotlines. We have processed hundreds of case reviews and provided analysis regarding suspicious claims, medical sources, and facilitators. In addition, we have provided information and data analysis regarding thousands of claims involving suspect medical sources and facilitators and coordinated the grand jury appearances by SSA and DDS personnel.

Training, Quality Initiatives, and Oversight

In response to the alleged fraud in Puerto Rico, we conducted training sessions focused on combatting fraud and provided reminder instructions to front-line staff.

Between 2011 and 2013, we completed several studies to assess the overall accuracy of our disability determinations in Puerto Rico. We found that accuracy was consistent with national figures, but this initiative provided another opportunity to identify potentially fraudulent activity. These studies also resulted in a number of new fraud referrals to OIG.

Changes Following Recent Indictments in New York

Due to the nature of this active criminal investigation, we cannot provide details at this time. We are working with OIG and law enforcement officials, and will continue to cooperate with the criminal investigation to ensure that all responsible individuals are brought to justice. However, as we are permitted, we are willing to privately brief the Committee in more detail if requested.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

Huntington, West Virginia Hearing Office

There has also been some Member interest relating to a former situation in our Huntington, West Virginia hearing office. Given the nature of certain ongoing investigations, we are limited in sharing information about the investigation in this report.[19] As we are permitted, we are willing to privately brief the Committee in more detail if requested.

We would emphasize, however, that we have taken significant actions to strengthen our hearings process. Over the last three years, we have implemented procedural changes, implemented new controls, implemented electronic system changes, implemented new management practices, improved data collection, and improved data analysis. While these improvements are paying off, we remain vigilant and continue to review national data for trends and fact patterns that suggest policy non-compliance or potential fraud. Appendix E provides more information about these activities.

V. Planned Improvements in Fraud Prevention Efforts

While there is a low level of fraud in the program, no amount of fraud is acceptable. We must continue to find new ways to detect, deter, and prevent fraud while we expand existing efforts with demonstrated impact. Below are actions we are undertaking.

Increase CDRs

As mentioned previously, CDRs are not designed to detect fraud. Rather, they determine whether an individual remains disabled or whether his or her entitlement to benefits should be terminated. However, in some cases, during the CDR process, information comes to light that might indicate fraud or other suspicious activities, and we investigate those cases. We estimate that the money spent on CDRs saves on average $9 for every dollar invested, including savings accrued to Medicare and Medicaid. As we have received additional program integrity funding provided from Congress for FY 2014, we will be able to complete substantially more CDRs this year and set the stage for handling even more next year.

Expand the CDI Program

With our current resources, we plan to expand the number of CDI units from 25 to 32 by the end of FY 2015. We also will expand the capacity of existing CDI units to investigate allegations of disability fraud by increasing the number of law enforcement investigators in a number of current units, including Puerto Rico and New York. Earlier, we outlined the role these units play in combatting fraud. Increasing the number of units and expanding existing units will significantly enhance our ability to prevent and detect disability fraud.

[19] For a general discussion of SSA's improvements in its hearing process, and our specific actions resulting from the Huntington, West Virginia investigation, see Appendix D, Statement of SSA Chief Administrative Law Judge Debra Bice before the Senate Committee on Homeland Security and Government Affairs Committee, Oct. 7, 2013 (also available at http://ssa.gov/legislation/testimony_100713.html).

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

Establish Specialized Fraud Units

As demonstrated by our strong support of the Puerto Rico and New York investigations and by our involvement in the CDI program, we are eager to help OIG in the fight against fraud. Along these lines, we will centralize our review of cases identified as potentially involving fraud, especially those cases involving facilitators. Specifically, we will dedicate staff to establish specialized fraud units. Highly qualified trained disability examiners, support staff, and, as needed, medical consultants (particularly in the area of psychiatric specialties) will comprise these units. The units will review *all* potential fraud cases from anywhere in the country.

We are establishing the first fraud unit in the New York region. By handling the redeterminations discussed previously, the New York region has developed expertise in identifying potential fraud and detecting possible fraud trends; we expect to bring that expertise to bear when reviewing future cases. The unit is being staffed with 20 examiners and necessary support positions.

This initiative will build on the success we experienced in establishing specialized units to combat possible fraud relating to our online portal, *my* Social Security. The *my* Social Security Fraud Analysis and Coordination Team (FACT) unit has been in operation since September 23, 2013. This new unit receives fraud allegations and compiles, analyzes, reports, and detects patterns and commonalities. The FACT team also works with regional staffs, recommends policy changes, and responds to inquiries regarding *my* Social Security fraud issues.

Data Analytics

Continuing to help OIG successfully combat fraud not only requires us to work harder, but also requires us to use new analytics tools. Toward that end, we are undertaking a special initiative to expand our use of data analytics to enhance our ability to detect and prevent disability fraud. Specifically, we will apply analytics tools that can determine common characteristics and patterns of fraud based on data from past allegations and known cases of fraud. We will apply these tools when reviewing initial applications or existing data on beneficiaries for potential fraud or other suspicious behavior. With these tools, we expect to be able to identify suspicious patterns of activity in disability claims and prevent fraudulent applications from being processed. During this fiscal year, we plan to pilot these analytic tools and demonstrate their value. For an indication of what data analytics can accomplish for disability adjudication purposes, please see the article titled “Leaning In: Government’s Push to Leverage Big Data” in Appendix F.

We have invited OIG to participate in this initiative, as it possesses valuable information on actual fraud cases that will inform our development of analytics software. We will keep you apprised of our progress as we develop and pilot potential tools and applications.

We are collaborating with the Department of the Treasury on using our benefit payment files to identify fraudulent activities and to explore opportunities to apply predictive analytics.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

Finally, we are developing a national common disability case processing system to replace the 54 separate systems currently in the DDSs. The common system will provide access to data and information to improve our national oversight abilities and will serve as a platform for data analytics to identify potential fraud or misuse. The common case processing system will utilize a National Vendor File. The National Vendor File will serve as a unified national medical provider database that will supply uniform information to our users across the country. We will use this information to provide consistent national oversight, resulting in enhanced capability to oversee our broad medical resources.

The National Anti-Fraud Committee

For many years, our regional offices have successfully collaborated with regional OIG agents and local law enforcement on regional anti-fraud committees. We are reinstituting the National Anti-Fraud Committee, which will be co-chaired by the Inspector General and our Deputy Commissioner for Budget, Finance, Quality, and Management. The National Anti-Fraud Committee leads and supports national and regional strategies to combat fraud, waste, and abuse. This Committee also provides an open forum for senior executives to collaborate on fraud challenges and opportunities at a strategic level.

Expand SSA's Fraud Prosecution Project

Given the success of our Fraud Prosecution Project, our OGC plans to hire 12 additional attorneys to serve as Special Assistant United States Attorneys dedicated to prosecuting Social Security fraud and other cases, thereby doubling our support for prosecuting fraud.

Submission of Evidence

In the past, there has been concern that claimants withhold medical evidence that could be unfavorable to their claims. Therefore, we propose to revise our regulations to require claimants to inform us about or submit all evidence (favorable *and* unfavorable) known to them that relates to their disability claim, subject generally to two exceptions for certain attorney-client privilege and attorney work product. This requirement would include the duty to submit all evidence obtained from any source in its entirety, unless the evidence is subject to one of these exceptions as defined in the rules. For example, if a claimant obtains his or her patient file from a health care provider, we would require the claimant to submit *all* of the medical records in that file. We also propose to require a representative to help the claimant obtain the information or evidence that the claimant must submit, and we would extend the protections afforded by attorney-client privilege and attorney work product to non-attorney representatives as well. These modifications would result in expanded case records, which would allow us to make more accurate disability determinations. The Office of Management and Budget completed its review of our proposed rules on February 6, and we expect to publish a notice of proposed rulemaking shortly.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

Current Research Efforts on Disability Adjudication Issues

We continually look for ways to ensure benefits are received only by people who meet our eligibility rules. We have undertaken the following research efforts to determine whether we could increase the objectivity of our individualized evaluation process. We believe these efforts may also help us prevent fraud. Two of our research efforts concern symptom evaluation and psychological testing.

Symptom Evaluation. We have asked the Administrative Conference of the United States (ACUS) to review the Act, current regulations, and our sub-regulatory policy regarding how decision makers at all levels evaluate claimants' symptoms in disability claims. ACUS will also review a sample of related Federal case law, conduct additional research concerning symptom evaluation in other formats, review international perspectives, and gather stakeholder perspectives on our current standards for evaluating disability claimants' symptoms.

Psychological Testing. We have asked the Institute of Medicine (IOM) to perform a comprehensive review of psychological testing, including symptom validity testing. IOM will examine the relevance of psychological testing to disability determinations in claims involving physical or mental disorders. IOM will also provide us guidance that we can use to help adjudicators interpret the results of psychological testing.

Representative Payee Criminal Bar Policy

When beneficiaries are unable to manage their own benefits due to their age, legal incompetence, or incapability, we appoint representative payees to receive and manage benefits on their behalf. We seek only qualified individuals and organizations to serve as representative payees, and we take steps to ensure continued qualification and proper use of the benefits.

Recently, we have been piloting a policy change that we believe will help us identify representative payee applicants who have committed certain serious crimes and bar them from serving as representative payees. Felony convictions for any of 12 crimes will bar the individuals from serving as a representative payee. [20]

Offices in our Philadelphia Region (Pennsylvania, Maryland, Delaware, Virginia, West Virginia, and the District of Columbia) began piloting this policy in June 2012. In June 2013, we introduced an electronic tool for use in the pilot to help identify representative payee applicants who have been convicted of any of the 12 crimes. Based on the results of the pilot, we expect to implement the criminal bar policy nationally by the end of February 2014.

[20] The twelve crimes are human trafficking, false imprisonment, kidnapping, rape or other sexual offense requiring registration as a sex offender, first degree murder, robbery, fraud to obtain governmental assistance, fraud by scheme, theft of government funds or property, abuse, neglect, forgery, or identity theft. 78 Fed. Reg. 9766 (2013).

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

VI. Recommendations for Congress

As noted at the hearing, Congress can play a critical role in our efforts to combat fraud. Below are some areas of consideration for Congress.

Increase CDI Units

As mentioned earlier, we are increasing the number of CDI units from 25 to 32 as a result of the funding level provided in the FY 2014 budget. With sustained, adequate funding, we will be able to continue to increase the number of units in future years.

Increase CDR funding

The *Consolidated Appropriations Act, 2014*, which the President signed on January 17, provides us with $11.697 billion for our Limitation on Administrative Expenses account, including $1.197 billion for program integrity work. Currently, we have a backlog of 1.3 million CDRs due to budgetary shortfalls. The $1.197 billion for program integrity is the same level authorized by the Budget Control Act (BCA). This funding will give us the ability to complete more CDRs, allowing us to save billions of taxpayer dollars and increase our chances of detecting possible fraud, and sets the stage for us to complete even more CDRs in FY 2015. Moreover, as mentioned before, we estimate that the money spent on CDRs saves on average $9 for every dollar invested, including savings accrued to Medicare and Medicaid. We will need sustained and adequate funding to clear the CDR backlog.

The FY 2014 President's Budget included a special legislative proposal that would provide a dependable source of mandatory funding to significantly ramp up our program integrity work. These mandatory funds would replace the discretionary cap adjustments authorized by the BCA. These funds would be reflected in a new account, the Program Integrity Administrative Expenses account, which would be separate, and in addition to, our Limitation on Administrative Expenses account. The funds would have been available for two years, providing us with the flexibility to aggressively hire and train staff to support the processing of more program integrity work.

Provide Adequate, Sustained Funding

If we are to succeed in our mission to serve our current beneficiaries and be excellent stewards of the programs, we need sustained, predictable funding that will allow us to hire and train highly qualified employees, having lost nearly 11,000 employees from FY 2011 through FY 2013. Sufficient funding also will allow us to make the right investments in technology to help us to be as efficient as possible, saving time for both the agency and public. While the *Consolidated Appropriations Act, 2014*, may allow us to replace some of the staffing losses we incurred over the last three years, we need your support in FY 2015 and beyond to ensure we have adequate staffing for our programs, including our anti-fraud and program integrity efforts.

Our employees are our best asset when it comes to serving the public and our first line of defense against fraud. They have responded heroically to serve every person who comes through our

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

front door or calls us—even as dwindling resources mean we have far fewer employees available to serve the public or to be on the lookout for suspicious activity.

Adequate funding also enables us to invest in tools and technology, which are vital for delivering quality service and supporting our stewardship activities. Technology benefits our customers by providing more options to do business with us over the Internet. We must build upon the success of our online tools, such as *my* Social Security, which provides Internet users a secure way to do business with us. As we perfect these self-service options, we can add more business functions to them. Adding these functions frees our employees to focus on complex work, such as program integrity work.

Support Electronic Death Reporting

The Act requires us to collect death information to ensure that we stop paying benefits following a beneficiary's death (and that we start appropriate survivors' benefits). Often, however, the death reports we receive are not as accurate as we require. We believe the most cost-effective way to ensure the greatest possible accuracy in the death reporting process would be to fully implement Electronic Death Reporting (EDR). EDR is a web-based data exchange application designed to allow a State's Bureau of Vital Statistics to verify a decedent's Social Security number (SSN) using the Internet prior to submitting reports of death. Through EDR, the reporting entity verifies the name and SSN of the deceased individual before sending the death information to us, ensuring that the death report is associated with the correct record. EDR results in more timely and accurate death reports.

We understand that the Department of Health and Human Services, through the Center for Disease Control (CDC), has responsibility for funding the States to assist in establishing EDR. Within CDC, the National Center for Health Statistics (NCHS) is responsible for collecting and disseminating national vital statistics. The President's FY 2014 budget request includes an increase for NCHS, a portion of which is to begin an effort to phase in full implementation of EDR in all States and other vital records jurisdictions. Although over half the States participate in EDR, implementation varies—some jurisdictions have no system, while others have a system with complete coverage. Therefore, we understand that the cost of full implementation in all jurisdictions is difficult to assess.

Support the OIG's Investigative Functions

As explained earlier, it is ultimately OIG's job to investigate fraud. Therefore, it is crucial to ensure OIG receives adequate funding. Given its expertise, and given its statutory role of leading and coordinating the prevention and detection of fraud, we also believe OIG should be included in any conversation regarding legislative solutions. Over the years, OIG has developed a number of legislative proposals relating to fraud prevention and other stewardship activities.

Below is a sample of the Inspector General's statements regarding these proposals. However, in listing these statements, we are not implying support for the legislation or policy.

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

- "[O]ur ability to detect schemes like the New York and Puerto Rico conspiracies is hampered by the ongoing lack of an exemption from the outdated requirements of the *Computer Matching and Privacy Protection Act* (CMPPA) and the *Paperwork Reduction Act*. While legislation granting an exemption has been introduced in the last several sessions of Congress, none has passed—although the OIG for the Department of Health and Human Services (HHS) has obtained its own CMPPA exemption. … If, for example, we were to try to extend what we learned in this case to other public-sector pension programs across the country, we would be stopped cold by the requirements of the CMPPA, which would either delay the project while we attempted to execute dozens of matching agreements; or would fail if the agreement could not be obtained."[21]

- "[T]he *Paperwork Reduction Act* makes it virtually impossible for us to conduct certain audits in a timely and effective fashion. Unable to ask a group of beneficiaries multiple questions without clearing time-consuming bureaucratic hurdles, we are often forced to abandon audits that could result in millions of dollars in savings."[22]

- "[T]he OIG's Civil Monetary Penalty program provides a valuable means of punishment, deterrence, and recovery of lost funds. Unfortunately, the penalty amount—$5,000—has not increased in the nearly two decades since the legislation creating these penalties was enacted. While other civil monetary penalties are tied to consumer indexes to take inflation into account, ours have remained stagnant. We would suggest that the time has come to tie these penalties to inflation indexes, and to consider higher penalties for third-party fraud facilitators such as doctors and lawyers than for beneficiaries." [23]

- "Finally, my office continues to pursue the establishment of a self-supporting program integrity fund for the integrity activities I've discussed here, including CDRs, redeterminations, and CDI investigations. An existing legislative proposal would provide for indefinite appropriations to make available to SSA 25 percent, and to OIG 5 percent, of actual overpayments collected. These funds would be available until spent for stewardship activities. Given the substantial return on investment of these activities, we believe this would be a highly effective use of limited resources."[24]

We also stand ready to provide technical assistance on any legislative proposals offered by Members and work with this Committee on fraud issues.

[21] Statement of Inspector General Patrick O'Carroll before the House Committee on Ways and Means, Social Security Subcommittee, Jan. 16, 2014, available at http://oig.ssa.gov/newsroom/congressional-testimony/jan16 (last visited on Feb. 14, 2014).
[22] *Id.*
[23] *Id.*
[24] Statement of Inspector General Patrick O'Carroll before the House Committee on Ways and Means, Social Security Subcommittee, Nov. 19, 2013, available at http://oig.ssa.gov/newsroom/congressional-testimony/nov19 (last visited on Feb. 14, 2014).

Follow-up Report on Anti-Fraud Efforts
Requested at the January 16, 2014 Hearing
On Disability Fraud

Conclusion

We take fraud seriously. Although there is a low level of fraud in our disability programs, no amount of disability fraud is acceptable. Using tools such as training, continuing education, and field instructions, we have instilled a culture of zero tolerance for fraud in our agency. In fact, field office and DDS employees alerted OIG to possible fraud in Puerto Rico and New York.

We must continue to find ways to detect, deter, and prevent fraud. We are confident that our new initiatives, such as expanding the use of data analytics, will strengthen our fraud detection and prevention abilities and reinforce the public's confidence in the disability program.

SOCIAL SECURITY

April 3, 2006

The Honorable Charles E. Grassley
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to provide the information you requested in your September 4, 2003 letter. The enclosed report provides information from our review of the Social Security Administration's disability programs—including overpayment rates and an analysis of four specific diagnosis groups.

If you have any questions or would like to be briefed on this issue, please call me or have your staff contact H. Douglas Cunningham, Assistant Inspector General for Congressional and Intra-Governmental Liaison, at (202) 358-6319.

Sincerely,

Patrick P. O'Carroll, Jr.
Inspector General

Enclosure

cc:
Jo Anne B. Barnhart, Commissioner

CONGRESSIONAL RESPONSE REPORT

Overpayments in the Social Security Administration's Disability Programs

A-01-04-24065

April 2006

Mission

We improve SSA programs and operations and protect them against fraud, waste, and abuse by conducting independent and objective audits, evaluations, and investigations. We provide timely, useful, and reliable information and advice to Administration officials, the Congress, and the public.

Authority

The Inspector General Act created independent audit and investigative units, called the Office of Inspector General (OIG). The mission of the OIG, as spelled out in the Act, is to:

- **Conduct and supervise independent and objective audits and investigations relating to agency programs and operations.**
- **Promote economy, effectiveness, and efficiency within the agency.**
- **Prevent and detect fraud, waste, and abuse in agency programs and operations.**
- **Review and make recommendations regarding existing and proposed legislation and regulations relating to agency programs and operations.**
- **Keep the agency head and the Congress fully and currently informed of problems in agency programs and operations.**

To ensure objectivity, the IG Act empowers the IG with:

- **Independence to determine what reviews to perform.**
- **Access to all information necessary for the reviews.**
- **Authority to publish findings and recommendations based on the reviews.**

Vision

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

Executive Summary

OBJECTIVE

Our objective was to address Senator Charles Grassley's September 2003 request for (1) an audit to focus on producing an improper payment rate for the Social Security Administration's (SSA) disability programs and (2) an analysis of the improper payment prevalence in four diagnosis groups (mental disorders; musculoskeletal system diseases; endocrine, nutritional and metabolic diseases; and injuries).

BACKGROUND

We obtained a file of 11.1 million individuals who were receiving disability benefits as of October 2003. After removing records for individuals age 62 or over and those where their medical diagnosis codes were not in SSA's records, the population was reduced to 8.9 million beneficiaries—representing about 80 percent of the 11.1 million beneficiaries. From the population of 8.9 million beneficiaries, including all diagnosis groups, we selected a sample of 1,532 beneficiaries.

When SSA calculates payment accuracy rates, it follows Office of Management and Budget (OMB) guidance on what type of payments to include in the rates. The Senator requested a statistically valid improper payment rate for SSA's disability programs without following OMB guidance. As a result, our review of all aspects of eligibility—medical and non-medical—is not directly comparable to any business process SSA has in place. For this report, we developed overpayment rates on the basis that—for any medical or non-medical reason—the Agency assessed an overpayment, would have assessed an overpayment, or would not have issued a payment given perfect knowledge of all the facts.

RESULTS OF REVIEW

Our analysis of SSA data resulted in a four-pronged approach to respond to Senator Grassley's request. We (1) quantified overpayments; (2) developed overpayment rates; (3) analyzed payments in four diagnosis groups; and (4) quantified benefits to potentially ineligible beneficiaries—such as those no longer disabled because of medical improvement.

First, based on our sample, we estimated the amount of overpayments occurring between October 2003 and November 2005 as a result of conditions that existed as of October 2003 or earlier. Specifically, SSA

- detected, through its normal processes, overpayments totaling about $1.9 billion.
- had not yet detected overpayments totaling approximately $3.2 billion.

Secondly, we developed overpayment rates. To calculate a statistically valid overpayment rate, the total amount of overpayments made in a given year should be

compared to the total payments issued during that same year. However, overpayments made in a given year—such as Fiscal Year (FY) 2004—may not be identified by SSA until FY 2005 or beyond. Because of this large span of time, the complexity of SSA's programs, limited available data, and SSA's reliance on others to report changes that impact eligibility, we developed several rates. Our analysis indicates that the overpayment rate is about 3.2 percent of payments. However, the precise rate may fall between 3.2 and 3.6 percent.

Although we believe the overpayment rate is between 3.2 and 3.6 percent of benefits paid, the rate could be as high as 5.2 percent. This higher rate represents the percentage of benefits the Agency would not have paid if it had perfect knowledge of all conditions affecting eligibility at the time the payments were issued. (See Appendix F, Tables F-18, F-19, and F-20 for a full description of the rates.)

Thirdly, where SSA did not already have information indicating possible payment issues, we conducted further analysis. We found that 55 percent of the overpayments and payments issued to ineligible beneficiaries were in the four diagnosis groups. Similarly, in SSA's general disability population, 54 percent of beneficiaries were in these same four diagnosis groups.

Lastly, we estimated about $2.1 billion in benefits were paid to potentially ineligible beneficiaries. This estimate of annual payments to ineligible beneficiaries was based on our sample cases where SSA stopped benefits during our review due to continuing disability reviews (CDR), income, prison/fugitive status, failure to cooperate, inability to locate, etc. Medical improvement was one of the main reasons beneficiaries became ineligible in our sample. According to the Agency's most recent annual CDR report to Congress, savings-to-cost ratios for the 8 FYs 1996 through 2003 averaged about $10.2 to $1.

At our request, SSA initiated medical CDRs for 105 beneficiaries in our sample, and 12 cases (or 11 percent) had benefits stopped because they were no longer disabled. Although these CDRs may have been conducted at some future date, the savings realized by immediately discontinuing payments to individuals who were no longer disabled would not have occurred had we not requested these CDRs. Therefore, SSA would have continued to pay these individuals until such time that a CDR showing medical improvement was completed.

CONCLUSION

Although our review of medical and non-medical factors could not provide a perfectly developed statistically valid overpayment rate, we believe the results of our analysis provide a point-of-time estimate of the amount of overpayments and payments SSA should not have made to ineligible disability beneficiaries. Further, it provides Congress, SSA and other decision-makers valuable information for making policy decisions—such as whether to provide additional resources for activities related to preventing overpayments and stopping benefit payments to individuals who are no longer eligible for them.

Table of Contents

Introduction

OBJECTIVE

Our objective was to address Senator Charles Grassley's September 2003 request for (1) an audit to focus on producing an improper payment rate for the Social Security Administration's (SSA) disability programs and (2) an analysis of the improper payment prevalence in four diagnosis groups.[1]

BACKGROUND

When SSA measures payment accuracy for the Old-Age, Survivors and Disability Insurance and Supplemental Security Income (SSI) programs, the Agency does not count some payment errors that result from limitations in the Agency's computer systems and/or limitations placed on SSA by law.[2] The Office of Management and Budget (OMB) provided SSA with specific guidance not to include certain items in its improper payment estimates. In addition, SSA does not include payment errors based on medical factors of eligibility when calculating payment accuracy.[3] (See Appendices B and C for additional information.)

Senator Grassley requested a statistically valid improper payment rate for SSA's Disability Insurance (DI) program and a separate improper payment rate for the Agency's SSI program, without following OMB guidance. As a result, our review of all aspects of eligibility—medical and non-medical—for the sampled beneficiaries is not directly comparable to any business process SSA has in place. Furthermore, while SSA makes an initial eligibility decision based on all medical and non-medical factors when an individual is first placed on the disability rolls, there is no post-entitlement review that incorporates both aspects simultaneously. Likewise, there is no SSA quality review incorporating both medical and non-medical factors. (See Appendix D for the Senator's full request, Appendix E for the interim response we provided him on October 15, 2003, and Appendix F for additional information on the scope, sampling methodology and results of our review.)

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[1] Senator Grassley also requested information on SSA's Cooperative Disability Investigations programs. We provided this to him on October 15, 2003 (see Appendix E).

[2] Under *The Improper Payments Information Act of 2002* (Pub. L. No. 107-300, 31 U.S.C. § 3321), Federal agencies—including SSA—must report annually on the extent of improper payments in its programs that are susceptible to significant improper payments. The Government Accountability Office (GAO) defines improper payments as payments that should not have been made or that were made for incorrect amounts. (GAO, *Strategies To Manage Improper Payments, Learning From Public and Private Sector Organizations* (GAO-02-69G), p. 1, October 2001.) The *President's Management Agenda* also includes an initiative to reduce erroneous payments in the Federal Government.

[3] SSA, *Performance Plan for FY 2006*, pp. 25-27, February 2005.

We obtained a file of the 11.1 million individuals who were receiving disability benefits as of October 2003. After removing records for individuals age 62 or over[4] and those whose medical diagnosis codes were not in SSA's records, the population was reduced to 8.9 million beneficiaries (or about 80 percent of all 11.1 million disabled beneficiaries).[5] From the population of 8.9 million records, which included all diagnosis groups, we selected a sample of 1,532 beneficiaries.

We established our sample based on the beneficiaries' disabilities to be able to analyze four specific diagnosis groups—and not the type of payment (DI or SSI), and we were unable to report on each program separately. Therefore, although Senator Grassley requested separate improper payment rates for the DI and SSI programs, we calculated rates for both programs combined. Additionally, we developed overpayment rates on the basis that—for any medical or non-medical reason—the Agency assessed an overpayment, would have assessed an overpayment, or would not have issued a payment given perfect knowledge of all the facts. (See Tables F-18, F-19, and F-20 in Appendix F for a full description of these rates.)

Included in Senator Grassley's September 4, 2003 letter to SSA's Inspector General was a request to conduct further analysis of the improper payment prevalence in the diagnosis groups below:

1. Mental disorders other than mental retardation;
2. Diseases of the musculoskeletal system;
3. Endocrine, nutritional, and metabolic diseases; and
4. Injuries.

SSA's definition of disability requires that an individual's inability to work must be related to a medically determinable physical or mental impairment(s).[6] Every physical or mental impairment is categorized into 1 of the 16 body systems listed below:[7]

1. Musculoskeletal System
2. Special Senses and Speech (vision and hearing)
3. Respiratory System
4. Cardiovascular System
5. Digestive System

[4] An individual can start to receive Social Security retirement benefits as early as age 62—SSA, Program Operations Manual System (POMS), RS 00201.001 A.

[5] We obtained a new file of all beneficiaries in current payment status on SSA's records as of June 2005 and compared this information to our data from October 2003. This new file included almost 1.9 million beneficiaries who were in current payment status in June 2005 but were not in current payment status on SSA's records in October 2003.

[6] Social Security Act § 216(i)(1), 42 U.S.C. § 416(i)(1).

[7] SSA, POMS, DI 26510.015 F. The 4 diagnosis groups are subsets of the 16 body systems.

6. Genito-Urinary System
7. Hematological (blood) Disorders
8. Skin Disorders
9. Endocrine System (Diabetes)
10. Multiple Body Systems (Down Syndrome)
11. Neurological
12. Mental Disorders
13. Malignant Neoplastic Diseases (Cancer)
14. Immune System
15. Growth Impairment (for children)
16. Special/Other

SSA has undertaken a number of key initiatives to identify and prevent overpayments—including reviews of continuing DI and SSI eligibility and data matches to detect income, deaths, prisoners, fugitives, and other issues that impact eligibility. In addition, SSA has made significant efforts over the past several years to increase the recovery of overpayments.

The continuing disability review (CDR) process is the primary method by which SSA identifies beneficiaries who are no longer eligible to receive disability benefits. A CDR includes confirming that the beneficiary is alive, investigating any indications of work activity, and determining whether a person's impairment has significantly improved since the most recent favorable determination. According to the Agency's annual CDR report to Congress (issued in October 2005), savings-to-cost ratios for the 8 Fiscal Years (FY) 1996 through 2003 averaged about $10.2 to $1.

In the course of our review, we asked for assistance from SSA in conducting medical CDRs, investigating income and work activity, locating beneficiaries and reviewing non-medical eligibility requirements. For the purpose of this review, we did not consider a beneficiary as having a payment issue unless SSA took action to assess an overpayment or stop benefits because of our review. The payments to ineligible beneficiaries are the amounts that would have been paid to the beneficiaries if SSA had not stopped paying benefits to individuals who were no longer eligible to receive them—beginning with the first month of non-payment. Our calculation for payments to ineligible beneficiaries is based on the amount of the last monthly payment issued multiplied by 12 months.

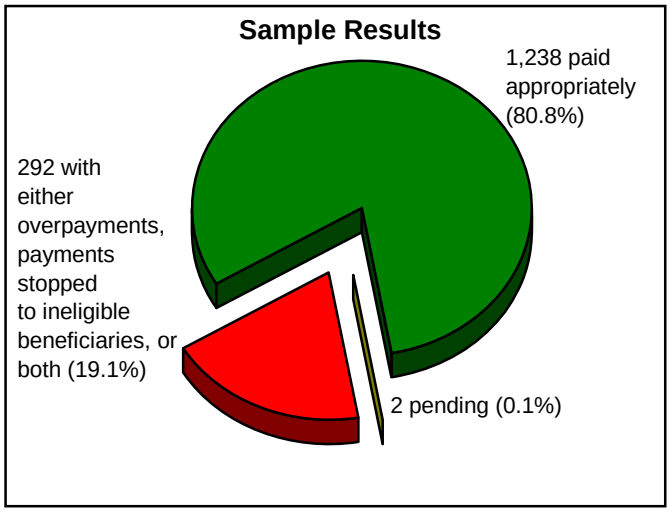
Results of Review

Our analysis of SSA data resulted in a four-pronged approach to respond to Senator Grassley's request. We (1) quantified overpayments; (2) developed overpayment rates; (3) analyzed payments in four diagnosis groups; and (4) quantified benefits to potentially ineligible beneficiaries—such as those no longer disabled because of medical improvement.

We estimate from our sample that SSA (a) detected, through its normal processes, overpayments totaling about $1.9 billion; and (b) had not yet detected overpayments totaling approximately $3.2 billion. Furthermore, we believe—based on certain assumptions and available data—that between 3.2 and 3.6 percent of disability benefits would ultimately result in payment issues that would require SSA to either stop benefits and/or assess overpayments.

Our review of 1,532 sample cases found that:

- 1,238 beneficiaries were paid appropriately.
- 292 beneficiaries were overpaid, had payments stopped because they were no longer eligible, or both totaling about $2.5 million.[8]
- 2 beneficiaries' cases were under review as of March 2006.[9]



OVERPAYMENTS

Based on our sample cases, we estimate $5.1 billion was overpaid in SSA's disability programs. These overpayments represent funds that should not have been paid over a span of time (from 1 month to several years). Specifically, we estimate that—between October 2003 and November 2005 for conditions that existed as of October 2003 or earlier—SSA

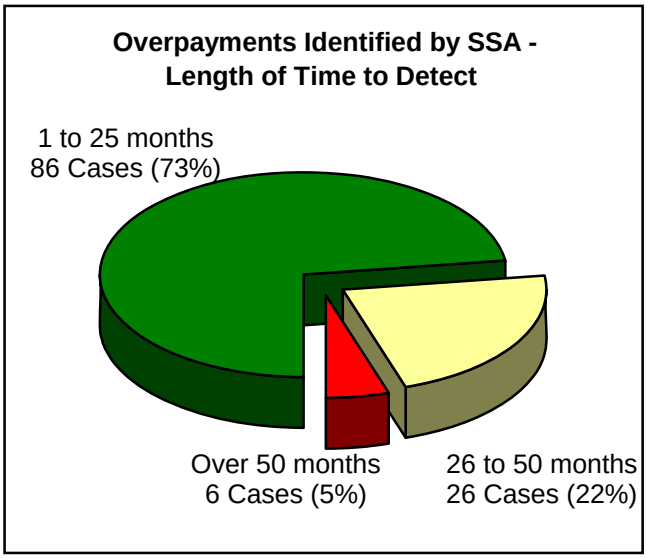
- detected overpayments for about 685,200 beneficiaries (from the population of 8.9 million beneficiaries) totaling approximately $1.9 billion through its normal business processes.

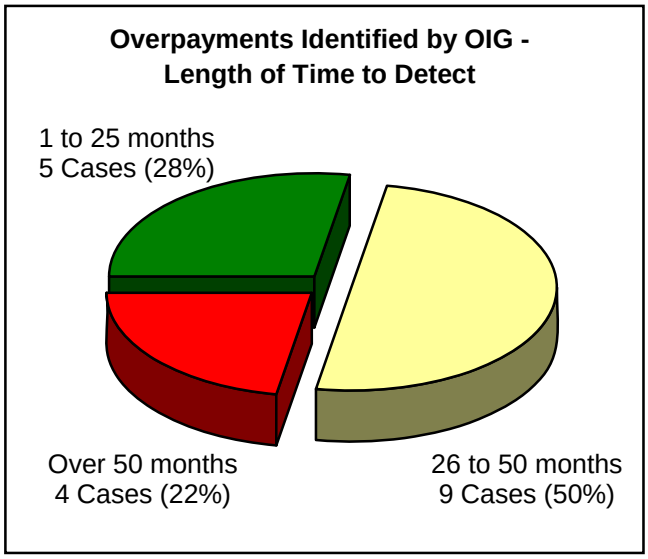
[8] Of the 292 beneficiaries, 92 had overpayments, 157 had payments stopped due to ineligibility, and 43 had both. (See Tables F-1, F-2, F-3, F-4 and F-5 in Appendix F for further analyses of the sample cases.)

[9] SSA is completing CDRs for these two cases.

- had not yet detected overpayments for about 104,500 beneficiaries totaling approximately $3.2 billion that existed at the time of our review.[10]

The overpayments (per beneficiary) identified by the OIG (and not SSA) tended to be much larger and spanned longer periods of time than the overpayments identified by SSA's normal processes. Additionally, the overpayments identified by the OIG tended to take longer to detect than the overpayments identified by SSA—as shown in the charts below and in Table F-2 in Appendix F.





Income or earnings from work activity was the most significant reason for overpayments in our sample.[11] This is consistent with two recent OIG reports—*Disabled Title II Beneficiaries with Earnings on the Master Earnings File* issued in July 2004 and *Disabled SSI Recipients with Earnings* issued in April 2005. Although SSA generally agreed with our recommendations to improve this area, resources needed to conduct work CDRs and develop income information for the volume of beneficiaries with earnings recorded on the Agency's Master Earnings File was cited as a barrier.[12]

[10] Since months or years may elapse before SSA identifies a benefit as having been overpaid, the Agency may eventually identify these overpayments. To be conservative in our estimate, we did not include the entire amount of a very large overpayment for one beneficiary that was identified based on the OIG's review. SSA assessed an overpayment of $133,316—substantially more than the next highest overpayment amount for this category. Therefore, in our estimates, we used $89,891—the amount of the next highest overpayment identified by the OIG's review. If we had included the $133,316, the estimate would have increased from $3.2 billion to $3.4 billion. Conversely, if we had excluded this one case altogether, the estimate would have decreased from $3.2 billion to $2.6 billion.

[11] See Appendix G for additional information on the overpayment reasons.

[12] In FY 2005, SSA implemented eWork—a new initiative to address disabled beneficiaries who work and may no longer be entitled to benefits.

Overpayments Identified due to OIG's Review

Of the 1,532 sample cases, 135 beneficiaries had overpayments—which included 18 that were identified as a result of OIG's review and subsequent request for SSA to take action between October 2003 and November 2005.[13] The overpayments for these 18 beneficiaries spanned different time periods—from 6 months to over 14 years.[14] Examples of cases with overpayments include:

- One beneficiary with a psychiatric disorder began receiving benefits in December 1986. She was overpaid more than $28,000 because she began working in 2001—after completing a "Certified Nurse Assistant" program—while continuing to receive disability benefits.
- One beneficiary and his dependents received more than $47,000 in benefits to which they were not entitled from May 2001 to October 2004. Although the beneficiary had a history of polio, he was working at a level which made him ineligible for benefits.[15]

Overpayments due to Fraud

As part of our review, we investigated all indications of potential fraud. For example, our investigators determined that one beneficiary in Massachusetts with a history of cancer had obtained multiple Social Security numbers and worked under one number while collecting disability benefits under a different number.[16] In March 2005, this beneficiary was arrested on the Federal charge of theft of Social Security disability benefits. Between October 1995 and August 2004, he received approximately $30,796 in disability benefits. A Federal grand jury returned an indictment charging the beneficiary with one count of theft of public money, property or records, in violation of Title 18 U.S.C. § 641. The beneficiary pleaded guilty to the charge, was sentenced in January 2006 to 3 years probation with the first 4 months in home confinement, and was ordered to pay $30,059 in restitution to SSA.

In July 2005, a beneficiary with osteoarthritis was sentenced to 4 months home detention and 3 years probation. The judge ordered him to repay over $17,000 in disability benefits that he received while concealing his work activity from SSA. In

[13] The remaining overpayment cases were identified by SSA's normal business processes.

[14] The 18 overpayments identified due to the OIG's review were avoidable within the Agency's guidelines. (See Appendix E for the OMB guidance on avoidable and unavoidable overpayments.) These 18 beneficiaries had overpayments assessed during our review due to events which occurred in October 2003 or earlier. In addition to these 18 beneficiaries, the OIG identified 13 beneficiaries who were overpaid after October 2003. If we included these overpayments in our estimate, the dollars overpaid would have increased.

[15] SSA defines disability, in part, as the inability to perform substantial work activity due to a physical or mental impairment. See 42 U.S.C. § 416(i)(1).

[16] We found similar cases in our review, *Individuals Receiving Benefits Under Multiple SSNs at the Same Address* (A-01-05-25002), April 2005.

addition, as of November 2005, the OIG was pursuing three other cases involving potential fraud for possible prosecution.[17] These beneficiaries have the following diagnoses: mental disorder, digestive problems, and chronic renal failure.

OVERPAYMENT RATES

To calculate a statistically valid overpayment rate, the total amount of overpayments made in a given year should be compared to the total payments issued during that same year. However, overpayments made in a given year—such as FY 2004—may not be identified by SSA until FY 2005 or beyond. Because of this large span of time, the complexity of SSA's programs, limited available data, and SSA's reliance on others to report changes that impact eligibility, we calculated three rates based on the available information. (See Tables F-18, F-19, and F-20 in Appendix F for additional details.)

- 3.2 percent is based on our sample cases and represents the amount of overpayments assessed for FY 2004 due to SSA's normal processes ($222,289) and OIG's review ($142,754)—which were detected during our review period of October 2003 and November 2005—and the amount of payments not issued to ineligible beneficiaries in FY 2004 as a result of our review ($59,432). This total was compared to the amount of benefits paid to our sampled beneficiaries in FY 2004 ($13.1 million).
- 3.6 percent is based on the amount of overpayments assessed by SSA for FY 2004 ($2.9 billion) plus the estimated overpayments for FY 2004 that were not detected by the Agency ($0.8 billion)[18] and the estimated payments issued to ineligible beneficiaries in FY 2004 as a result of our review ($0.3 billion). These amounts were compared to the total DI and SSI payments made in FY 2004 ($110.4 billion).

Although we believe the overpayment rate is between 3.2 and 3.6 percent of benefits, the rate could be as high as 5.2 percent. This rate represents the percentage of benefits the Agency would not have paid if it had perfect knowledge of all conditions affecting eligibility at the time the payments were issued. The rate was calculated with the amounts used to develop the 3.6 percent, replacing the $0.3 billion in estimated payments issued to ineligible beneficiaries in FY 2004 with the estimate of annual payments to ineligible beneficiaries ($2.0 billion)[19] based on our sample cases where SSA stopped benefits during our review due to medical CDRs, income, prison/fugitive status, failure to cooperate, inability to locate, etc. If SSA was able to identify all issues impacting benefits as soon as they occurred, the Agency would have likely stopped these benefits sooner.

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[17] These cases are included in the 292 cases with overpayments, payments stopped due to ineligibility, or both. However, the OIG is continuing to investigate the beneficiaries for possible fraud.

[18] These overpayments for FY 2004 would not have been recorded on SSA's financial statements because they were not identified until FY 2005.

[19] The $0.3 billion (used in the 3.6 percent rate) is part of the $2.0 billion used in developing the 5.2 percent rate.

FOUR DIAGNOSIS GROUPS

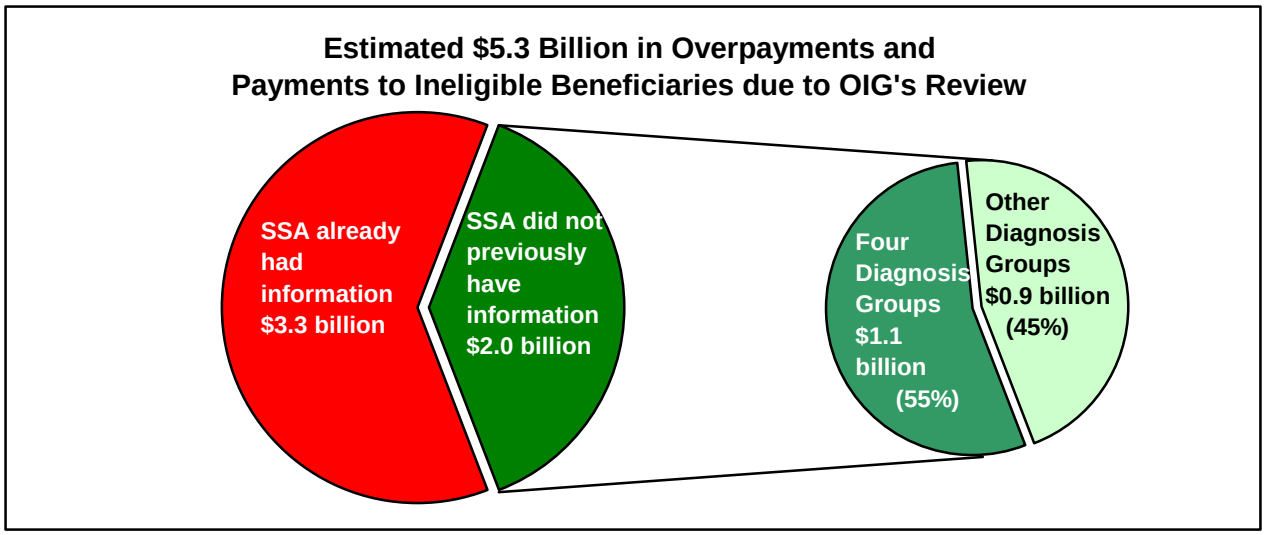
The estimated $3.2 billion in overpayments—and the estimated $2.1 billion in payments to ineligible beneficiaries (described later in the report)—for a total of $5.3 billion are based on the OIG's review of 1,532 sample cases and the development of information that SSA had not taken action on prior to our request to do so. Specifically, of the 292 sample cases (out of the 1,532) with overpayments, payments stopped to ineligible beneficiaries, or both, SSA identified the payment issues for 245 of the cases based on information it already had and developed in its normal business processes. However, SSA did not take action on 47 beneficiaries' cases to stop benefits or assess an overpayment until we requested the Agency's assistance during our review.

As previously noted, income was one of the top reasons for overpayments and payments to ineligible beneficiaries; and we found that SSA already had income/earnings information for 14 of the 47 cases recorded on its Master Earnings File—indicating that these beneficiaries might be working and may no longer be eligible for disability benefits. However, the Agency did not identify the overpayments and/or stop benefits prior to our review.

For the remaining 33 beneficiaries, SSA did not have information indicating possible overpayments or payments to ineligible beneficiaries prior to our review.[20] In these 33 cases, the OIG's interviews with beneficiaries and third parties, as well as other research of available information, indicated that these individuals might not be eligible for benefits. At our request, SSA completed a review of each case and concluded that these 33 individuals were not eligible for certain benefit payments.

The chart below shows that—for the estimated overpayments and payments to ineligible beneficiaries based on the 33 cases where the OIG developed information that SSA did not already have—55 percent of the funds were in the four diagnosis groups. Similarly, in SSA's general disability population, 54 percent of beneficiaries were in these same four diagnosis groups.

[20] This includes 4 cases with earnings due to work activity that had not yet been recorded on SSA's Master Earnings File.



PAYMENTS STOPPED TO INELIGIBLE BENEFICIARIES

We estimate that SSA prevented about $7.0 billion in payments from being issued to ineligible beneficiaries through its normal processes. However, we estimate that SSA did not prevent an additional $2.1 billion in payments from being issued to ineligible beneficiaries.[21] The Agency could have prevented the majority of these payments if it had been able to conduct more work or medical CDRs.

Although SSA informs beneficiaries to report to the Agency changes to their circumstances that could impact benefit payments (such as returning to work), beneficiaries often fail to do so. Therefore, months or years could elapse before SSA detects an issue that might impact benefits already paid.

When SSA stops paying benefits to individuals who are no longer eligible for them, the Agency achieves savings since it no longer has to pay those monthly benefits. From our sample of 1,532 beneficiaries, 200 became ineligible for benefits during our review. The top three reasons for individuals becoming ineligible for benefits were: (1) death, (2) income/work activity, and (3) medical improvement. (See Table G-2 in Appendix G for additional information on the reasons.)

SSA stopped paying benefits to 76 individuals in our sample because they died. SSA detected these deaths through its normal processes—indicating that SSA has controls to identify and prevent payments after death. However, SSA's efforts to prevent

[21] This estimate was calculated by multiplying the last payment received by 12. We believe 12 months is reasonable, since only 2 of the 44 beneficiaries used to develop the estimate had benefits suspended less than 12 months as of March 2006 and could potentially come back on the rolls and reduce the estimate. (The 2 cases had benefits suspended for 8 and 11 months, respectively.) Furthermore, if we had used the October 2003 benefit amount, our estimate of $2.1 billion would have decreased to $2.0 billion. This $2.0 billion was used in developing the 5.2 percent rate described in the prior section of this report.

overpayments due to beneficiaries' income exceeding the limits established for eligibility could be improved. Also, SSA's disability programs could be strengthened if more medical CDRs were conducted to determine whether a beneficiary's impairment has improved.

Benefits Stopped due to Medical CDRs

Upon our request, SSA initiated medical CDRs for 105 beneficiaries; and by November 2005, the Agency had completed 103 of them. Of the 103 completed medical CDRs, SSA determined that 12 (or 11 percent) were no longer eligible due to medical improvement and took action to stop the benefits.[22] We estimated savings associated with the 12 beneficiaries because the CDRs were conducted earlier than they would have been conducted through the Agency's normal business process.[23]

For example, one beneficiary with a diagnosis of affective disorders (a psychiatric impairment) started receiving disability benefits in 1997. OIG investigators observed activities that seemed inconsistent with the beneficiary's impairment; and therefore, we requested that SSA conduct a CDR. As a result of this CDR, SSA found that medical improvement had occurred and stopped the beneficiary's benefits—resulting in 12 months of savings of about $6,948. If SSA had not conducted the CDR at the time of our request, benefits would have continued to be paid to this individual.

Benefits Stopped due to OIG's Review

Of the 1,532 sample cases, 200 had payments stopped because the beneficiaries were no longer eligible. Of the 200 sample cases, 44 beneficiaries had payments stopped because of the OIG's review and subsequent request for SSA to take action.[24] As of November 2005, SSA terminated benefits for 35 of the 44 beneficiaries. To resume benefits in the future, these individuals will have to file new applications. For the remaining 9 beneficiaries, 1 had benefits suspended for only 6 months[25] and 8 had benefits suspended but not terminated. These benefits could be restarted if the

[22] We requested 105 medical CDRs and 103 had been completed by November 2005—with 2 pending. For 2 of the 12 cases in which benefits were ceased due to medical improvement, SSA had established medical review diary dates of October 2003 or earlier. However, SSA did not initiate a CDR until we requested it in FY 2004. (The medical review diary date is one of many factors used in SSA's CDR selection process to predict the probability of medical improvement.)

[23] Of the 12 beneficiaries no longer eligible due to medical improvement, one was appealing the Agency's decision to stop benefits as of March 2006.

[24] For the remaining cases, SSA prevented the payments to ineligible beneficiaries through its normal business processes. In addition to the 44 beneficiaries, 3 others had overpayments identified by the OIG but did not have their benefits stopped. Therefore, in the previous section on "Four Diagnosis Groups," we reported on all 47 cases.

[25] For this one beneficiary, benefits were suspended April through September 2005. Therefore, we counted only the 6 months as savings—not 12 months as for the remaining cases with payments stopped to ineligible beneficiaries.

beneficiaries take certain actions, such as cooperating with the Agency.[26] The following table shows the length of time the benefits for these 8 beneficiaries have been suspended.

Number of Months in Suspense—as of March 2006	Number of Cases with Benefits Suspended
12 or more months	6
11 months	1
8 months	1
Total Suspended Cases	**8**

[26] If these 8 beneficiaries began receiving benefits again in April 2006, we would only achieve savings from the month of suspension through March 2006 (as shown in the table). This would cause our overall payments to ineligible beneficiaries estimate of about $9.1 billion to decrease by approximately $14 million—as a result of 2 cases having payments stopped for less than 12 months. (See Table F-15 in Appendix F.)

Conclusion

Although our review of medical and non-medical factors could not provide a perfectly developed statistically valid overpayment rate, we calculated overpayment rates based on the available data. We estimated that between 3.2 and 3.6 percent of disability benefits would ultimately result in payment issues that would require SSA to either stop benefits and/or assess an overpayment.

Where SSA did not already have information, the OIG conducted further analysis and found that 55 percent of overpayments and payments to ineligible beneficiaries were in the four diagnosis groups. Similarly, in SSA's general disability population, 54 percent of beneficiaries were in these same four diagnosis groups.

Our review of all aspects of eligibility—medical and non-medical—provides a point-of-time estimate of the amount of overpayments and payments SSA should not have made to ineligible disability beneficiaries. Further, it provides Congress, SSA and other decision-makers valuable information for making policy decisions—such as whether to provide additional resources for activities related to preventing overpayments and stopping benefit payments to individuals who are no longer eligible for them. The OIG will continue to conduct audits and investigations related to SSA's disability programs in an effort to recommend cost-effective solutions for improvements in the disability area.

Appendices

Acronyms

CDI	Cooperative Disability Investigations
CDR	Continuing Disability Review
C.F.R.	Code of Federal Regulations
DDS	Disability Determination Services
DI	Disability Insurance
EDR	Electronic Death Registration
EVS	Enumeration Verification System
GAO	Government Accountability Office
FY	Fiscal Year
LDO	Legally Defined Overpayment
MIRS	Medical Improvement Review Standard
OASI	Old-Age and Survivors Insurance
OASDI	Old-Age, Survivors and Disability Insurance
OIG	Office of the Inspector General
OMB	Office of Management and Budget
POMS	Program Operations Manual System
Pub. L. No.	Public Law Number
SGA	Substantial Gainful Activity
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
U.S.C.	United States Code
VA	Department of Veterans Affairs

Background

In recent years, the President and Congress have expressed interest in measuring the universe of erroneous payments within the Government. In August 2001, the Office of Management and Budget (OMB) published *The President's Management Agenda, Fiscal Year (FY) 2002*, which includes a Governmentwide initiative for improving financial performance. Under this initiative, the Administration establishes a baseline of the extent of erroneous payments and requires agencies to include in their annual budget submissions information on erroneous payment rates. Using this information, OMB works with agencies to establish goals to reduce erroneous payments for each program.[1]

In October 2001, the Government Accountability Office (GAO) issued an executive guide on Strategies to Manage Improper Payments.[2] This guide defined overpayments as payments that should not have been made or that were made for incorrect amounts. Examples of overpayments include inadvertent errors, payments for unsupported or inadequately supported claims, payments for services not rendered, payments to ineligible beneficiaries, and payments resulting from fraud and abuse by program participants and/or Federal employees. GAO further stated that overpayments occur for many reasons, including insufficient oversight or monitoring, inadequate eligibility controls and automated system deficiencies. The risk of overpayments increases in programs with: (1) a significant volume of transactions, (2) complex criteria for computing payments, and/or (3) an emphasis on expediting payments.

In November 2002, Congress enacted *The Improper Payments Information Act of 2002*.[3] The Act instructs the head of each agency to: (1) annually review all programs and activities susceptible to significant overpayments, (2) estimate and report the annual amount of overpayments in those programs, and (3) report on actions being taken to reduce overpayments. OMB issued guidance on implementing the Act in May 2003.[4]

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[1] OMB, *The President's Management Agenda for Fiscal Year 2002*, p. 20, August 2001.

[2] GAO, *Strategies To Manage Improper Payments, Learning From Public and Private Sector Organizations* (GAO-02-69G), October 2001.

[3] Pub. L. No. 107-300, 31 U.S.C. § 3321.

[4] OMB, *Memorandum for Heads of Executive Departments and Agencies: Implementation Guidance for the Improper Payments Information Act of 2002, Pub. L. No. 107-300*, p. 1, May 2003.

DETECTING AND PREVENTING OVERPAYMENTS

The Social Security Administration (SSA) is responsible for issuing benefit payments under the Old-Age, Survivors and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs. In FY 2004, SSA issued almost $531 billion in benefit payments to about 53 million beneficiaries.[5] Considering the volume and amount of payments SSA makes each month, the complexity of computing eligibility and amount of payments, and SSA's emphasis on getting beneficiaries into pay status timely, the Agency is at risk of issuing significant overpayments. SSA has implemented controls to reduce overpayments. However, with the size of the OASDI and SSI programs, even the slightest error in the overall process can result in millions of dollars in overpayments.

The table below shows that SSA identified and assessed over $2 billion in new debt (i.e., overpayments) for each of the last 5 years for its Disability Insurance (DI) and SSI programs.

Fiscal Year	New Debt Detected by SSA[6] (in millions)			Total Benefits Paid for DI and SSI[7] (in millions)			Percentage of New Debt (in relation to benefits paid)
	DI	SSI	Total	DI	SSI	Total	
2001	$859	$1,951	**$2,810**	$59,207	$27,733	**$86,940**	**3.2%**
2002	$887	$2,050	**$2,937**	$66,964	$30,239	**$97,203**	**3.0%**
2003	$990	$1,936	**$2,926**	$69,800	$33,217	**$103,017**	**2.8%**
2004	$927	$1,979	**$2,906**	$75,169	$35,216	**$110,385**	**2.6%**
2005	$1,352	$2,050	**$3,402**	$89,731	$36,224	**$125,955**	**2.7%**

SSA has performance indicators to measure payment accuracy for the OASDI and SSI programs. For FY 2005, SSA estimated that 93.6 percent of SSI payments and 99.8 percent of OASDI payments were free of preventable overpayments.[8] However, these estimates do not count unavoidable errors that result from limitations in the Agency's computer systems and/or limitations placed on SSA by law. In addition, the reviews do not include errors based on medical factors of eligibility.[9]

SSA has undertaken many projects to identify and improve areas where the Agency could do more to reduce overpayments. Specifically, SSA has been working to improve

[5] SSA, *FY 2005 Performance and Accountability Report,* p. 8 and p. 193, November 2005.

[6] SSA, *Report on Receivables Due From the Public,* FY 2001 – FY 2005.

[7] SSA, *Performance and Accountability Report,* FY 2001 – FY 2005.

[8] SSA, *FY 2005 Performance and Accountability Report*, p. 63, November 2005.

[9] SSA, *Performance Plan for FY 2006*, pp. 25-27, February 2005.

its ability to prevent overpayments by obtaining beneficiary information from independent sources sooner and/or by using technology more effectively. In this regard, SSA has initiated new computer matching agreements and obtained on-line access to wage and income data.

SSA reports that several initiatives have helped to increase the detection and prevention of overpayments. For example, the June 2002 SSI Corrective Action Plan stated, "...SSI overpayment collections are 33 percent higher since FY 1998, and detections are 32 percent higher."[10] Additionally, SSA is focusing on initiatives that have proven potential in preventing overpayments, rather than merely detecting additional overpayments. For example, the Agency reported that in FY 2001, matching wage data from the Office of Child Support Enforcement prevented an estimated $183 million in overpayments; and matching prisoner data resulted in an estimated $424 million in payments to ineligible beneficiaries. Further, SSA reported that it increased the number of SSI redeterminations beginning in 2002 to ensure that approximately one of every three SSI recipients has his/her eligibility reviewed each year.

RECOVERY OF OVERPAYMENTS

SSA has made significant efforts over the past several years to recover OASDI and SSI overpayments. The Agency has a number of tools in place—and others being reviewed for possible implementation—for overpayment recovery, including:

- Tax refund offset of Federal tax refunds;
- Administrative offset from other non-tax Federal payments;
- Referral of overpayments to credit bureaus;
- Recovery from representative payees;
- Cross program recovery between OASDI and SSI payments;
- Recovery by compromise settlements with beneficiaries;
- Administrative wage garnishment;
- Federal salary offset;
- Private collection agencies; and
- Charging interest.

In recent audits, we reported that—at the end of FY 2002—SSA had recovered 57 percent of OASDI overpayments and 39 percent of SSI overpayments subject to recovery between FYs 1996 and 2002.[11]

[10] In 1997, GAO designated the SSI program as "high risk" since it lacked an effective plan to address the level of debt that results from overpayments. As a result, SSA developed a corrective action plan, which was updated in June 2002. The SSI program was removed from the "high risk" list in 2005.

[11] SSA OIG, *Supplemental Security Income Overpayments* (A-01-04-24022), April 2004, and *Overpayments in the Old-Age, Survivors and Disability Insurance Program* (A-01-04-24023), August 2004.

DISABILITY PROGRAMS DESIGNATED AS HIGH RISK

GAO designates programs as high risk due to their vulnerabilities to fraud, waste, abuse and mismanagement and due to areas where agencies need to focus on major economy, efficiency, or effectiveness challenges. In January 2003, modernizing Federal disability programs was placed on the high risk list.[12] Although overpayments in SSA's disability programs were not the main focus of GAO's review, the designation draws attention to the size, impact and need for accuracy and quality in these programs. Specifically, GAO found that:

> Disability programs have been growing and are poised to grow even more rapidly as more baby boomers reach their disability prone years. This growth is taking place despite greater opportunities for people with disabilities to work. Moreover, this growth is occurring at the same time that agencies such as the Social Security Administration (SSA) and the Department of Veterans Affairs (VA) are struggling to provide timely and consistent disability decisions. While the agencies are taking some actions to address these problems in the short term, longer-term solutions are likely to require fundamental changes including legislative action.
>
> GAO believes that SSA and VA should take the lead in examining the fundamental causes of program problems such as outmoded disability criteria and seek both management and legislative solutions as appropriate to bring their programs in line with the current state of science, medicine, technology and labor market conditions. At the same time, these agencies should continue to develop and implement strategies for improving the accuracy, timeliness, and consistency of disability decision-making. Further, both agencies should pursue more effective quality assurance systems.

[12] GAO, *High-Risk Series: An Update* (GAO-03-119), January 2003.

The Continuing Disability Review Process

The Social Security Act requires the Agency to periodically conduct continuing disability reviews (CDR) for all beneficiaries receiving disability benefits.[1] The purpose of the review is to determine if a person's impairment has improved since the most recent favorable determination and to determine if the person can perform substantial gainful activity (SGA).[2]

In Fiscal Year (FY) 2004, the Social Security Administration (SSA) processed approximately 1.6 million periodic CDRs—614,838 of which were full medical reviews which resulted in the cessation of benefits for 96,934 beneficiaries (i.e., a 16 percent cessation rate). SSA reported that it achieved about $10.2 in program savings for every $1 in administrative costs invested in conducting CDRs for the 8 FYs 1996-2003.[3]

SSA processes CDRs through either a mailer process or a full medical review of the beneficiary's impairment(s). The mailer is a questionnaire through which a beneficiary provides information about his or her health, medical care, work history, and training. If, in response to the mailer, the beneficiary indicates that his or her health is better, SSA will generally conduct a full medical review. Otherwise, the CDR is generally deferred to a later date or is referred for additional non-medical development by SSA staff.

In those cases where a full medical review is scheduled—either by CDR profiling criteria[4] or referral from the mailer process, the individual is notified, offered the opportunity to submit medical or other evidence, and informed that the review could result in the termination of benefits. If an individual is found not to meet the disability criteria of the law, SSA must suspend or terminate benefit payments, and the individual is notified of the decision in writing and given an opportunity to appeal. These procedures apply to both SSA's disabled Title II beneficiaries and Title XVI recipients.

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[1] Social Security Act § 221(i)(1), as amended, 42 U.S.C. § 421(i)(1), as amended.

[2] SSA, POMS, DI 10501.001: SGA 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. As of 2005, "Countable earnings" of employees indicate SGA and "countable income" of the self-employed is "substantial" if the amount averages more than $830 per month for non-blind individuals or $1,380 for blind individuals.

[3] SSA, *Annual Report to Congress on Continuing Disability Reviews, Fiscal Year 2004*, p. 3, 4 and 6, October 2005. The 96,934 cessations resulted from the initial level of review—prior to appeals. SSA's Office of the Chief Actuary estimates that, after all appeals, approximately 63,800 reviews (10 percent of the 614,838 full medical reviews) will result in termination of benefits.

[4] One of the many factors SSA considers in its CDR selection process to predict the probability of medical improvement is the medical review diary date the Agency established when the case was last reviewed (indicating when medical improvement may be expected). SSA, POMS, DI 28001.015.

In 1984, Amendments to the Social Security Act[5] provided the medical improvement review standard. Under this review standard, a recipient of disability benefits will be found no longer disabled only if the evidence clearly shows both: (1) medical improvement related to the ability to work and (2) ability to engage in SGA.[6]

In addition to reviews which are scheduled periodically based on the category of medical improvement, CDRs can be initiated by other events, such as: a report of work activity; income in excess of a specified amount posted after disability has been established; or a report from someone in a position to know of the individual's physical or mental condition indicating that the person is not disabled, is not following required treatment, or has returned to work, and it appears the report could be substantially correct.

Eligibility for disability benefits ends when at least one of the following events occurs:

- There has been medical improvement (as related to the ability to work) in the individual's impairment or one of certain exceptions to medical improvement applies and the impairment considered together with the individual's age, education, and work experience, where appropriate, does not prevent the individual from engaging in SGA.
- Subject to the trial work period provisions, the individual demonstrates, by working, the ability to engage in SGA.
- The individual does not cooperate with SSA.
- SSA cannot find the individual.
- The individual fails to follow the prescribed treatment, which would be expected to restore his or her ability to engage in SGA.

[5] The Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, 42 U.S.C. § 405. Prior to 1984, disability adjudicators considered only the beneficiary's current ability to engage in SGA.

[6] There are some cases where the medical improvement review standard does not apply: lost folder cases; cases in which a permanent, severe impairment is present and medical improvement is not expected to occur; cases involving work incentive provisions; etc.

Senator Grassley's September 2003 Request

United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

September 4, 2003

Via U.S. Mail and telefax (410) 966-9201

The Honorable James G. Huse, Jr.
Inspector General
Social Security Administration
6401 Security Boulevard
Room 300, Altmeyer Building
Baltimore, Maryland 21235

Dear Inspector General Huse,

The purpose of this letter is to request an audit of both the disability programs administered by the Social Security Administration (SSA), namely, Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). Specifically, I would like the audit to focus on producing a statistically valid improper payment rate for each program.

I understand that your office has recently surveyed private sector long term disability insurers and discovered that their estimated improper payment rate is approximately 10%. I cannot say whether SSA's rate is better or worse than that of private insurers. I can say, however, that the SSDI and SSI programs, at $66 billion and $28 billion respectively in 2002, represent an enormous potential improper payment risk to taxpayers. Using the private disability insurance improper payment rate as a proxy for SSA's rate, I can say that I am gravely concerned that the federal government could be wasting in the vicinity of $10 billion a year of taxpayer money.

Concerns about SSDI and SSI overpayment are not new. Indeed, in a 1995 investigation of SSA disability programs, Heather MacDonald, now of the Manhattan Institute, begins with the illustration of a Boston family. The family matriarch immigrated to United States in 1968. Twenty-seven years later, her surviving 16 children and their 89 progeny were collecting somewhere between $750,000 and $1 million annually in federal disability.

Much more recently, I have come across videotape revealing several people on disability involved in activities absolutely incongruent with their disability status, including loading boxes onto a cargo truck and amateur wrestling.

Further, I read in late August on the AP wire about a former Mrs. Minnesota International and Mrs. Iowa International who is accused of falsely claiming she was disabled by a 1995 automobile accident. Notwithstanding her claimed injuries, she won her Mrs. Minnesota International title by participating in aerobic and evening gown events. All told, she is alleged to have collected over $190,000 in disability benefits during her seven years on disability.

The anecdotes above are used for illustrative purposes only. It is an unfortunate fact that one would not be hard pressed to find many more examples.

At the same time that SSA is providing disability benefits to those like the former beauty queen who apparently are defrauding the program, I read in the Charlotte Observer about applicants who are literally dying while waiting for a benefit decision. This troubles me because I believe that SSA must balance its responsibility for program stewardship with its responsibility for timely benefit distribution. In order to best balance its responsibilities, SSA must find a way to prevent ineligible people from receiving disability benefits in the first place. This would help protect the fisc and free up staff currently devoted to finding fraudsters to assist in making benefit determinations more quickly.

While I am on the subject of finding disability fraudsters, I understand that the SSA Office of Inspector General (OIG) has implemented a Cooperative Disability Investigation (CDI) program, in which OIG criminal investigators work with other federal law enforcement officials and with state and local law enforcement officials to uncover disability fraud. I would like a full report on this program, including its scope, its cost, and the total recovery it has provided the fisc.

Obviously, the challenges facing SSA with respect to improper disability payments are real. In fact, in conversations you and your staff have had with my staff, you have indicated that your work to date in this field leads you to believe four specific diagnosis groups are particularly susceptible to overpayment. The diagnosis groups include mental diseases, musculoskeletal diseases, and endocrinal, nutritional and metabolic diseases. Intuitively, this assessment makes sense and I would appreciate a further analysis of the improper payment prevalence in these four diagnosis groups.

Upon completion of your work, I expect to hold a hearing on this important issue. To meet that end, my Committee on Finance staff will be coordinating closely with you and your staff. Please contact Robert Kerr or Dan Donovan should you wish to discuss this request further. They are available at 224-4515.

Sincerely,

Chuck Grassley

Charles E. Grassley
Chairman

cc: The Honorable JoAnn Barnhart, Commissioner, Social Security Administration
The Honorable David Walker, Comptroller General, General Accounting Office

OIG's Initial Response to Senator Grassley's Request—Dated October 15, 2003

SOCIAL SECURITY

October 15, 2003

The Honorable Charles E. Grassley
Chairman, Senate Finance Committee
United States Senate
Washington, D.C. 20510

Dear Chairman Grassley:

I am pleased to provide you the information requested in your September 4, 2003 letter regarding the Social Security Administration's disability programs.

The enclosed report provides information regarding the following:

- a proposed audit to calculate overpayment rates for the Social Security Administration's disability programs,
- a status report on the Cooperative Disability Investigations units, and
- a proposed audit on the prevalence of improper payments in four specific diagnosis groups.

If you have any questions or would like to be briefed on these issues further, please call me or have your staff contact Douglas Cunning ham, Executive Assistant, at (202) 358-6319.

Sincerely,

/s/

James G. Huse, Jr.

Enclosure

cc:
Jo Anne B. Barnhart, Commissioner

Request for an Audit to Produce a Statistically Valid Overpayment Rate for Each SSA Disability Program

We will initiate a audit in Fiscal Year 2004 to calculate a statistically valid overpayment rate for the Social Security Administration's (SSA) Disability Insurance (DI) and Supplemental Security Income (SSI) programs. The overpayment rates we calculate for this audit will include *all* known overpayments—avoidable and unavoidable—identified by SSA. This rate will include legally defined overpayments as well as non-legally defined overpayments.[1]

Since the Improper Payments Information Act of 2002 was enacted and the Office of Management and Budget (OMB) issued its May 2003 guidance on implementing this law, we have had ongoing discussions with SSA to determine whether certain circumstances, unique to the Agency, should be included in SSA's payment accuracy rates. In August 2003, OMB decided that SSA should only include avoidable overpayments in its improper payment estimate because these payments could be reduced through changes in administrative actions. Unavoidable overpayments that result from legal or program requirements are not to be included in SSA's improper payment estimate. (Please see OMB's August 2003 guidance on pages 2 and 3.)

SSA will continue to calculate its improper payment rates in accordance with OMB's August 2003 guidance. However, our audit will calculate an overpayment rate that does not exclude the overpayments specified by OMB.

We have started to develop a methodology to produce statistically valid overpayment rates for SSA's disability programs, including *all* overpayments. One option we are still researching is to obtain SSA data of all overpayments identified for a given year (such as 1999). This would include all overpayments detected in 1999 and in subsequent years. By selecting 1999 as the year of analysis, sufficient time should have elapsed for SSA to identify and assess the overpayments. From this data, we may be able to total the amount of overpayments identified for the DI and SSI programs.

By comparing the total amount of identified DI and SSI overpayments in 1999 to the total amount of disability benefit payments issued in 1999 for these two programs, we will be able to calculate an overpayment rate.

We are still exploring the feasibility of obtaining *all* overpayment data from SSA's systems and the time frames that would be involved in not only obtaining this data, but testing its accuracy and reliability. However, another option for calculating an

[1] A legally defined overpayment (LDO) means that a determination has been made that a beneficiary has been paid more than he/she is actually due for a specified period of time. Due process is required for each and every LDO. SSA must give advance written notice explaining the amount of the overpayment, how the overpayment occurred, how SSA plans to recover the overpayment, and all appeal rights associated with the planned action BEFORE the Agency withholds any money to recover the LDO. Due process also requires that sufficient time is allowed for the overpaid person to exercise his/her appeal rights before action is taken.

overpayment rate would be to quantify the overpayments and actual payment due for a statistically valid sample of beneficiaries from the DI and SSI rolls. This option may be needed if total overpayment amounts for each DI and SSI beneficiary for a specific year cannot be easily extracted from SSA's systems. Also, sampling may be a more efficient and timely method for calculating an overpayment rate. A sample of approximately 300 cases from each of the two programs would result in an overpayment estimate at the 90 percent confident level (plus or minus 3 percent).

OMB Guidance on Defining Erroneous Payments (issued August 2003)

The following table identifies the types of SSA payments, programs affected, current reporting status, reasons for the payments, and their classification. There are two classifications:

- Unavoidable - Payments resulting from legal or policy requirements. These payments are not considered erroneous.
- Avoidable - Payments that should be reflected in the erroneous payment estimate because they could be reduced through changes in administrative actions.

Types of Payments	Program	Current Status	Reason for Overpayment/Underpayment	OMB Classification
Payments following a cessation of eligibility due to a continuing disability review (CDR)	DI and SSI	Not currently reflected as an error	When SSA is required by law to make payments during the appeals process, these payments are not erroneous.	Unavoidable
Payments made under the Goldberg-Kelly due-process Supreme Court decision.	SSI	Reported as unavoidable erroneous payment in APP.	When due process requires SSI payments to continue, although the agency has determined that a payment reduction or termination is in order, such payments are not erroneous.	Unavoidable
Payments made incorrectly due to program design	SSI	Reported as unavoidable erroneous payment in APP.	The law requires SSI payments to be made on the first of the month based on projected income for that particular month. Changes in the recipient's status can occur during the month, which causes the recipient's eligibility to change. Because SSA cannot prevent the overpayment from being made, this situation should not be reflected in the agency's erroneous payment rate.	Unavoidable
Payments issued after Death	Old-Age and Survivors Insurance (OASI), DI and SSI	Not currently reflected as an error	Dollars released after death (either electronically or in the form of a paper check), which are reclaimed by Treasury or returned unendorsed, should not be reflected in the Agency's erroneous payment rate. Conversely, payments made after death which are improperly cashed or withdrawn, and are subject to overpayment recovery, should be reported.	Unavoidable except for fraud or misuse
Non-Receipt of Payment	OASI, DI and SSI	Not currently reflected as an error	Duplicate payments issued in accordance with the Robinson-Reif Court decision are unavoidable and should not be reflected in the Agency's reports on erroneous payments. The only exception is duplicates incorrectly sent to abusers.	Unavoidable except for fraud or misuse

Types of Payments	Program	Current Status	Reason for Overpayment/Underpayment	OMB Classification
Payments based on medical eligibility	DI and SSI	Not currently reflected as an error	Payments are not erroneous if they are the result of a medical improvement review standard or a situation where the beneficiary would have been ineligible had the law permitted retroactive ineligibility.	Should not be included in the erroneous payment estimate
Payments made for title II beneficiaries based on earnings estimates	DI and OASI	Not currently reflected as an error	When program design requires that the agency make payments based on estimated earnings, these payments should not be considered erroneous.	Unavoidable
Undetected Error	OASI, DI and SSI	Not currently reported as an error	The agency should not reflect undetected error in its erroneous payment rate unless it has evidence that a specific type of erroneous payment was made.	Should not be included in the erroneous payment estimate
Duplicate payments to attorneys, vendors and employees	Admin. Expense	Not currently reported as an error	Systems do not capture when the overpayment occurs; however, this type of error does not meet the reporting threshold.	Avoidable

Report on the OIG's Cooperative Disability Investigations Program—Including its Scope, Cost, and Total Recovery

In 1998, the Cooperative Disability Investigations (CDI) program began as a joint effort among Federal and State agencies to effectively pool resources for the purpose of preventing or terminating improper payments in SSA's Title II and Title XVI disability programs, and related Federal and State programs. This major special investigative project supports the Agency's strategic goal of establishing zero tolerance for fraud, thus ensuring public confidence in the integrity of SSA's programs and operations.

Purpose – Provide greater investigative support in proximity to the disability decision making process to facilitate correct and timely decisions. Disability Determination Services (DDS) adjudicators refer suspicious claims for investigation using guidance found in SSA's Program Operations Manual System. Disability fraud allegations received by the SSA Fraud Hotline and the field offices likewise may be referred to the appropriate CDI unit. This enhances the ability to identify fraud at the onset to prevent payment on fraudulent initial applications, and ensures timely investigation and termination when fraud is detected during continuing disability reviews (CDR) or as a result of investigations of SSA Fraud Hotline or Field Office referrals.

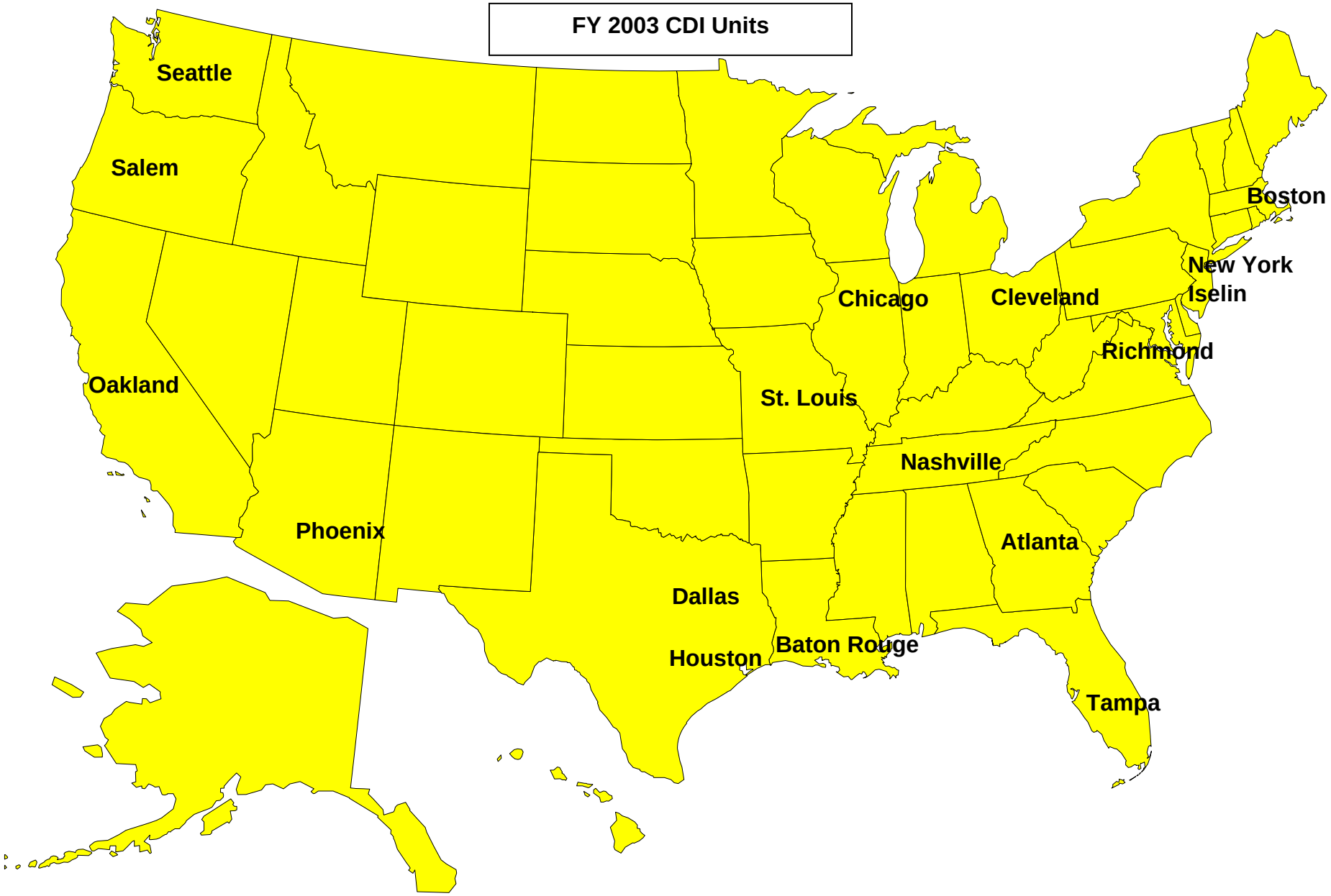
Mission – At present, the program consists of 17 CDI units nationwide, whose mission is to obtain evidence of material fact sufficient to resolve questions of fraud in SSA's disability programs for purposes of criminal and/or civil prosecution. Within that context, the CDI Unit will provide the State DDS with credible and independent evidence for its use in making timely disability eligibility determinations. This supports the Agency's strategic goal of ensuring the integrity of Social Security programs, with zero tolerance for fraud and abuse.

Composition – CDI units are typically comprised of Special Agents from SSA's OIG, State or local law enforcement agency investigators, DDS examiners, and SSA Management Support Specialists (or other similar non-bargaining unit employees). The DDS or law enforcement agency may provide investigative assistants to the CDI units if needed and supported by current resources. Every effort is made to ensure a high level of communication and cooperation among the more than two dozen participating SSA, DDS, OIG, Office of Hearings and Appeals, and law enforcement components. Together, these agencies have dedicated almost 100 full-time staff to the initiative.

Evolution – In FY 1998, five units were formed in New York City, Chicago, Oakland, Atlanta, and Baton Rouge. The success of these units led to additional units being added each year to the current 17 operational units. (See map on page 7 for CDI unit locations.)

Accomplishments – Since inception through August 2003, the CDI units have received over 10,400 allegations of fraud, opened over 6,000 cases with over 4,500 confirmed cases of fraud or similar fault. The projected savings of CDI efforts were over $268 million to SSA programs and over $146 million to related State programs.

Estimated Cost – For FYs 2002 and 2003, the estimated costs were $6 million and $5.9 million, respectively. These are total spending dollars for the CDI units—including salary, benefit, and overtime costs for DDS staff and investigators, but not considering salary and benefit costs for SSA and OIG staff.


FY 2003 CDI Units
Seattle
Salem
Oakland
Phoenix
Dallas
Houston
St. Louis
Chicago
Cleveland
Baton Rouge
Nashville
Atlanta
Tampa
Richmond
New York
Iselin
Boston

Request for Further Analysis of the Improper Payment Prevalence in the Diagnosis Groups Susceptible to Overpayments

We plan to start a comprehensive statistical analysis to quantify the amount of undetected improper payments in SSA's disability programs—with an emphasis on the four diagnosis groups we believe are more susceptible to fraud and overpayments based on our prior audit and investigative work.

Our plan is to review a statistically valid sample of 1,532 Title II and Title XVI disability cases. This sample would be stratified into 2 groups:

- approximately 919 beneficiaries (60 percent) whose disabilities fall into one of the four diagnosis groups[2] we believe are most susceptible to fraud, and
- 613 beneficiaries (40 percent) whose disabilities fall into one of the remaining 13 diagnosis groups.

A sample of 1,532 cases would allow us to estimate the amount of improper payments at a 95 percent confidence level (plus or minus 1.5 percent).

The OIG would review each sample case and conduct an investigation to determine whether the beneficiary is *really* disabled and eligible for benefits. We will also need SSA to conduct CDRs on these cases to evaluate the beneficiaries' medical conditions.[3] Based on the detailed analysis of the 1,532 cases, we will be able to

- estimate the amount of undetected improper payments in SSA's disability programs in each of our two groups—those with diagnoses more susceptible to fraud and those with other diagnoses.
- develop recommendations to improve SSA's efforts to identify and prevent improper payments in SSA's disability programs.

We expect this audit to take approximately 12 months to complete, as follows:

- 4 months for OIG to conduct the initial planning for the audit; develop, obtain and test computer data; review sample cases to determine whether a CDR is needed and/or conduct an investigation to determine whether the beneficiary is *really* disabled.

[2] These 4 diagnosis groups are: (1) endocrine, nutritional, and metabolic diseases; (2) mental disorders (other than mental retardation); (3) diseases of musculoskeletal system; and (4) injuries.

[3] We will only ask SSA to conduct CDRs on sample cases that have not had a CDR in the last 12 months. We will rely on the most recent CDR information for those sample cases that had a CDR within the last year. Further, we will not ask SSA to conduct CDRs for beneficiaries using tickets under the Ticket to Work and Work Incentive Improvement Act of 1999 (Public Law 106-170)—since a CDR is precluded for beneficiaries utilizing this program.

- 6 months for SSA to conduct CDRs.
- 2 months for OIG to analyze and summarize the sample results, develop recommendations to improve the identification and prevention of improper payments, and provide feedback to SSA.

Scope, Sampling Methodology and Results

To accomplish our objective, we:

- Reviewed applicable sections of the Social Security Act, Code of Federal Regulations, Social Security Administration's (SSA) Program Operations Manual System, Office of Management and Budget (OMB) guidance, and Government Accountability Office reports.

- Obtained a file of 11,111,388 disabled individuals[1] who were in current payment status on SSA's records in October 2003. We tested the beneficiary and recipient data obtained for our audit for accuracy and completeness and determined it to be sufficiently reliable to meet our audit objectives.

  From the file of 11.1 million individuals, we excluded:

  - 342,969 beneficiaries with blank diagnosis codes because we were stratifying the sample by diagnosis code.[2]
  - 103,591 beneficiaries receiving more than one benefit and where the records had different diagnosis codes that would cause the case to fall into both strata.
  - 1,768,331 beneficiaries age 62 and above because some individuals in the population were coded as receiving disability benefits but were actually receiving—or would have been entitled to—benefits based on age without considering disability.

- Stratified the remaining population of 8,896,497 beneficiaries—about 80 percent of all 11.1 million disabled beneficiaries—into two groups:

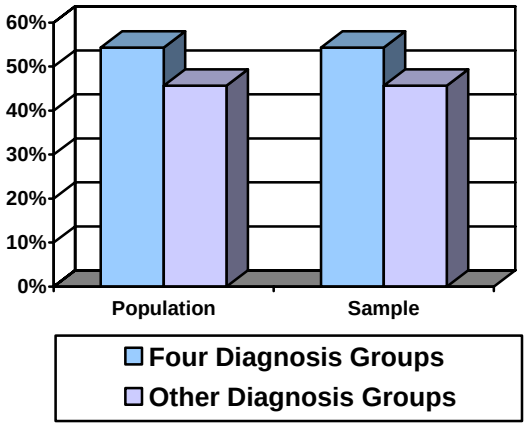
  - Stratum A was 4,830,214 beneficiaries (54 percent) whose diagnosis codes fell into one of the four diagnosis groups mentioned in Senator Grassley's September 4, 2003 letter to the Inspector General: (1) mental disorders other than mental retardation; (2) diseases of musculoskeletal system; (3) endocrine, nutritional, and metabolic diseases; and (4) injuries.

[1] The original data files contained 13.9 million payment records. However, if an individual appeared more than once in the file because he/she was receiving both DI and SSI benefits, we combined the records. Therefore, the 13.9 million payment records represented 11.1 million unique individuals.

[2] The OIG issued a report in March 2000 on the *Reliability of Diagnosis Codes Contained in the Social Security Administration's Data Bases* (A-01-99-61001).

⇨ Stratum B was 4,066,283 beneficiaries (46 percent) whose diagnosis codes did not fall into one of these four diagnosis groups.[3]

From the population, we selected 1,532 individuals using proportional allocation methodology—Stratum A included 832 individuals (54 percent) and Stratum B included 700 individuals (46 percent).



The sample size was established to ensure projections were made at a 95 percent confidence level with a precision of +/- 1.5 percent and an expected error rate of 10 percent or less.

We tested the sample and concluded that it was representative of the population. Specifically, we found that the average Disability Insurance (DI) and Supplemental Security Income (SSI) payments in the sample—$784 and $442 respectively—were reasonably similar to the average amounts SSA reported for all DI and SSI payments—$841 and $433 respectively. Additionally, we found that the number of DI, SSI and concurrent beneficiaries in the sample was reasonably similar to the population—as shown in the table below.

SSA Program	Sample	Population
Individuals Receiving DI	785 (51%)	4.6 million (51%)
Individuals Receiving SSI	547 (36%)	3.4 million (39%)
Individuals Receiving both DI and SSI (i.e., concurrent beneficiaries)	200 (13%)	0.9 million (10%)

- Obtained and analyzed the Master Beneficiary Record, the Supplemental Security Income Record, the Numident Record, disability data, and earnings records for each of the sample cases.
- Gathered information on the sample cases—with the assistance of the Office of Investigations—through a wide range of techniques, including direct and third party interviews, public and private source data queries, surveillances, and investigations of work activities.

[3] The other diagnosis groups fall within the following body systems: Special Senses and Speech, Respiratory System, Cardiovascular System, Genito-Urinary System, Hematological Disorders, Skin Disorders, Multiple Body Systems, Neurological, Mental Retardation, Malignant Neoplastic Diseases, Immune System, Growth Impairment, and Special/Other.

- Quantified the amount of benefits paid for each sample beneficiary in October 2003, and then multiplied this amount by 12 to estimate amount of benefits paid for the Fiscal Year.
- Referred selected cases to SSA—based on the information we gathered—to determine whether the individuals were still disabled and eligible for benefits. If SSA determined the individuals were no longer eligible for benefits or were overpaid as a result of our referral, we quantified:
    1. The amount of overpayments assessed by the Agency as a result of our review between October 2003 and November 2005—based on events that occurred in October 2003 or earlier.
        - ⇨ Overpayments tend to span varying time periods (from 1 month to many years) and, although the overpayments were identified and assessed during our audit period (October 2003 – November 2005), the amounts may actually represent payments made to the beneficiaries outside of this time period.
        - ⇨ We only included overpayments if the event (such as work activity) that caused the overpayment occurred in October 2003 or earlier because these events were known or should have been known to SSA at the time we initiated our review.
    2. The amount of potential benefits SSA could have saved over a 12-month period—beginning with the first month of non-payment—where, as a result of our review, the Agency determined that the individual was no longer eligible for benefits and stopped payments between October 2003 and November 2005. The amount of payments to ineligible beneficiaries we reported was the amount of the last monthly payment issued multiplied by 12 months.[4]
- Quantified for each sample case:
    1. The amount of overpayments identified and assessed by SSA's normal processes between October 2003 and November 2005 for events that occurred in October 2003 or earlier.
    2. The amount of annual payments saved by SSA by stopping benefits to ineligible beneficiaries through its normal processes between October 2003 and November 2005. The amount of annual payments stopped to ineligible beneficiaries was the last monthly payment issued multiplied by 12.

[4] SSA may eventually detect the payments to ineligible beneficiaries or overpayments through its normal processes. However, at the time of our review, the Agency was not developing information on these cases.

- Based on the sample results, we estimated the amount of overpayments assessed, as well as the amount of potential funds SSA could save over a 12-month period.[5] The estimate of potential payments to ineligible beneficiaries was based on the last monthly payment received by each beneficiary whose benefits were stopped during our review (and not the October 2003 payment amount when we obtained our data file).[6]
- Referred instances of suspected fraudulent activity to the appropriate offices to pursue remedies, such as criminal or civil prosecution, civil monetary penalties or administrative sanctions.
- Obtained, from SSA, the amount of new debt assessed (i.e. overpayments) in each of the last 5 Fiscal Years (FY)—FY 2001 through FY 2005.
- Obtained, from SSA's *Performance and Accountability Report*, the amount of DI and SSI payments made in FY 2001 through FY 2005.
- Calculated the percent of disability benefits that should not have been paid:
    - We totaled the amount of overpayments assessed for FY 2004 for our sample cases which were detected during our review period of October 2003 and November 2005 and the amount of payments not issued to ineligible beneficiaries in FY 2004 as a result of our review. This total was compared to the amount of benefits paid to our sampled beneficiaries in FY 2004.
    - We added the new debt assessed by SSA in FY 2004, the estimated overpayments for FY 2004 that were not detected by the Agency, and the estimated payments issued to ineligible beneficiaries in FY 2004 as a result of our review. This total was compared to the total DI and SSI payments made in FY 2004.
    - We added the new debt assessed by SSA in FY 2004, the estimated overpayments for FY 2004 that were not detected by the Agency, and the estimate of all benefits paid to potentially ineligible individuals. This total was compared to the total DI and SSI payments made in FY 2004.

We performed our audit between October 2003 and November 2005 in Boston, Massachusetts and Office of Investigations field divisions throughout the United States. The entities audited were the Office of Disability and Income Security Programs under the Deputy Commissioner for Disability and Income Security Programs and the Office of

[5] Several beneficiaries had overpayments and/or payments to ineligible beneficiaries identified by SSA, but they also had additional overpayments and/or payments to ineligible beneficiaries identified due to the OIG's review. To ensure beneficiaries were not double-counted, we considered these beneficiaries to have been identified by SSA (and not the OIG). However, the dollar amounts in our sample and estimates are separate and distinct—depending on whether SSA identified them through its normal processes or if the amounts were identified due to the OIG's review.

[6] We used the last payment amount because of the length of time it took to select sample cases, review them, and refer them to SSA for appropriate action. In addition, it took the Agency 6 to 12 months to complete its actions—such as reviews of beneficiaries' medical condition or work activity.

Operations under the Deputy Commissioner for Operations. We conducted our audit in accordance with generally accepted government auditing standards.

SAMPLE RESULTS AND PROJECTIONS[7]

Table F-1: Summary of Sample Results—Dollars		
	Detected by SSA between October 2003 and November 2005	Detected by OIG between October 2003 and November 2005 (Undetected by SSA)
Overpayments in Sampled Cases		
Total overpayments	$333,187	$586,786
Average amount overpaid	$2,824	$32,599
Range[8]	$2 to $55,184	$4,355 to $133,316
Median overpayment	$775	$24,481
Overpayment Ranges	**Number of Cases**	**Number of Cases**
Under $1,000	66	0
$1,000 - $4,999	38	0
$5,000 - $9,999	6	6
$10,000 or more[9]	7	12
Total Cases	**117**	**18**
Payments Stopped to Ineligible Beneficiaries in Sampled Cases		
Payments Stopped to Ineligible Beneficiaries[10]	$1,208,587	$369,162

[7] The amounts in the tables are rounded to the nearest whole dollar. Any differences are due to rounding.

[8] The $133,316 was the largest overpayment detected by the OIG. This amount is substantially more than the next highest overpayment amount for this category, which was $89,891.

[9] One beneficiary had an overpayment detected by SSA of $1,126 and another overpayment due to the OIG's review of $38,668. We classified this case in the group of cases that were detected as a result of the OIG's review in the "$10,000 or more" category. We did not include it in the group of cases detected by SSA in the "$1,000 to $4,999" category. Although we counted this case only once, the overpayment dollars are reported in the appropriate category.

[10] While SSA reports savings for CDRs, the Agency does not report savings for all beneficiaries suspended/terminated (such as for fugitives). Therefore, there is no number comparable to our savings estimate. However, our cessation rate due to medical improvement for the period October 2003 through November 2005 in our sample was 13 percent, which is lower than the 16 percent cessation rate SSA had for a similar time period (October 2003 through May 2005).

Table F-2: Summary of Sample Results—Number of Months		
	Detected by SSA between October 2003 and November 2005	Detected by OIG between October 2003 and November 2005 (Undetected by SSA)
Months Overpaid	**Number of Months**	**Number of Months**
Average	13	43
Range	1 to 60	6 to 177
Median	10	30
Mode	1	30
Length of Time to Discover Overpayment	**Number of Months**	**Number of Months**
Average	18	41
Range	0 to 67	5 to 108
Median[11]	15	34
Mode[12]	2	29, 41, 82

[11] The median is the value of the middle item when the items are arranged by size. Within our sample, the median is the middle item when the number of months were listed from low to high.

[12] The mode is the value that occurs most frequently. Of the 18 overpayments detected by the OIG, 29 months, 41 months, and 82 months each occurred twice; whereas the number of months for the remaining cases only occurred once.

Table F-3: Sample Results of Overpaid Cases Identified Due to OIG's Review (Not Through SSA's Normal Processes)					
	Overpaid From	**Overpaid To**	**Months**	**Amount**	**Reason**
1	January 1990	September 2004	177	$38,668	Income/Work Activity[13] (identified by OIG and not on SSA's records)
2	November 1997	August 2004	82	$47,578	Income/Work Activity
3	February 1998	October 2004	81	$133,316	Income/Work Activity
4	July 1998	November 2004	77	$89,891	Income/Work Activity
5	May 2000	March 2004	47	$47,846	Income/Work Activity
6	June 2001	July 2004	39	$28,390	Income/Work Activity
7	December 2001	May 2004	30	$25,511	Income/Work Activity
8	January 2002	March 2004	27	$33,170	Income/Work Activity
9	March 2002	August 2004	30	$23,051	Fugitive[14]
10	March 2002	January 2005	35	$43,460	Income/Work Activity
11	December 2002	March 2005	28	$17,763	Income/Work Activity (identified by OIG and not on SSA's records)
12	March 2003	February 2005	16	$7,831	SSI Eligibility Not Met[15]
13	March 2003	November 2005	32	$19,070	Income/Work Activity (identified by OIG and not on SSA's records)
14	May 2003	April 2004	12	$7,904	Inability to Locate
15	June 2003	February 2004	9	$4,356	Fugitive/Prisoner
16	June 2003	February 2005	19	$9,418	Income/Work Activity
17	October 2003	March 2004	6	$4,704	Fugitive
18	January 2004	June 2005	18	$4,859	Not Cooperating[16]
		Total Overpayments[17]		**$586,786**	

[13] For the 12 cases with overpayments due to income/work activity, 9 had earnings recorded on SSA's Master Earnings File (above $6,000) and the Agency should have been aware of the potential for overpayments or ineligibility. However, for 3 of the 12 cases with overpayments, SSA did not have earnings information prior to our review. (The OIG also identified five beneficiaries who were not overpaid but had benefits stopped because of the earnings. Four of the beneficiaries already had earnings information recorded on SSA's systems and one did not.)

[14] The prisoner/fugitive information was developed by the OIG and was not known to SSA prior to October 2003.

[15] The recipient was overpaid because his step-father's income exceeded the limits for SSI eligibility. The Agency was not aware of the income because the recipient's mother did not inform SSA of her marriage. Therefore, the family's total income was not linked together in the Agency's records.

[16] SSA assessed an overpayment for this beneficiary based on our review for the period January 2004 through June 2005 due to failure to cooperate which involved the beneficiary not providing his tax returns for prior years. These tax returns are likely to show that he had earnings above SSA's substantial gainful activity levels prior to October 2003.

[17] Of the $586,786 in overpayments detected by OIG in our sample, $142,754 was overpaid in FY 2004. The remaining $440,032 was overpaid in other years.

Table F-4: Percent of Disabled Beneficiaries in Sample with Payments Stopped to Ineligible Beneficiaries, Overpayments, or Both	
Sample	1,532
Beneficiaries with payments stopped to ineligible beneficiaries, overpayments, or both	292
Percent	**19%**
Beneficiaries that SSA identified with payments stopped to ineligible beneficiaries, overpayments or both	245
Percent of Sample	**16%**
Beneficiaries that the OIG identified that resulted in SSA stopping payments to ineligible beneficiaries, overpayments, or both	47
Percent of Sample	**3%**

Table F-5: Sample Results by Program					
	DI		**SSI**		**Total**
Payments stopped to ineligible beneficiaries	$1,006,767		$570,982		$1,577,749
Overpayments	$680,891		$239,082		$919,973
Total	**$1,687,658**	**68%**	**$810,064**	**32%**	**$2,497,722**

Table F-6: Audit Population as a Percent of Total Disability Population	
Total disability population as of October 2003	11,111,388
Population for OIG's review	8,896,497
Percent of population for OIG's review from total population	**80%**

Table F-7: Sample Results and Projections Estimated Overpayments Based on Events in October 2003 or Earlier[18]			
	Stratum A Four Diagnosis Groups	**Stratum B Other Diagnosis Groups**	**Total**
Population size	4,830,214	4,066,283	8,896,497
Sample size	832	700	1,532
Dollar Projections – Overpayments Based on SSA's Normal Processes			
Sample results[19]	$178,480	$154,707	$333,187
Point estimate	$1,036,174,546	$898,686,418	$1,934,860,964
Projection lower limit			$1,025,896,916
Projection upper limit			$2,843,825,012
Dollar Projections – Overpayments Based on OIG's Review[20]			
Sample results	$195,632	$347,730	$543,362
Point estimate	$1,135,749,350	$2,019,953,382	$3,155,702,732
Projection lower limit			$1,252,447,922
Projection upper limit			$5,058,957,543
Total Estimated Overpayments			
	$2,171,923,896	$2,918,639,800	$5,090,563,696

Note: All projections were calculated at the 95-percent confidence level.

[18] To be conservative in the development of our estimate, we did not include the entire amount of a very large overpayment for one beneficiary that was identified based on the OIG's review. SSA assessed an overpayment of $133,316—substantially more than the next highest overpayment amount for this category. Therefore, in our estimates, we used $89,891—the amount of the next highest overpayment identified by the OIG's review. See Table F-8 for the estimate with the full overpayment amount included for this case and Table F-9 for the estimate excluding the entire overpayment for this case.

[19] Of the $333,187 in overpayments detected by SSA in our sample, $222,289 was overpaid in FY 2004. The remaining $110,898 was overpaid in other years.

[20] The only number calculated by SSA that could be compared to our total overpayment estimate is the amount of new debt detections reported by SSA on its financial statements. SSA reported $6.3 billion in new debt for FYs 2004 and 2005 and this is similar to our reporting period of October 2003 through November 2005 where we estimated $5.1 billion in overpayments. (SSA's $6.3 billion includes overpayments for non-disabled beneficiaries, i.e., individuals collecting Social Security or SSI benefits based on old-age. Therefore, it is reasonable that our estimate of $5.1 billion for DI and SSI disabled beneficiaries would be lower.)

Table F-8: Sample Results and Projections Estimated Overpayments Based on Events in October 2003 or Earlier—With Outlier			
	Stratum A Four Diagnosis Groups	Stratum B Other Diagnosis Groups	Total
Population size	4,830,214	4,066,283	8,896,497
Sample size	832	700	1,532
Dollar Projections—Overpayments Based on SSA's Normal Processes			
Sample results	$178,480	$154,707	$333,187
Point estimate	$1,036,174,546	$898,686,418	$1,934,860,964
Projection lower limit			$1,025,896,916
Projection upper limit			$2,843,825,012
Dollar Projections—Overpayments Based on OIG's Review			
Sample results[21]	$195,632	$391,154	$586,786
Point estimate	$1,135,749,350	$2,272,206,991	$3,407,956,341
Projection lower limit			$1,200,140,828
Projection upper limit			$5,615,771,854
Total Estimated Overpayments			
	$2,171,923,896	$3,170,893,409	$5,342,817,305

Note: All projections were calculated at the 95-percent confidence level.

Table F-9: Sample Results and Projections Estimated Overpayments Based on Events in October 2003 or Earlier—Excluding Outlier			
	Stratum A Four Diagnosis Groups	Stratum B Other Diagnosis Groups	Total
Population size	4,830,214	4,066,283	8,896,497
Sample size	832	700	1,532
Dollar Projections—Overpayments Based on SSA's Normal Processes			
Sample results	$178,480	$154,707	$333,187
Point estimate	$1,036,174,546	$898,686,418	$1,934,860,964
Projection lower limit			$1,025,896,916
Projection upper limit			$2,843,825,012
Dollar Projections—Overpayments Based on OIG's Review			
Sample results	$195,632	$257,838	$453,470
Point estimate	$1,135,749,350	$1,497,777,585	$2,633,526,935
Projection lower limit			$1,026,133,759
Projection upper limit			$4,240,920,110
Total Estimated Overpayments			
	$2,122,592,549	$2,377,411,956	$4,500,004,505

Note: All projections were calculated at the 95-percent confidence level.

[21] Of the $586,786 in overpayments detected by OIG in our sample, $142,754 was overpaid in FY 2004. The remaining $440,032 was overpaid in other years.

Table F-10: Sample Results and Projections Estimated Beneficiaries with Overpayments Due to OIG's Review			
	Stratum A Four Diagnosis Groups	Stratum B Other Diagnosis Groups	Total
Population size	4,830,214	4,066,283	8,896,497
Sample size	832	700	1,532
Attribute Projections			
Sample cases	8	10	18
Point estimate	46,444	58,090	104,534
Projection lower limit			56,511
Projection upper limit			152,558

Note: All projections were calculated at the 95-percent confidence level.

Table F-11: Sample Results and Projections Estimated Beneficiaries with Overpayments Detected by SSA's Normal Processes			
	Stratum A Four Diagnosis Groups	Stratum B Other Diagnosis Groups	Total
Population size	4,830,214	4,066,283	8,896,497
Sample size	832	700	1,532
Attribute Projections			
Sample cases[22]	63	55	118
Point estimate	365,749	319,494	685,243
Projection lower limit			566,396
Projection upper limit			804,090

Note: All projections were calculated at the 95-percent confidence level.

Table F-12: Sample Results and Projections Estimated Overpayments SSA Assessed after FY 2004 for the Period October 2003 through September 2004			
	Stratum A Four Diagnosis Groups	Stratum B Other Diagnosis Groups	Total
Population size	4,830,214	4,066,283	8,896,497
Sample size	832	700	1,532
Dollar Projections			
Sample results	$85,756	$91,594	$177,350
Point estimate	$497,858,111	$532,066,973	$1,029,925,084
Projection lower limit			$607,477,569
Projection upper limit			$1,452,372,599

Note: All projections were calculated at the 95-percent confidence level.

[22] One beneficiary in Stratum B had both an overpayment identified by SSA's normal processes and an overpayment identified by the OIG's review. Although the overpayment dollars are in the appropriate categories, we did not include this case in Table F-11 because the case was included in Table F-10.

Table F-13: Sample Results and Projections Estimated Payments Stopped to Ineligible Beneficiaries for 12-Months Based on Last Monthly Payment Issued			
	Stratum A Four Diagnosis Groups	**Stratum B Other Diagnosis Groups**	**Total**
Population size	4,830,214	4,066,283	8,896,497
Sample size	832	700	1,532
Dollar Projections – Potential Payments Stopped to Ineligible Beneficiaries Based on SSA's Normal Processes			
Sample results	$419,564	$789,023	$1,208,587
Point estimate	$2,435,799,590	$4,583,413,586	$7,019,213,176
Projection lower limit			$5,755,848,109
Projection upper limit			$8,282,578,244
Dollar Projections – Potential Payments to Ineligible Beneficiaries Based on OIG's Review			
Sample results[23]	$149,081	$220,081	$369,162
Point estimate	$865,495,393	$1,278,446,346	$2,143,941,739
Projection lower limit			$1,478,812,456
Projection upper limit			$2,809,071,023
Total Estimated Potential Payments Stopped/Not Stopped to Ineligible Beneficiaries			
	$3,301,294,983	$5,861,859,932	$9,163,154,915

Note: All projections were calculated at the 95-percent confidence level.

Table F-14: Sample Results and Projections Estimated Ineligible Beneficiaries Whose Payments Should be Stopped			
	Stratum A Four Diagnosis Groups	**Stratum B Other Diagnosis Groups**	**Total**
Population size	4,830,214	4,066,283	8,896,497
Sample size	832	700	1,532
Attribute Projections			
Sample cases	78	122	200
Point estimate	452,833	708,695	1,161,528
Projection lower limit			1,012,409
Projection upper limit			1,310,646

Note: All projections were calculated at the 95-percent confidence level.

[23] Of the $369,162 in payments stopped in our sample because of OIG's review, $59,432 would have been paid in FY 2004. The remaining $309,730 would have been paid after FY 2004.

Table F-15: Sample Results and Projections Estimated Payments Stopped to Ineligible Beneficiaries for 12-Months Based on Last Monthly Payment if Benefit Payments Resumed in April 2006 for Beneficiaries Placed in Suspense Based on OIG's Review			
	Stratum A Four Diagnosis Groups	**Stratum B Other Diagnosis Groups**	**Total**
Population size	4,830,214	4,066,283	8,896,497
Sample size	832	700	1,532
Dollar Projections – Payments Stopped to Ineligible Beneficiaries Based on SSA's Normal Processes			
Sample results	$419,564	$789,023	$1,208,587
Point estimate	$2,435,799,590	$4,583,413,586	$7,019,213,176
Projection lower limit			$5,755,848,109
Projection upper limit			$8,282,578,244
Dollar Projections – Payments to Ineligible Beneficiaries Based on OIG's Review			
Sample results	$146,666	$220,081	$366,747
Point estimate	$851,475,001	$1,278,446,346	$2,129,921,347
Projection lower limit			$1,467,348,308
Projection upper limit			$2,792,494,386
Total Estimated Payments Stopped/Not Stopped to Ineligible Beneficiaries			
	$3,287,274,591	$5,861,859,932	$9,149,134,523

Note: All projections were calculated at the 95-percent confidence level.

Table F-16: Summary of Estimated Overpayments and Payments Stopped to Ineligible Beneficiaries		
	Dollars	**Percent**
Estimated Overpayments Identified by SSA's Normal Processes	$1.9 billion	37%
Estimated Overpayments Identified due to OIG's Review	$3.2 billion	63%
Total Estimated Overpayments Identified Between October 2003 and November 2005 Based on Conditions that Existed in October 2003 or Earlier in Sample (From Table F-7)	**$5.1 billion**	**100%**
Estimated Payments Stopped to Ineligible Beneficiaries due to SSA's Normal Processes	$7.0 billion	77%
Estimated Payments Not Stopped to Ineligible Beneficiaries due to OIG's Review	$2.1 billion	23%
Total Estimated Annual Payments Stopped/Not Stopped to Ineligible Beneficiaries Based on Sample (From Table F-13)	**$9.1 billion**	**100%**

Table F-17: Analysis of Four Diagnosis Groups Based on Cases in Which OIG Developed Information SSA Did Not Already Have—Sample Results and Projections of Overpayments and Potential Payments to Ineligible Beneficiaries			
	Stratum A Four Diagnosis Groups	Stratum B Other Diagnosis Groups	Total
Population size	4,830,214	4,066,283	8,896,497
Sample size	832	700	1,532
Dollar Projections			
Sample results	$189,846	$160,600	$350,446
Point estimate	$1,102,159,624	$932,923,823	$2,035,083,447
Projection lower limit			$1,143,137,823
Projection upper limit			$2,927,029,071

Note: All projections were calculated at the 95-percent confidence level.

To calculate a statistically valid overpayment rate for SSA's disability programs, the total amount of overpayments made in a given year should be compared to the total payments issued during that same year. However, overpayments made in a year—such as FY 2004—may not be identified until FY 2005 or beyond.[24] Because of this long span of time, the complexity of SSA's programs, limited data, and SSA's reliance on others to report changes that impact eligibility, we calculated several rates described below. These overpayment rates were developed on the basis that—for any medical or non-medical reason—the Agency assessed an overpayment, would have assessed an overpayment, or would not have issued a payment.

Table F-18 shows that the overpayment rate for FY 2004 was about 3.2 percent of benefits paid. This rate is based on our sample cases and represents the amount of overpayments assessed for FY 2004 due to SSA's normal processes and OIG's review—which were detected during our review period of October 2003 and November 2005—and the amount of payments not issued to ineligible beneficiaries in FY 2004 as a result of our review. This total was compared to the amount of benefits paid to our sampled beneficiaries in FY 2004.

Table F-18: Overpayment Rate Based on Sample Cases with Overpayments and Payments Not Issued to Ineligible Beneficiaries	
Overpayments detected by SSA in sample for FY 2004	$222,289
Overpayments detected by OIG in sample for FY 2004	$142,754
Payments not issued for FY 2004 to ineligible beneficiaries due to the OIG's review	$59,432
Total	**$424,475**
Benefits paid in October 2003	$1,096,118
Annual benefits paid in FY 2004 for sample (October 2003 benefit multiplied by 12)	**$13,153,421**
Overpayment Rate ($424,475/$13,153,421)[25]	**3.2%**

We also developed a second rate of 3.6 percent shown in Table F-19. This rate represents the amount of overpayments assessed by SSA for FY 2004 plus the estimated overpayments for FY 2004 that were not detected by the Agency and the estimated payments issued to ineligible beneficiaries in FY 2004 as a result of our review. These amounts were compared to the total DI and SSI payments made in FY 2004.

[24] Within our sample of 1,532 cases, a period of 1 month up to 14 years elapsed before SSA identified a benefit as having been overpaid.

[25] By excluding the $59,432 in payments stopped to ineligible beneficiaries for FY 2004 due to the OIG's review, the 3.2 percent decreases to 2.8 percent.

Table F-19: Estimated Overpayment Rate Based on Overpayments and Payments to Ineligible Beneficiaries in FY 2004 for SSA's DI and SSI Programs	
Overpayments assessed by SSA in FY 2004 for its DI and SSI programs[26]	$2.9 billion
Estimated overpayments detected by OIG for FY 2004[27]	$0.8 billion
Estimated payments to ineligible beneficiaries detected by OIG for FY 2004[27]	$0.3 billion
Total	**$4.0 billion**
DI benefits paid in FY 2004[28]	$75.2 billion
SSI benefits paid in FY 2004[29]	$35.2 billion
Total	**$110.4 billion**
Overpayment Rate ($4.0 billion/$110.4 billion)	**3.6%**

Although we believe that the overpayment rate is between 3.2 and 3.6 percent of benefits paid, the rate could be as high as 5.2 percent, as shown in Table F-20. This rate represents the percentage of benefits the Agency would not have paid if it had perfect knowledge of all conditions affecting eligibility at the time the payments were issued. The rate was calculated using the amounts used to develop the 3.6 percent, replacing the $0.3 billion in estimated payments issued to ineligible beneficiaries in FY 2004 with the estimate of annual payments to ineligible beneficiaries ($2.0 billion) based on our sample cases where SSA stopped benefits during our review due to medical CDRs, income, prison/fugitive status, failure to cooperate, inability to locate, etc. If SSA was able to identify all issues impacting benefits as soon as they occurred, the Agency would have likely stopped these benefits sooner.

[26] SSA, *Report on Receivables Due From the Public*, Fiscal Year 2004, pages 113, 122, and 131. The SSI overpayments relate to disabled individuals, as well as individuals who became eligible for SSI based on age (65 or older). About 1.2 million individuals received SSI based on age and the average payment was $342—compared to about 5.6 million individuals receiving SSI based on disability and an average payment of $433 (SSA, *Annual Statistical Supplement, 2004*). These overpayments were identified during FY 2004. However, the overpayments may have occurred during periods prior to FY 2004.

In Table F-7, we estimated that SSA identified $1.9 billion in overpayments during our period of review—October 2003 through November 2005—for our sample population representing 80 percent of all disabled beneficiaries. Assuming similar findings in the remaining 20 percent of disabled beneficiaries, our projection would increase to about $2.4 billion, and the upper and lower limits of our projection would adjust accordingly. Therefore, the $2.9 billion SSA reported would fall within the range of these adjusted upper and lower limits—and our estimate of $1.9 billion is a reasonable proxy for the amount of overpayments identified by SSA in its disability programs.

[27] The estimates were $829.1 million and $345.2 million—and we rounded down to $0.8 billion and $0.3 billion in the Table. The OIG estimates are conservative, since our sample was only based on a population of 8.9 million disability beneficiaries—and does not include the 2.2 million beneficiaries (20 percent) we excluded from our original data file of 11.1 million beneficiaries.

[28] SSA, *FY 2004 Performance and Accountability Report*, page 169, November 2004.

[29] SSA, *FY 2004 Performance and Accountability Report*, page 169, November 2004. SSI payments in FY 2004 include payments to disabled individuals, as well as individuals who became eligible for SSI based on age (65 or older).

Table F-20: Estimated Overpayment Rate Based on Overpayments and Annual Payments to Ineligible Beneficiaries for SSA's DI and SSI Programs	
Overpayments assessed by SSA in FY 2004 for its DI and SSI programs[30]	$2.9 billion
Estimated overpayments detected by OIG for FY 2004[31]	$0.8 billion
Estimated annual payments to ineligible beneficiaries detected by OIG[32]	$2.0 billion
Total	**$5.7 billion**
DI benefits paid in FY 2004	$75.2 billion
SSI benefits paid in FY 2004	$35.2 billion
Total	**$110.4 billion**
Overpayment Rate[33] ($5.7 billion/$110.4 billion)	**5.2%**

[30] SSA, *Report on Receivables Due From the Public*, Fiscal Year 2004, pages 113, 122, and 131. The SSI overpayments relate to disabled individuals, as well as individuals who became eligible for SSI based on age (65 or older). About 1.2 million individuals received SSI based on age and the average payment was $342—compared to about 5.6 million individuals receiving SSI based on disability and an average payment of $433 (SSA, *Annual Statistical Supplement, 2004*). These overpayments were identified during FY 2004. However, the overpayments may have occurred during periods prior to FY 2004.

In Table F-7, we estimated that SSA identified $1.9 billion in overpayments during our period of review—October 2003 through November 2005—for our sample population representing 80 percent of all disabled beneficiaries. Assuming similar findings in the remaining 20 percent of disabled beneficiaries, our projection would increase to about $2.4 billion, and the upper and lower limits of our projection would adjust accordingly. Therefore, the $2.9 billion SSA reported would fall within the range of these adjusted upper and lower limits—and the $1.9 billion is a reasonable estimate for the amount of overpayments identified by SSA in its disability programs.

[31] The OIG estimates are conservative since our sample was only based on a population of 8.9 million disability beneficiaries—and does not include the 2.2 million beneficiaries (20 percent) we excluded from our original data file of 11.1 million beneficiaries.

[32] This estimate represents the amount of benefits SSA paid over a 12-month period by not stopping payments to individuals no longer eligible for benefits. This estimate was based on sample cases identified during our review—not SSA's normal processes. Once we identified a case, SSA made the determination that the individual was no longer eligible for benefits and stopped the benefit payments during our review. Our estimates of payments to ineligible beneficiaries were calculated by multiplying the amount of the October 2003 benefit by 12 months. (If we had used the last payment received instead of the October 2003 payment, our estimate of $2.0 billion would have increased to $2.1 billion—as reported in Table F-15—and the rate would increase from 5.2 percent to 5.3 percent.) The $0.3 billion from Table F-19 is part of the $2.0 billion in Table F-20. These estimates are based on our population of 8.9 million beneficiaries, whereas the $2.9 billion in overpayments and $110 billion in DI and SSI paid are based on all disabled beneficiaries. Any overpayments/payments to ineligible beneficiaries that occurred to individuals outside our population and undetected by SSA were excluded from the rate. For the individuals paid benefits in October 2003, but excluded from our population, we did not estimate any overpayments or payments to ineligible beneficiaries. Page F-1 of this report has a description of the adjustments made to our population prior to selecting the sample.

[33] We looked at the distribution of cases with overpayments identified by SSA, and determined that 73 percent were detected within 25 months. Based on this analysis, 5 cases with overpayments identified by the OIG may have been eventually identified by SSA because they were detected within 25 months (as shown in the charts on page 5 of this report). If these 5 cases were removed from the estimates in Table F-20, the estimated overpayments detected by OIG for FY 2004 would decrease to $0.7 billion, and the estimated annual payments to ineligible beneficiaries detected by OIG would decrease to $1.9 billion. Therefore, the rate would decrease from 5.2 percent to 5.0 percent ($5.5 billion/$110.4 billion).

Reasons Why Sampled Beneficiaries Were Overpaid or Became Ineligible for Payments

Overpayments were assessed and payments were stopped to ineligible beneficiaries in our sample cases for several reasons in our review of 1,532 disabled beneficiaries, as shown in Tables G-1 and G-2 below.

Table G-1: Reasons for Overpayments in Sampled Cases

Reason for Overpayments in Sample	Identified by SSA's Normal Processes		Identified Due to OIG's Review		Total Number of People[1]	Total Over-payments
	Number of People	Over-payments	Number of People	Over-payments		
Income/Work Activity	94	$252,151	12	$534,082	105	$786,233
Prisoner/Fugitive	2	$7,186	3	$32,110	5	$39,296
SSI Eligibility Not Met	8	$30,724	1	$7,831	9	$38,555
Incorrect Computation	5	$30,822	0	$0	5	$30,822
Payments After Death[2]	2	$9,141	0	$0	2	$9,141
Inability to Locate	0	$0	1	$7,904	1	$7,904
Not Cooperating	0	$0	1	$4,859	1	$4,859
Duplicate Payments	7	$3,163	0	$0	7	$3,163
Total	**118**	**$333,187**	**18**	**$586,786**	**135**	**$919,973**

[1] Five beneficiaries had multiple overpayments identified by the Social Security Administration's (SSA) normal processes that fell into more than one category. Also, one beneficiary had overpayments identified by SSA's normal processes and by the Office of the Inspector General's (OIG) review. These beneficiaries are included in the category with the higher dollar amount, but the dollars for each case are in the appropriate category.

[2] Two beneficiaries died prior to October 2003 but SSA was not notified until after October and was therefore unable to prevent these payments from being issued after death. Therefore, these 2 beneficiaries were in current payment status when we obtained our data file and selected our sample. Additionally, 74 beneficiaries died during our review—between October 2003 and November 2005. In total, 76 beneficiaries in our sample died.

Table G-2: Reasons for Payments Were Stopped to Ineligible Beneficiaries in Sampled Cases						
Reason for Beneficiaries in Sample	Identified by SSA's Normal Processes		Identified Due to OIG's Review		Total Number of People	Total 12 Month Estimate of Payments to Ineligible Beneficiaries
	Number of People	12-Months of Payments	Number of People	12-Months of Payments		
Death[3]	75	$780,696	0	$0	75	$780,696
Income/Work Activity	44	$197,816	16	$161,743	60	$359,559
Medical Improvement	19	$141,972	12	$89,075	31	$231,047
Prisoner/Fugitive	7	$38,399	5	$35,471	12	$73,870
Not Cooperating	4	$28,632	3	$18,725	7	$47,357
Inability to Locate	0	$0	4	$34,886	4	$34,886
SSI Eligibility Not Met	5	$13,350	2	$13,716	7	$27,066
Voluntary Termination	1	$342	2	$15,546	3	$15,888
OASDI Entitlement Not Met	1	$7,380	0	$0	1	$7,380
Total	**156**	**$1,208,587**	**44**	**$369,162**	**200**	**$1,577,749**

INCOME AND WORK ACTIVITY

Individuals may no longer be entitled to disability benefits if their impairments improve or they demonstrate their ability to engage in substantial gainful activity (SGA) by working. For this reason, SSA conducts medical or work-related continuing disability reviews (CDR) to determine whether beneficiaries continue to be disabled and entitled to benefits. Because an individual's entitlement to benefits is generally based on the determination that he or she does not have the ability to engage in SGA, SSA must perform a CDR when there is an indication that the beneficiary has returned to work.[4]

Although disabled Title II beneficiaries are required to report work activity, individuals often fail to report their income. Consequently, SSA developed the CDR Enforcement Operation. This enforcement process compares earnings reported on the Master

[3] Of the 1,532 sample cases, 76 beneficiaries died. However, we only counted payments to ineligible beneficiaries for 75 of the 76 beneficiaries during our review period of October 2003 through November 2005. The remaining beneficiary appropriately received payments through November 2005 and payments to ineligible beneficiaries would not start until December—which was beyond our audit period.

[4] 20 C.F.R. §§ 404.1590(b)(5) and 416.990(b)(5).

Earnings File to the benefit rolls to alert the Agency of disabled beneficiaries with potentially unevaluated substantial earnings after disability onset.

Because of SSA's limited resources and competing workloads, the Agency limits the number of work-related CDRs that are performed as a result of earnings identified through its enforcement process. Although earnings may be identified through enforcements, SSA screens out cases for work-related CDRs if the earnings are below the Agency's pre-defined "screen-out" amounts. Limiting work-related CDRs to enforcement cases with higher earnings allows SSA to use its resources to develop only those cases that the Agency believes are more likely to involve SGA.

THE MEDICAL IMPROVEMENT REVIEW STANDARD

Most disability claims are initially processed through a network of Social Security Field Offices and State Disability Determination Services (DDS). Once SSA establishes an individual is eligible for disability benefits under either the Disability Insurance or SSI program, the Agency turns its efforts toward ensuring the individual continues to receive benefits only as long as SSA eligibility criteria are met. For example, a CDR may show the individual no longer meets SSA's disability criteria or has demonstrated medical improvement.

The current Medical Improvement Review Standard (MIRS) was implemented in 1984 through changes to the Social Security Act.[5] MIRS requires that before benefits can be ceased, SSA must find medical improvement since the last medical decision and this improvement must be related to the individual's ability to work.[6]

Constitutional Due Process requirements oblige SSA to pay benefits until an individual is found to be no longer disabled during a CDR and is notified, even if the medical impairments improved at an earlier time.[7]

FUGITIVES AND PRISONERS

SSI Provisions for Fugitives

An individual is ineligible for SSI payments for any month during which he/she is:

- fleeing to avoid prosecution for a crime which is a felony (or in New Jersey, a high misdemeanor) under the laws of the place from which the person flees;
- fleeing to avoid custody or confinement after conviction for a crime which is a felony (or in New Jersey, a high misdemeanor) under the laws of the place from which the person flees; or

[5] Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460.

[6] 20 C.F.R. § 404.1594.

[7] SSA, POMS, DI 12027.005.

- violating a condition of probation or parole imposed under Federal or State law.[8]

SSA revised its application and redetermination forms on October 23, 2000 to ensure that all potential SSI recipients are advised of the effect that fugitive status or parole/probation violations have on eligibility for payments. These new forms solicit specific information from individuals to determine whether fugitive ineligibility applies.

To identify SSI recipients who did not report their outstanding warrants to SSA, the Agency—in partnership with the Office of the Inspector General—entered into agreements with the United States Marshals Service, the National Crime Information Center, the Federal Bureau of Investigations, and over 20 State and local law enforcement agencies to obtain fugitive data.

Old-Age, Survivors, and Disability Insurance Provisions for Fugitives

Fugitive provisions for Old-Age, Survivors, and Disability Insurance (OASDI) beneficiaries were implemented in January 2005. Generally, payment is prohibited for any month in which a beneficiary has an unsatisfied warrant that has been outstanding for more than 30 consecutive days for:

- a crime, or attempted crime, that is a felony or, in jurisdictions that do not classify crimes as felonies, a crime that is punishable by death or imprisonment for more than 1 year (regardless of the actual sentence imposed); or
- violation of a condition of Federal or State probation/parole.[9]

For both SSI and OASDI benefits suspended due to fugitive status, the suspension will end and benefits will resume in the month after the month the warrant has been satisfied. Warrants are satisfied in one of three ways:

(1) the subject is arrested; or

(2) the subject surrenders to law enforcement; or

(3) a judge dismisses, vacates, cancels, or otherwise voids the warrant.

Provisions for Prisoners

SSA is prohibited from making OASDI payments to individuals for any month during which they are confined in a penal institution as a result of being convicted of a criminal offense.[10] In addition, the Agency is prohibited from making monthly SSI payments to individuals for any month throughout which they reside in a public institution, such as a correctional facility.[11] Further, the Act permits Federal, State, or county and local

[8] Social Security Act § 1611(e)(4), 42 U.S.C. § 1382(e)(4).

[9] Social Security Act § 202(x)(1)(A)(iv) and (v), 42 U.S.C. § 402(x)(1)(A).

[10] Social Security Act § 202(x)(1)(A)(i) and (ii), 42 U.S.C. § 402(x)(1)(A)(i) and (ii).

[11] Social Security Act § 1611(e)(1)(A), 42 U.S.C. § 1382(e)(1)(A).

agencies to make available to SSA, upon written request, the name and Social Security number (SSN) of any individual who is confined in a penal institution or a correctional facility.[12]

To determine whether prisoners are receiving OASDI or SSI payments, SSA negotiates computer matching agreements or Memorandums of Understanding with Federal, State, county, and local correctional agencies to obtain prisoner information. Depending upon the individual agreement, the prisoner information is obtained in either a computer-processable format or on paper reports and forwarded to either SSA's field offices or SSA's central office. The information obtained by SSA includes the prisoner's name, SSN, date of birth, gender, and dates and place of confinement.

Prisoner information is matched against SSA's recipient or beneficiary information. As part of the computerized matching process, SSA passes the information through its Enumeration Verification System (EVS). EVS matches each prisoner record to SSA's enumeration records to determine whether the prisoner is using the correct SSN. EVS also tries to find the correct SSN for prisoners when the SSN submitted by the correctional Agency is erroneous, invalid, or missing.

SSA also receives prisoner information on paper from local correctional agencies in accordance with agreements established with those facilities. The information is manually processed by SSA field office staff, who screen the prisoner information received against SSA's records.

The purpose of both manual screening and electronic matching is to identify prisoners receiving benefits. If SSA identifies benefit payments issued under an SSN used by a prisoner, an alert is issued for appropriate SSA staff to verify the beneficiary's identity and determine whether payments should be stopped.

FAILURE TO COOPERATE AND INABILITY TO LOCATE

When SSA and the State DDS conduct a CDR—or if there is a question about whether a beneficiary continues to be eligible for disability benefits, the beneficiary has a responsibility to cooperate with and to take any required action requested by the Agency or DDS to complete the CDR. A beneficiary's failure to cooperate, without good cause, is a basis for the DDS to terminate Title II and/or Title XVI benefits when there is not enough evidence to justify a continuance. A failure to cooperate does not apply if there is enough evidence to make a determination to continue benefits.[13]

[12] Social Security Act §§ 202(x)(3)(B)(i) and 1611(e)(1)(I)(i), 42 U.S.C. §§ 402 and 1382.

[13] SSA, POMS, DI 28075.005C.

Inability to locate is a basis for SSA to find cessation and to terminate Title II benefits. For Title XVI cases, inability to locate is a basis to suspend but not to terminate SSI payments until the recipient is located.[14] Eligibility for SSI payments is automatically terminated after 12 consecutive months of benefit suspension for any reason, beginning with the first month the recipient was no longer eligible for payments.[15]

SSI ELIGIBILITY

Title XVI of the Social Security Act specifies who is eligible to receive SSI benefits, the amount of cash payments, and the conditions under which payments can be made.[16] An individual who applies for SSI and meets the conditions in the law is eligible for benefits.

Generally, the eligibility requirements for SSI are as follows:

- Age 65 or older, blind or disabled; and
- Reside in one of the 50 States, the District of Columbia, or the Northern Mariana Islands (except for a child of military parent(s) assigned to permanent duty anywhere outside the United States or certain students temporarily abroad); and
- Citizen or national of the United States or an alien lawfully admitted for permanent residence in the United States or an alien permanently residing in the United States under color of law; and
- Have income and resources within specified limits; and
- Fugitive provisions (as described previously) do not apply; and
- File an application for SSI benefits.

VOLUNTARY TERMINATION OF SSI PAYMENTS

A SSI recipient, his legal guardian, or his representative payee may terminate his eligibility for benefits by filing a written request for termination, which shows an understanding that such termination may extend to other benefits resulting from eligibility for SSI payments. If a recipient has a representative payee, the Agency must determine that no hardship would result if an eligible recipient were not covered by the SSI program prior to stopping benefits. When such a request is filed, the recipient ceases to be an eligible individual effective with the month following the month the request is filed with SSA unless the recipient specifies some other month. Once SSA stops paying benefits at the request of the recipient, legal guardian or representative payee, eligibility can be reestablished only upon the filing of a new application.[17]

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[14] Id.

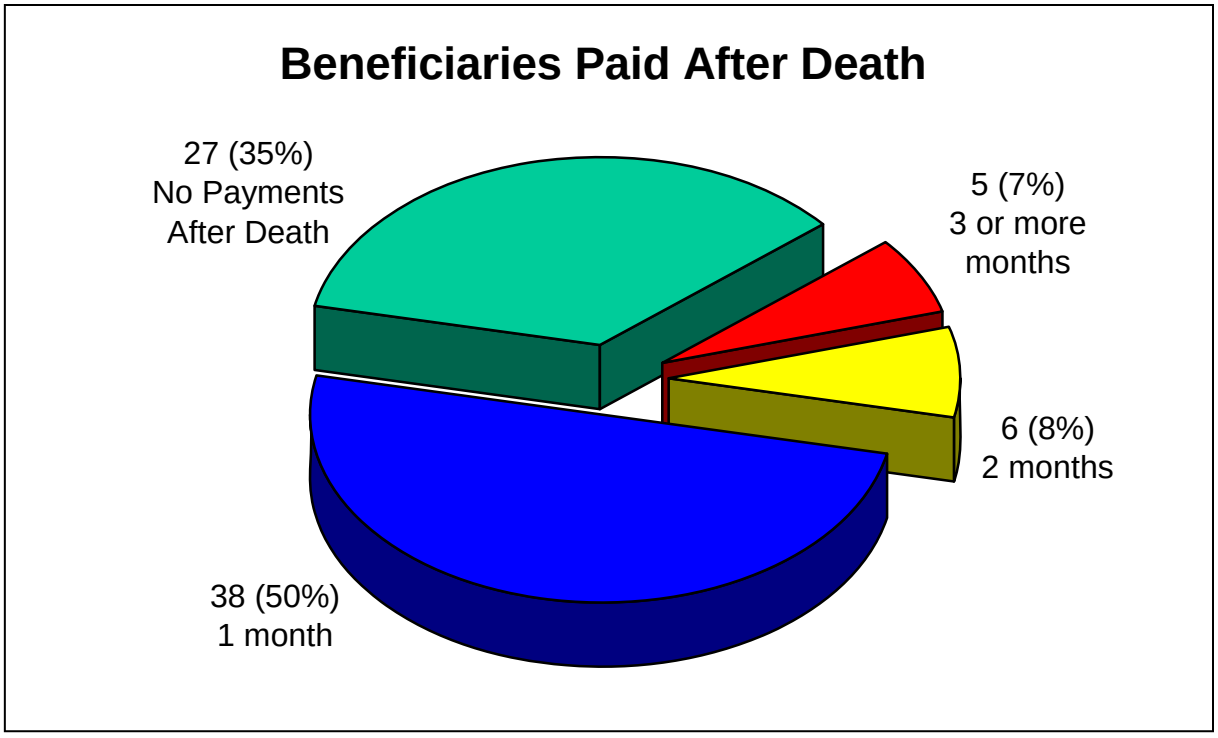
[15] 42 U.S.C. § 1383(j) and 20 C.F.R. § 416.1335.

[16] Social Security Act § 1611(a) – (c), 42 U.S.C. § 1382(a) – (c).

[17] 20 C.F.R. § 416.1333.

PAYMENTS AFTER DEATH

In our sample of 1,532 disabled beneficiaries, 76 died during the period of our review. SSA was notified of these deaths through its normal business processes and stopped payments the same month it received notification. However, for 49 of these deceased beneficiaries, the Agency issued payments for at least one month after death—either due to untimely notification of death or the notification was received too late to stop issuance of the payment. Within our sample, we found that the Agency recovered $50,442 of the $55,924 in funds paid after death (90 percent).



SSA is working with State governments to improve the current paper-based process under an initiative known as *Electronic Death Registration* (EDR). EDR would enable SSA to receive verified death data within 24 hours of receipt in the State Bureau of Vital Statistics and within 5 days of death. EDR would also improve the accuracy of SSA's death master file, which is shared with other Federal agencies.

There are contracts in place for EDR in 15 States and 2 cities (New York City and Washington, D.C.); and by the end of Fiscal Year (FY) 2004 EDR had been implemented in New Hampshire, South Dakota, Minnesota and Montana. SSA will continue the nationwide expansion of EDR by awarding contracts to as many States as funding allows in FYs 2005 and 2006.

SUMMARY OF PRIOR OIG REPORTS

Earnings and Work Activity	
Report	**Date Issued**
Disabled SSI Recipients with Earnings (A-01-04-14085)	April 2005
Disabled Title II Beneficiaries with Earnings Reported on the Master Earnings File (A-01-03-13019)	July 2004
Medical Improvement	
Report	**Date Issued**
Continuing Disability Reviews for SSI Recipients Approved Based on Low Birth Weight (A-01-02-12031)	June 2002
Failure to Cooperate and Inability to Locate	
Report	**Date Issued**
Review of Entitlement Determination Procedures for Unlocated Title II Disabled Beneficiaries (A-06-95-00076)	July 1997
Fugitives	
Report	**Date Issued**
Assessment of the SSI Fugitive Felon Project (A-01-03-23070)	September 2003
Screening Representative Payees for Fugitive Warrants (A-01-02-12032)	March 2003
Identifying Representative Payees Who Had Their Own Benefits Suspended Under the Fugitive Provisions of Pub. L. No.104-193 (A-01-02-12073)	October 2002
OASDI Benefits Paid to Fugitives (A-01-00-10014)	August 2000
Identification of Fugitives Receiving SSI Payments (A-01-98-61013)	August 2000
Prisoners	
Report	**Date Issued**
SSA's Prisoner Incentive Payment Program (A-01-04-24067)	July 2004
Follow-up on Prior OIG Prisoner Audits (A-01-02-12018)	July 2003
Effectiveness of SSA's Procedures to Process Prisoner Information, Suspend Payments and Collect Overpayments (A-01-96-61083)	June 1997
Effectiveness in Obtaining Records to Identify Prisoners (A-01-94-02004)	May 1996

SSI Eligibility	
Report	**Date Issued**
Deeming of Income to Establish Initial Eligibility for SSI Recipients (A-05-99-21005)	September 2001
The Adequacy of the Residency Verification Process for the Supplemental Security Income Program (A-06-96-62001)	May 1997
Review of Asset Transfers for SSI Eligibility (A-09-95-01017)	September 1996
Voluntary Termination	
No Prior OIG Work	
Payments After Death	
Report	**Date Issued**
Follow-up Review of OASDI Benefits Paid to Deceased Auxiliary Beneficiaries (A-01-03-13037)	June 2003
Congressional Response Report: SSA's Efforts to Process Death Reports and Improve its Death Master File (A-09-03-23067)	January 2003
OASDI and SSI Payments to Deceased Beneficiaries and Recipients (A-06-02-12012)	October 2002
Controls Over SSA's Processing of Death Records from the Department of Veterans Affairs (A-01-01-21038)	February 2002
OASDI Benefits Paid to Deceased Auxiliary Beneficiaries (A-01-00-20043)	June 2001
Improving the Usefulness of SSA's Death Master File (A-09-98-61011)	July 2000

Generally, SSA agreed to the recommendations in the reports listed in the table above. Additionally, the Government Accountability Office has conducted some reviews in these areas.

DISTRIBUTION SCHEDULE

Commissioner of Social Security

Office of Management and Budget, Income Maintenance Branch

Chairman and Ranking Member, Committee on Ways and Means

Chief of Staff, Committee on Ways and Means

Chairman and Ranking Minority Member, Subcommittee on Social Security

Majority and Minority Staff Director, Subcommittee on Social Security

Chairman and Ranking Minority Member, Subcommittee on Human Resources

Chairman and Ranking Minority Member, Committee on Budget, House of Representatives

Chairman and Ranking Minority Member, Committee on Government Reform and Oversight

Chairman and Ranking Minority Member, Committee on Governmental Affairs

Chairman and Ranking Minority Member, Committee on Appropriations, House of Representatives

Chairman and Ranking Minority, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, House of Representatives

Chairman and Ranking Minority Member, Committee on Appropriations, U.S. Senate

Chairman and Ranking Minority Member, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, U.S. Senate

Chairman and Ranking Minority Member, Committee on Finance

Chairman and Ranking Minority Member, Subcommittee on Social Security and Family Policy

Chairman and Ranking Minority Member, Senate Special Committee on Aging

Social Security Advisory Board

Overview of the Office of the Inspector General

The Office of the Inspector General (OIG) is comprised of our Office of Investigations (OI), Office of Audit (OA), Office of the Chief Counsel to the Inspector General (OCCIG), and Office of Resource Management (ORM). To ensure compliance with policies and procedures, internal controls, and professional standards, we also have a comprehensive Professional Responsibility and Quality Assurance program.

Office of Audit

OA conducts and/or supervises financial and performance audits of the Social Security Administration's (SSA) programs and operations and makes recommendations to ensure program objectives are achieved effectively and efficiently. Financial audits assess whether SSA's financial statements fairly present SSA's financial position, results of operations, and cash flow. Performance audits review the economy, efficiency, and effectiveness of SSA's programs and operations. OA also conducts short-term management and program evaluations and projects on issues of concern to SSA, Congress, and the general public.

Office of Investigations

OI conducts and coordinates investigative activity related to fraud, waste, abuse, and mismanagement in SSA programs and operations. This includes wrongdoing by applicants, beneficiaries, contractors, third parties, or SSA employees performing their official duties. This office serves as OIG liaison to the Department of Justice on all matters relating to the investigations of SSA programs and personnel. OI also conducts joint investigations with other Federal, State, and local law enforcement agencies.

Office of the Chief Counsel to the Inspector General

OCCIG provides independent legal advice and counsel to the IG on various matters, including statutes, regulations, legislation, and policy directives. OCCIG also advises the IG on investigative procedures and techniques, as well as on legal implications and conclusions to be drawn from audit and investigative material. Finally, OCCIG administers the Civil Monetary Penalty program.

Office of Resource Management

ORM supports OIG by providing information resource management and systems security. ORM also coordinates OIG's budget, procurement, telecommunications, facilities, and human resources. In addition, ORM is the focal point for OIG's strategic planning function and the development and implementation of performance measures required by the Government Performance and Results Act of 1993.

Appendix B

Statement for the Record of Beatrice Disman,
Regional Commissioner for New York Region
Social Security Administration
before the House Committee on Ways and Means
Subcommittee on Social Security
September 19, 2013

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee:

Thank you for this opportunity to discuss our stewardship of the disability program.

My name is Bea Disman, and I am the Regional Commissioner of the Social Security Administration's New York Region. In this role, I have direct authority over the agency's operations in New York, New Jersey, Puerto Rico, and the United States Virgin Islands. This area encompasses an annual administrative budget of approximately $400 million for approximately 3,900 employees in 117 field offices and card centers, 4 teleservice centers, the Northeastern Program Service Center, and the New York Regional Office. More than 7 million beneficiaries receive over $88 billion in Social Security and Supplemental Security Income (SSI) benefits in the New York Region each year.

Like you, I am outraged whenever anyone attempts to defraud the disability program. I am especially chagrined that a former Social Security employee, acting as a non-attorney claimant representative, was an integral part of the complex conspiracy uncovered in Puerto Rico. This individual betrayed his former colleagues by violating the public trust. We applaud the recent news that law enforcement officials indicted the former employee, several physicians, and approximately 70 disability claimants for allegedly defrauding the disability program. While the Federal Grand Jury investigation is active and ongoing, evidence suggests that the involved parties conspired to submit evidence of fabricated or exaggerated medical conditions in order to fraudulently receive benefits.

This criminal behavior is unconscionable. Many deserving people with severe disabilities depend on their hard-earned Social Security benefits for life's necessities. This is especially true in Puerto Rico, where the inability to work due to severe disability is further exacerbated by high poverty and lower overall education levels. All members of the public rightfully expect that taxpayer dollars go towards paying benefits to only the right people in the right amount and at the right time. We understand and take this obligation seriously.

Mindful of our stewardship responsibility, we continuously work with our partners in the Office of the Inspector General (OIG) to root out fraud wherever we suspect it. This has been especially true during this long and complex investigation.

Key to our efforts is the robust fraud detection and referral process we have in place to identify, investigate, and prosecute fraud to the fullest extent of the law. All of our employees receive annual fraud awareness reminders, as well as training on fraud detection and prevention. There is an established process to forward fraud allegations to the OIG, which is responsible for fraud investigations and recommending cases to the United States Attorney's Office for possible prosecution.

In the recent case in Puerto Rico, it was the diligent employees of the Puerto Rico Disability Determination Services (DDS)—funded and trained by Social Security to make medical determinations—who first identified the criminal actions of the doctors. The DDS employees

suspected fraudulent medical evidence was being submitted and referred the fraud allegation to us in March 2009 during an onsite visit of my staff and quality reviewers. After the identification and analysis of a number of cases from the referred medical provider, we referred the fraud allegation along with information about the non-attorney representative to the OIG in November 2009. During that period, my staff also reviewed other cases from medical providers identified from other sources in Puerto Rico.

In addition to referring the case to the OIG, we took aggressive steps to identify any additional cases and develop a process for reviewing the cases. These steps ensured that we could reliably handle any high-volume case review that might result from the investigation. While our quality data had shown the Puerto Rico DDS performing similarly to very high regional and national averages, we needed to verify the data and isolate the fraud. We brought Federal resources to bear in Puerto Rico to assist in the investigation, monitor the DDS's operations, and help decide cases. We also redirected and trained staff on medical issues from our Puerto Rico field offices and our Northeastern Program Service Center in New York City. These additional staff resources were focused on Puerto Rico cases, including those involved in the investigation. In addition, we authorized the New Jersey DDS to hire bilingual disability examiners to assist with Puerto Rico cases. Other DDSs—both inside and outside the New York Region—provided workload assistance to the Puerto Rico DDS, which added more outside eyes to the cases being filed in Puerto Rico. Finally, a sustained, multi-year, cross-training effort, as well as additional quality studies, further bolstered our work with the Puerto Rico DDS and ensured that quality remained strong and the fraud identified.

Without question, our anti-fraud activities in Puerto Rico have worked. Those who committed fraud are being brought to justice, and we have suspended over $130,000 in monthly benefit payments for the month of August for the approximately 70 individuals that were indicted. We will review approximately 6,600 disability applications (out of the 185,000 in total current workers with approved disability applications in Puerto Rico) in which we awarded benefits based, in part, on medical evidence supplied by the involved doctors. In re-determining these cases, we will disregard the tainted medical evidence. If the remaining evidence does not support our original allowance, we will suspend the benefits, providing the opportunity to submit additional medical evidence prior to making a final determination. Beneficiaries will receive notification if we terminate their benefits and assess an overpayment. These reviews will occur outside Puerto Rico in New York City and New Jersey.

With the establishment of a Puerto Rico Cooperative Disability Investigations (CDI) unit this fiscal year (FY), which I will describe in greater detail later in my testimony, we have another tool in place to prevent the problems identified in Puerto Rico.

Looking ahead, we know that it is critical that Congress fully fund our cost-saving program integrity activities, while ensuring that we have the resources to serve the deserving disability applicants who turn to us for help. Investigations like the one in Puerto Rico are time-consuming and labor-intensive. It has required close coordination between Social Security, the Puerto Rico DDS, and multiple layers of law enforcement, including the OIG, the Federal Bureau of Investigation, the Puerto Rico Police Department, and the United States Attorney's Office.

Regrettably, over the past 2 years, Congress has appropriated $421 million less for program integrity reviews than what it authorized for us in the Budget Control Act of 2011 (BCA). Over the past 3 years, we received an average of nearly a billion dollars less than what the President requested for our administrative budget. The net effect has been the loss of more than 11,000 employees at Social Security—that means drastically fewer people standing watch for the next attempted theft and drastically fewer people available to serve those who truly need us.

Aggressive Management Response in Puerto Rico

Sharing management information and best practices across Federal-State boundaries is integral to the public service we provide at Social Security. In Puerto Rico—a territory that accounts for less than 1 percent of our agency's disability benefit applications nationwide—a collaborative relationship with the New York Regional Office was the basis for uncovering the fraud conspiracy in March 2009.

At that time, staff from the New York Regional Office visited the Puerto Rico DDS to review the prior year's quality findings and discuss medical policy issues. Over the course of the visit, the Puerto Rico DDS medical consultants raised concerns regarding boilerplate medical evidence that was being submitted by a particular treating source. The New York Regional Office staff developed the evidence further and referred the case to the OIG. Thereafter, fraud referrals continued to be made by the Puerto Rico DDS and other components assisting in processing disability applications for Puerto Rico.

Key to generating the fraud leads, as well as interpreting many of the cases that the OIG investigated, were the Federal and State personnel

that we either redirected or hired to scrutinize cases from Puerto Rico. Currently, we have dedicated 48 employees, located outside Puerto Rico, to do this work. They support the 64 disability examiners in the Puerto Rico DDS who make disability determinations.

We have 14 Federal employees from Puerto Rico offices adjudicating disability cases, monitoring trends, and referring information to the OIG investigation as appropriate. These employees also assist the Puerto Rico CDI unit by answering calls to the special fraud hotline that we established in Puerto Rico.

An additional 20 Federal bilingual employees will work in the Northeastern Program Service Center in New York City. They are trained disability examiners who work exclusively on disability cases from Puerto Rico, including cases related to the fraud investigation.

We then allocated another 14 hires to the New Jersey DDS to work exclusively on Puerto Rico cases, including cases related to the fraud investigation. These employees are also bilingual and trained disability examiners.

In addition, other Social Security Regional Offices and DDSs outside the New York Region have helped process Puerto Rico cases over the past several years. These Federal and State personnel are not a dedicated resource, but they have been available, as needed, to assist the Puerto Rico DDS with its case backlogs. For example, at this time, we have 9 Federal disability examiners in Dallas assisting the Puerto Rico DDS.

Through our efforts deploying outside assistance to the Puerto Rico DDS, we continue to validate the overall quality of the decisions being made in Puerto Rico, even while identifying areas for additional training and business process improvement. Importantly, at this point in time, we have seen no evidence that any current Federal or Puerto Rico DDS employee is involved in the fraud conspiracy.

We work with the Puerto Rico DDS on areas for improvement through hands-on training. In the area of quality, we helped the Puerto Rico DDS improve its disability case documentation. We sent a team of program experts from the New York Regional Office and Social Security Headquarters to Puerto Rico. They trained both DDS and hearing office employees on case development, medical policy, evidence assessments, and questionable medical assessments. The Puerto Rico DDS was also among the first places in the New York Region to implement the Electronic Claims Analysis Tool, or eCAT. This web-based tool helps disability examiners apply policies correctly throughout the disability decision-making process and provides a source of national programmatic management information on DDS determinations. We are examining eCAT information as confirmed by other management information sources and case reviews to identify programmatic trends at the DDS level.

We have also identified areas, unrelated to quality improvement and identifying fraud, for which we believe business process improvements could better help the Puerto Rico DDS manage its workloads. For example, when we noticed that the Puerto Rico DDS was not maximizing its technology system to better manage its backlogs, we arranged for Puerto Rico DDS officials to visit the Florida DDS, which used the same system, and to receive training.

In addition, a number of years ago we discovered that the parent agency of the Puerto Rico DDS and the Puerto Rico Department of Treasury were not making timely payments to medical providers. These providers were threatening to stop sending medical evidence or conduct consultative examinations needed for disability determinations. We developed a plan to pay these bills directly and this plan, with some modifications, has been ongoing for 7 years.

Along with the substantial assistance and training provided the Puerto Rico DDS, we have also relied upon our quality reviewers to take an independent look at specific data in Puerto Rico. They have identified areas for further study and management improvement in Puerto Rico; however, their data reflect our general experience on the ground that the quality of the decision-making is high. We continue to work with the Puerto Rico DDS to identify opportunities for further improvement and remain vigilant. Notwithstanding the complexity of the criminal conspiracy that we helped bring to light, we see no evidence of a systemic failure in the Puerto Rico DDS at this time.

Anti-Fraud Initiatives across the Country

Because the investigation in Puerto Rico is ongoing, I cannot discuss any more specifics of the case today. However, I will highlight for you the multiple anti-fraud activities we have in place across the country.

All of these activities stem from a strong agency culture of fraud detection and deterrence, and they are ingrained in our organization. For example, all 10 Social Security Regional Offices—including the New York Regional Office—have an anti-fraud committee co-chaired by the

Regional Commissioner and OIG Special Agent-in-Charge. These committees meet on a quarterly basis to discuss fraud cases and trends, as well as ideas for possible anti-fraud projects. All regions also have a "Think Twice First" monthly bulletin, in which employees learn about fraud awareness and reporting, among other topics. Each year, our offices conduct fraud referral training, and the agency publicizes how to report fraud, waste, or abuse on its homepage, www.ssa.gov.

Of course, our most important resource and first line of defense when it comes to fighting fraud are our dedicated employees across the country. They are highly trained professionals in the administration of the disability program, and they are both the best qualified and in the best position to identify and refer fraud. We support their efforts with a series of anti-fraud initiatives that target the investigation and prosecution of fraud.

As mentioned earlier, an important fraud investigation tool that we have in place are CDI units. CDI units investigate individual disability applications and beneficiaries to identify attorneys, doctors, translators, and other third parties, including non-attorney representatives, who facilitate disability fraud. The results of these investigations may be presented to Federal and State prosecutors for criminal or civil prosecution, as well as to the Office of the Counsel in the OIG for the imposition of civil monetary penalties. We may also impose sanctions on claimant representatives for violating agency ethical standards.

There are currently 25 CDI units operating throughout the United States with the most recent one established in Puerto Rico. According to the OIG, since the program's inception in FY 1998 through FY 2012, CDI efforts nationwide have resulted in $2.2 billion in projected savings to our disability programs and over $1.4 billion in projected savings to non-Social Security programs, such as Medicare and Medicaid. These savings are the result of CDI units opening about 40,000 cases and developing evidence to support about 30,000 actions, resulting in a denial, suspension, or termination of benefits.

We also continue to develop new initiatives to combat the kind of fraud uncovered in Puerto Rico. For example, according to the OIG, a new and very promising anti-fraud initiative just began as a pilot on July 1, 2013, and focuses on third-party facilitators, including medical providers and claimant representatives. The pilot combines the resources of the OIG with our hearings operation. Together, these investigators are looking at ways to mine our data to identify areas of suspicious behavior. If the pilot proves successful, it is anticipated that it would expand in FY 2015.

Simultaneously, we continue to ramp up our program integrity reviews, as well as our quality assurance activities, which can help us to detect fraud and remediate its effects. Through our efforts, we have achieved a very low incidence of fraud in our disability programs. In fact, in FY 2012, we made over 26,000 fraud referrals to the OIG nationwide, from which the OIG opened about 5,300 cases and referred 236 to the United States Attorney's Office for criminal prosecution. That same year, in Puerto Rico, we made 254 fraud referrals to the OIG, from which the OIG opened 3 cases and referred none to the United States Attorney's Office.**1** Overall, in FY 2012, nearly 3.2 million people applied for disability under our disability programs, and about 15 million people received benefits.

Increasing Program Integrity Reviews and Decisional Quality

We are committed to protecting program dollars from waste, fraud, and abuse. The recent arrests in Puerto Rico demonstrate how seriously we take our responsibility to maintain the public's trust by effective stewardship of program dollars and administrative resources. While we recognize that not all improper payments result from fraud, we work diligently to correct them and pursue them wherever they may lead.

An important part of our program integrity activities are periodic medical re-evaluations, called continuing disability reviews (CDR), which we use to determine if beneficiaries are still disabled.

The FY 2014 President's Budget includes a special legislative proposal that would provide a dependable source of mandatory funding to significantly ramp up our program integrity work. These mandatory funds would replace the discretionary cap adjustments authorized by the BCA. These funds would be reflected in a new account, the Program Integrity Administrative Expenses account, which would be separate, and in addition to, our Limitation on Administrative Expenses account. If approved, the funds would be available for 2 years, providing us with the flexibility to aggressively hire and train staff to support the processing of more program integrity work.

Over the past several years, the annual appropriations process has not provided us with the resources necessary to conduct all of our scheduled CDRs. We estimate that each dollar spent on CDRs would save the Federal Government $9,**2** yet we have a backlog of 1.3 million CDRs.

In FY 2014, the proposal would provide $1.227 billion, allowing us to handle significantly more CDRs. With this increased level of funding, the associated volume of medical CDRs is 1.047 million, although it may take us some time to reach that level. For comparison, we conducted 443,000 CDRs in FY 2012. With your support, we could do much more.

In addition to program integrity reviews, strict adherence to our program rules improves our adjudicators' ability to identify fraud and reduces the potential for an improper payment. Accordingly, we have performance standards and multiple layers of quality review to ensure uniform and correct application of our program rules. In FY 2014, we will be establishing a new review process at the field office level. It is called the Continuous Quality Area Director Reviews Process. One of the areas reviewed will be front-end disability accuracy in field offices.

Having a scrupulous quality assurance (QA) operation is critical to ensuring programmatic compliance. We require all of the DDSs to have an internal QA function. In addition, our Office of Quality Performance (OQP) conducts QA reviews of samples of the initial, reconsideration, and CDR determinations of the DDSs. Between FY 2008 and FY 2012, OQP reviews showed that the DDSs improved their accuracy across the board. The DDSs increased their initial claims decisional accuracy from approximately 94.4 percent to 96.4 percent. They increased their reconsideration decisional accuracy from approximately 92.1 percent to 95.1 percent. Moreover, they increased their CDR decisional accuracy from approximately 96.8 percent to 97.9 percent.**3** For the same timeframe, the Puerto Rico DDS followed similar patterns. Initial decisional accuracy improved from approximately 92.7 percent to 98.1 percent. Reconsideration decisional accuracy increased from approximately 93.1 percent to 97.0 percent. Finally, CDR decisional accuracy increased from approximately 97.7 percent to 99.8 percent.

As required by the Social Security Act (Act), we also perform a pre-effectuation review of at least 50 percent of all DDS initial and reconsideration allowances for Social Security and SSI disability for adults. We likewise review a sufficient number of DDS CDR determinations that continue benefits. These pre-effectuation reviews, which are separate from the OQP reviews mentioned above, allow us to correct errors we find before we issue a final decision. The quality of the Puerto Rico DDS in these reviews is better than the national average. These reviews result in an estimated $751 million in lifetime program savings, including savings accruing to Medicare and Medicaid. Based on our most recent data, the return on investment is roughly $13 for every $1 of the total cost of the reviews.**4**

To improve the consistency and quality of DDS decisions, we established the Request for Program Consultation (RPC) process. The RPC process allows DDSs and our quality reviewers to resolve differences of opinion they have on cases that OQP has cited as deficient. In general, DDSs use the process to resolve the most complex cases. Our policy experts in headquarters thoroughly review these cases. We post all RPC resolutions and related data on our intranet site, accessible to every disability examiner, medical consultant, and QA and supervisory staff. The process serves several key functions. It provides real-life examples of proper policy application, identifies issues and areas for improved disability policy, and provides our Regional Offices and DDSs information to assess local quality issues. Since 2007, we have reviewed about 5,000 cases and posted their resolutions online. Further, the RPC team has worked directly with policy components to develop policy clarifications, training, and other resources that can further improve the consistency and quality of disability determinations at all adjudicative levels.

Conclusion

The criminal conduct that we first uncovered in Puerto Rico in 2009 was appalling. Working with the OIG, we are dismantling a complex conspiracy to defraud the Social Security disability program.

Key to our efforts was the robust fraud detection and referral process that we put in place to identify, investigate, and prosecute fraud to the fullest extent of the law. The process worked in Puerto Rico, and it continues to work nationwide.

We have already begun to take remedial action in Puerto Rico by reviewing the cases with tainted medical evidence, establishing a CDI unit, and vigorously pursuing additional anti-fraud activities both in the territory and nationwide. These efforts, combined with our other program integrity and QA activities, help minimize fraud in the disability program and support highly accurate decisions.

It is incumbent upon Congress to meet its responsibility to the taxpayer by adequately funding both our stewardship and service efforts so that only those who truly need us receive the help they deserve. We need your support to keep the disability program strong.

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1 Puerto Rico referrals exclude those made by components outside Puerto Rico providing assistance in determining disability cases.

2 Details can be found in the FY 2010 "Annual Report of Continuing Disability Reviews" at http://www.socialsecurity.gov/legislation/FY%202010%20CDR%20Report.pdf.

3 The percent is based upon a statistically valid sample of cases OQP reviews. It reflects the percent of cases reviewed where OQP agrees with the decision made by the DDS.

4 Details can be found in the "Annual Report on Social Security Pre-effectuation Reviews of Favorable State Disability Determinations" at http://ssa.gov/legislation/PER%20fy11.pdf.

Region		Location	State	Start	OIG's Personnel Costs – FY13	SSA's Program Costs – FY13	SSA's Personnel Costs – FY13	Total CDI Program Costs – FY13
Boston	1	Boston	Massachusetts	2001	$178,208	$360,362	$110,312	$648,882
New York	2	San Juan	Puerto Rico	2013	$178,208	$163,814	$220,624	$562,646
	3	New York	New York	1998	$178,208	$829,850	$110,312	$1,118,370
Philadelphia	4	Richmond	Virginia	2002	$178,208	$246,678	$110,312	$535,198
Atlanta	5	Atlanta	Georgia	1998	$178,208	$277,477	$220,624	$676,309
	6	Nashville	Tennessee	2001	$178,208	$245,248	$110,312	$533,768
	7	Columbia	South Carolina	2009	$178,208	$326,327	$220,624	$725,159
	8	Tampa	Florida	1999	$178,208	$392,943	$110,312	$681,463
	9	Lexington	Kentucky	2011	$178,208	$363,297	$110,312	$651,817
	10	Jackson	Mississippi	2011	$178,208	$466,242	$110,312	$754,762
Chicago	11	Chicago	Illinois	1998	$178,208	$628,889	$110,312	$917,409
	12	Cleveland	Ohio	2002	$178,208	$968,477	$110,312	$1,256,997
Dallas	13	Baton Rouge	Louisiana	1998	$178,208	$453,602	$110,312	$742,122
	14	Dallas	Texas	2002	$178,208	$485,751	$110,312	$774,271
	15	Houston	Texas	2000	$178,208	$561,751	$110,312	$850,271
	16	Oklahoma City	Oklahoma	2011	$178,208	$359,482	$110,312	$648,002
Kansas City	17	Kansas City	Missouri	2009	$178,208	$523,732	$110,312	$812,252
	18	St. Louis	Missouri	1999	$178,208	$542,799	$110,312	$831,319
Denver	19	Denver	Colorado	2004	$178,208	$494,616	$110,312	$783,136
	20	Salt Lake City	Utah	2011	$178,208	$332,704	$110,312	$621,224
San Francisco	21	Los Angeles	California	2005	$178,208	$955,558	$330,936	$1,464,702
	22	Oakland	California	1998	$178,208	$600,198	$220,624	$999,030
	23	Phoenix	Arizona	2000	$178,208	$265,090	$110,312	$553,610
Seattle	24	Salem	Oregon	1999	$178,208	$900,582	$110,312	$1,189,102
	25	Seattle	Washington	2002	$178,208	$1,117,890	$110,312	$1,406,410
Total					$4,455,200	$12,863,359	$3,419,672	**$20,738,231**

Appendix D

Social Security Testimony Before Congress

Statement of Debra Bice,
Cheif Administrative Law Judge
Social Security Administration
before the Senate Committee on Homeland Security and Government Affairs

October 7, 2013

Chairman Carper, Ranking Member Coburn, and Members of the Committee:

Thank you for this opportunity to discuss our hearings process. As Chief Administrative Law Judge (ALJ) for the Socia l Security Administration (SSA), I am responsible for overseeing the hearings operation in the Office of Disability Adjudication and Review (ODAR), including approximately 1,500 ALJs. I appreciate this opportunity to discuss our hearings process, which is now responsible for adjudicating over 800,000 cases per year, and the improvements we have made over the past decade.

I also thank the Committee for including recommendations in your recent report on the Huntington hearing office aimed at further improving the hearing process. SSA' s responses to the recommendations are attached to this testimony.

Before discussing our hearings process, I will briefly discuss the vital programs that we administer.

Introduction

We administer the Old-Age, Survivors, and Disability Insurance program, commonly referred to as "Social Security," which protects against loss of earnings due to retirement, death, and disability. Social Security provides a financial safety net for millions of Americans-few programs touch as many Americans. We also administer the Supplemental Security Income (SSI) program, funded by general revenues, which provides cash assistance to persons who are aged, blind, and disabled, as defined in the Social Security Act, with very limited means.

We also handle lesser-known, but critical services that bring millions of people to our field offices or prompt them to call us each year. For example, we issue replacement Medicare cards and help administer the Medicare low-income subsidy program.

Accordingly, the responsibilities with which we have been entrusted are vast in scope. To illustrate, in fiscal year (FY) 2012, we:

- Handled over 56 million transactions on our National 800 Number Network;
- Received over 65 million calls to field offices nationwide;
- Served about 45 million visitors in over 1,200 field offices nationwide;
- Completed over 8 million claims for benefits and 820,000 hearing dispositions;
- Paid over $800 billion to almost 65 million beneficiaries;
- Handled almost 25 million changes to beneficiary records;
- Issued about 17 million new and replacement Social Security cards;
- Posted over 245 million wage reports;

- Handled over 15,000 disability cases in Federal District Courts;
- Completed over 443,000 full medical continuing disability reviews (CDR); and
- Completed over 2.6 million non-medical redeterminations of SSI eligibility.

When the American people tum to us for any of these vital services, they expect us to deliver a quality product. We take pride in delivering caring, effective service. The aging of the baby boomers, the economic downturns, additional workloads like the growing demand for verifications for other programs, and tight budgets increase our challenges to delivering quality public service.

Program Integrity Work

Further, while outside my direct scope as Chief ALJ, as Acting Commissioner Carolyn Colvin has explained, budgets also have affected our ability to conduct vital program integrity work. which helps ensure that only those persons eligible for benefits continue to receive them. It has been our agency's long standing commitment to issue the right decision to the right person at the right time. By focusing on this commitment, we demonstrate our stewardship and preserve the public's trust in our programs. Although we estimate that we save the Federal government $9 per dollar spent on continuing disability reviews (CDRs), we have a backlog of 1.3 million CDRs because we have not received annual appropriations that would allow us to conduct all of our scheduled CDRs.

The FY 2014 President's Budget includes a legislative proposal that would provide a dependable source ofmandatocy funding to significantly ramp up our program integrity work.**1** In FY 2014, the proposal would provide $1.227 billion, allowing us to process hundreds of thousands more CDRs.**2**

Appreciation for the Committee's Efforts

Many people with severe disabilities depend on their hard-earned Social Security benefits for life's necessities. While rare, schemes that undermine the public trust in these vital programs can hurt us all. Any attempt to compromise the disability programs is unconscionable. We want to be clear on this point. We continue to analyze and explore all possible avenues regarding the issues identified by and through the work of this Committee, the other examining organizations, and our employees.

We appreciate the Committee's interest and efforts in helping us to further improve our programs and processes through its investigation and report on the former situation in our Huntington hearing office. Hearings like this one bring to light shared concerns and help identify effective solutions. Since the beginning of this Committee's investigation, the agency has cooperated fully. We welcomed staff members in our offices and made dozens of employees available for interviews. When the Committee sought documents, the agency worked quickly to provide the Committee with hundreds of thousands of electronic and paper documents.

We also appreciate that the Committee's efforts have led to a positive development. With the benefit of the Committee's work, we now have reliable evidence that certain cases contained pre-completed forms without an independent review of findings, which is sufficient to show 'similar fault' under the Social Security Act**3**. Based on this new evidence, we can redetermine these cases consistent with the requirements of the Social Security Act. The agency will review the affected cases and disregard the tainted medical evidence. If the remaining evidence does not support the original allowance, we will provide the beneficiary the opportunity to submit additional medical evidence before making a final determination. Beneficiaries will receive notification if we ultimately terminate their benefits and assess an overpayment. We are in the process of identifying and reviewing those cases and will be glad to update this Committee on our redeterminations as we progress with our reviews. While we welcome any opportunity to continue our conversation about SSA's hearings operation, we hope the Committee understands that the agency is limited in sharing certain information in a public forum. As you know, the Committee's investigation is not the only investigation of the Huntington hearing office. The Department of Justice and our Office of the Inspector General (OIG) also have conducted investigations - with which we are cooperating fully and these investigations remain open. Until they are completed, we are not able to take certain actions. While we do not condone inappropriate behavior, we must protect the integrity of the ongoing investigations and adhere to the requirements of the law.

Significant Action Following The Investigation

I want to emphasize that when the issues in the Huntington office emerged, we took significant management action to improve our hearings process to help detect and prevent future abuses. We immediately closed loopholes, strengthened our business processes, and enhanced internal controls. We implemented measures to ensure that the employees of the Huntington office complied with long-standing agency

policies. Where we received clearance that our actions would not affect the ongoing investigations, we also commenced our own internal administrative investigations on several related matters.

We strengthened the agency's policy for management officials to assign cases to ALJs in rotation. Since 2006, our policy is, to the extent practicable, to assign cases on a first-in and first-out basis. We learned that there was a technical loophole in our electronic case management system that allowed an individual to assign cases to himself in violation of agency policy. Our system now prevents this practice. We also issued a series of national reminders about the importance of adhering to long-standing policies, including case assignment and case rotation.

In addition, we established a national policy capping the total number of cases assigned to an ALJ in a given year. In July 2011, we set the cap at no more than 1,200 case assignments per year. In November 2012, we reduced that number to 960 case assignunents per year. Effective October 1, 2013, we reduced that cap to 840 case assignments per year.

We also went "back to basics" to refresh managers on rules about time and attendance, and leave. We held calls with all Regional Chief ALJs and managers to reinforce the importance of leave rules and to discuss how to handle situations involving employees with low leave balances. In fact, we required all managers nationwide to take leave management training.

We launched a campaign for all of our hearing office employees and managers entitled "if you see something, say something," encouraging any employee who believes that he or she has witnessed something inappropriate to report it immediately to the OIG. We also told our managers that they need to take appropriate action when employees raise concerns. In addition, we augmented our existing ethics training for all agency judges.

Comprehensive Improvements in the National Hearings Process

While we took these specific actions to address some of the alleged issues, we must emphasize that over the last ten years we have proactively implemented numerous changes to comprehensively improve our national hearings process. We have made a huge investment in modernizing the hearings process - not an easy undertaking given the size of our adjudicatory system that must decide hundreds of thousands of cases each year.**4** We have fully implemented one of the largest electronic processing and record keeping systems in the world, which moved us from a largely paper-based process to an electronic one that provides additional efficiencies and management tools. This electronic infrastructure has helped us to conduct over 150,000 video hearings annually and to ensure nationwide consistency with uniform electronic business processes for our hearings operation. The Administrative Conference of the United States (ACUS) has cited SSA's video hearings process as a best practice for all Federal agencies.

Our electronic systems allow us to monitor the flow ofwork through the hearings operation. Previously, we did not have the robust management information that we have today. While we continue to improve our electronic capabilities, the management information we have today has allowed us to significantly strengthen and improve the integrity and efficiency of our business processes. For example, within the last few years, we have been able to collect data on many aspects of our appeals process that we now analyze to ensure that employee training and policy clarifications are data-driven. Data also help us to identify anomalies.

Our move to electronic processing and record keeping systems have helped us tremendously in addressing one of the greatest challenges facing the agency over the past decade - a massive case backlog. In 2007, there was widespread discontent with backlogs and delays in the disability system. The numbers tell the story. The average wait for a person to receive a hearing decision was over 500 days. Over 63,000 people waited over 1,000 days for a hearing. Some people waited as long as 1,400 days. Congress agreed that these timeframes were unconscionable and made it clear that reducing them should be our top priority.

We decided that we could not take the easy road of short-term fixes on backlogs. We implemented a comprehensive operational plan, initially designed by former Chief ALJ Frank Cristaudo and containing over 30 initiatives, to manage our unprecedented workload. This plan addressed the many issues we must balance in the hearing process quality, accountability, and timeliness. It included increasing the number of ALJs and support staff, increasing the number of hearing offices, establishing national hearing centers, expanding video conferencing to conduct hearings, improving information technology, standardizing business processes, and implementing quality initiatives. In moving forward with this plan, we relied significantly on the support of Congress. In fiscal years 2008 through 2010, Congress provided additional resources, which were critical to support our improvements. Those resources also allowed us to develop the quality program discussed below.

Our efforts were successful. With more employees and judges to decide cases and improved workload management that included wider use of video hearings, we reduced average processing time from an all-time high of 532 days in August 2008, to a low of 340 days in October 2011. Since 2007, we have reduced our national case processing times by approximately 30 percent. We have decided nearly a million of the cases that had been waiting the longest for a decision since FY 2007, and today, we have virtually no hearing requests over 700 days old, with the vast majority of our cases falling between 100 to 400 days old.

However, we must caution that these gains may prove temporary. Because of cutbacks in the budget, the average processing time from the request for hearing date has started trending upwards and is currently at 382 days. Further, due to reduced budgets, we may not be able to perform as many quality reviews or to initiate new quality initiatives. In short, without adequate funding, our gains may soon diminish.

Ensuring High Quality, and Policy Compliant Decisions

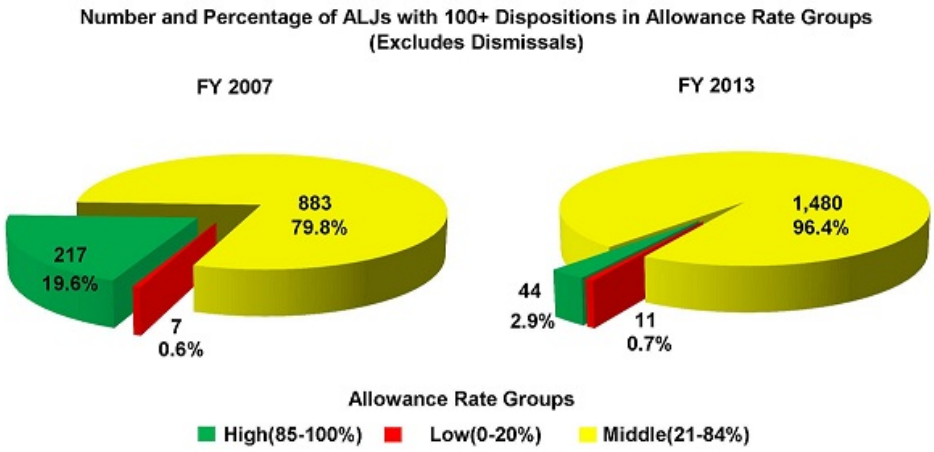
Part of our effort to improve the hearings process has focused on quality. Given its vital importance to agency leadership, I will describe in greater detail the steps we have taken. However, before describing our improvements in this crucial area, I first must address an issue that has historically affected the public's perception of our decisional quality. Over the past several decades, we have been accused of sacrificing quality by reflexively denying too many disability claims or by granting them too readily. For instance, in 2007, there were prominent stories in the media about the agency's "culture of denial." Recently, the pendulum has appeared to swing to allegations that our ALJs are approving too many cases. However, these more recent allegations omit a key fact-the allowance rate at the hearing level has declined over the last several years.

Regardless of the recent trend of lower allowance rates, our efforts to improve the hearings operation - and its quality - are not about whether we allow or deny "too many" cases. There is no predetermined or ideal allowance rate. Our focus is on improving the policy compliance of ALJ decisions across the Nation to ensure that individuals who qualify for benefits receive them, and that those who do not qualify do not receive benefits. This particular focus on quality over the past six years has helped to ensure that the right decision is made on a claim for benefits whether it is an allowance or a denial.**5** See Figure 1.

The data show that quality is improving. This improvement is not happenstance, but the result of several changes from the way we hire, to the way we train, to the way we give feedback. For denial decisions, we have seen ever-increasing concordance between ALJ decisions and the Appeals Council. We now have increasing amounts of data to detect areas of policy non-compliance on both denials and allowances, and we are using that data to provide better feedback to adjudicators to improve policy compliance.

This improved quality means that the Appeals Council is remanding fewer cases to our ALJs for possible corrective action. The percentage of cases appealed to Federal court is also decreasing. These improvements are not possible without the commitment to quality from our employees. I hope that you and the American public do not allow the bad actions of a few to sully the proven good work of the many.

Figure 1



Another aspect of our operational plan to improve quality has been to leverage the unique vantage point that the Office of Appellate Operations (OAO), under the leadership of Judge Patricia Jonas, has at the final level of administrative review. The Appeals Council (AC) within the OAO has regulatory authority to, on its own motion, review cases before a decision is effectuated (paid). For many years, limited resources, rising backlogs, the inability to provide timely feedback, and concerns about how extensively the AC, on its initiative, could review ALJ decisions**6** caused the AC to focus solely on reviewing ALJ denial decisions appealed by claimants and its Federal court workload responsibilities.

In recent years, the AC developed better electronic case processing systems with robust management information, which has permitted the AC also to focus on giving timely feedback to adjudicators. Initially, the data were limited to case information on claimants' request for review of unfavorable or partially favorable ALJ decisions. However, without data from favorable decisions, we had an incomplete picture of the extent to which adjudicators complied with agency policy.

To address this issue, in 2010, Judge Jonas created the Division of Quality (DQ). DQ considers a random sample of unappealed hearing decisions for possible own motion review. Our regulations prohibit us from selecting cases based on individual offices or adjudicators.

These reviews address concerns in particular claims, but they also support consistent, quality, and policy compliant decision-making throughout the disability adjudication process. Through these reviews, DQ collects data about recurring issues in decision making, analyzes the adjudication of each case beginning with the initial application, suggests improvements in policies and procedures, and identifies training opportunities for adjudicators and other agency employees involved in the adjudication process.**7**

In addition to this sampling, since 2011, DQ has conducted post-effectuation quality reviews focused on identifying recurrent decisional issues that can be addressed through training, policy clarification, procedural changes, and software, as well as to provide feedback to ALJs, senior attorneys, and hearing offices to improve their adjudication. Unlike the pre-effectuation reviews, we can select a specific ALJ or office.**8** Subjects of completed focused quality reviews include hearing offices, physicians, attorney advisors, claimant representatives, and abandonment dismissals of hearing requests.

This data driven approach utilizes feedback tools like "How MI Doing?," which allows ALJs to see information about their AC remands, including why the case was returned and also to see where their performance fits in relation to other ALJs in their office, their region, and the nation.

In addition, the data collected by DQ provide us with a tremendous tool to identify trends. We review our electronic records for anomalies; when we find them, we look to identify whether such anomalies can be explained or whether administrative action is appropriate. When we suspect fraud or other suspicious behavior, we refer the matter to our OIG.

Training is critical to policy compliance. We continue to improve and expand the training we provide to our ALJs and support staff to help ensure that our hearings and decisions are consistent with the law, regulations, rulings, and agency policy. For example, we are developing

training modules related to each of the identified reasons for remand that we will link to the "How MI Doing?" tool. ALJs will be able to receive immediate training right at their desks that is targeted to the specific reasons for the remand.

Since FY 2007, our newly appointed ALJs have undergone a more rigorous selection process and have participated in a two-week orientation, four-week in-person training, formal mentoring, and supplemental in-person training. During my tenure, we have enhanced our continuing education program. We can now gather and analyze common adjudication issues and we provide quarterly continuing education training to all adjudicators to target these common issues. In addition, we have continued our training program, which we began in 2007, to provide in-person technical training for approximately 350 experienced ALJs each year, on a rotational basis. Our emphasis on data driven feedback is giving us the information we need to move from training based on anecdotal information to training on identifiable areas needing improvement.

For the past several years, our new ALJ training has included a session that explains the scope and limits of an ALJ's authority in the hearing process, including the ALJ's obligation to follow the agency's quality standards, rules and policies, and the Standards of Ethical Conduct for Employees of the Executive Branch. We also have implemented the ALJ Mentor Program, which pairs a new ALJ with an experienced ALJ, who provides advice, coaching, and expertise. Additionally, we provide regular guidance to ALJs through Chief Judge guidance, memoranda, and bulletins, Interactive Video Teletraining sessions, and in response to specific queries from the field. We have greatly improved and expanded our training of new hearing office chief ALJs, hearing office directors, and group supervisors. We have provided periodic training for more experienced hearing office ALJs and managers.

To improve quality further, we are currently piloting the Electronic Bench Book (eBB), a policy-compliant web-based tool that aids in documenting, analyzing, and adjudicating a disability case in accordance with agency policy. We designed this electronic tool to improve quality, accuracy, and consistency throughout the disability evaluation process.

To address concerns about changes to various aspects of our disability programs, we have contracted with the Administrative Conference of the United States (ACUS) to review several issues for us. ACUS has looked at challenging and potentially controversial issues that affect the hearings process, including the submission of evidence and duty of candor, the treating source rule, closing the record, and video hearings. We are actively discussing many of these issues, and we are gathering objective evidence and consider input from all stakeholders, which takes time.

Additionally, as part of a broader government-wide initiative for transparent and open government, we have taken significant steps to enhance the transparency of our hearings process. For example, beginning in 2010, we posted on our website data relating to our ALJs and our hearings operation. In this regard and as part of this government-wide initiative, we disclose publicly for each ALJ the number of case dispositions per year; the number of decisions per year; and the number of dismissals, allowances, and denials per year.

The Agency's ALJ Corps

In addition to our other efforts to improve the hearings process, we also have worked diligently to improve the quality and consistency of the service that our hearings employees, including ALJs, provide to the public. For our hearing process to operate fairly, efficiently, and effectively, our ALJs must treat members of the public and staff with dignity and respect, adhere to ethical standards and agency policy, be proficient at working electronically, and be able to handle a high-volume workload, while maintaining quality and legal sufficiency. The vast majority of adjudicators care very much about making the right decision and being good stewards of the trust funds. We are committed to helping them do their jobs effectively.

When Judge Cristaudo became the Chief ALJ in 2006, he and other agency leaders focused on strengthening the hearings operation. Judge Cristaudo's previous experience as a line ALJ, hearing office chief ALJ, and regional chief ALJ provided him significant insight on the importance of holding ALJs accountable to the agency and the American public. Under his leadership, and with the support of other agency executives, the Office of the Chief ALJ made great strides in improving the quality of ALJ decision making and correctly holding ALJs accountable for failure to adhere to agency policy or for engaging in misconduct.

To enhance ALJ accountability, Judge Cristaudo delegated authority to the Regional Chief ALJs to reprimand ALJs – thus giving Regional Chief ALJs an important management tool to address personnel issues that Judge Cristaudo did not have when he held that position. He also established a new office, the Division of Quality Service, to facilitate consistency and accountability nationally. Additionally, recognizing the critical need for hiring outstanding judges, Judge Cristaudo was instrumental in modifying the ALJ hiring process to better identify

candidates with exceptional qualities and to eliminate those candidates who lacked the temperament, ability, or character to serve in the critical role of ALJ.

Further, Judge Cristaudo and agency leadership took significant steps to ensure that ALJs who refused to do their jobs properly or who otherwise betrayed the public trust would be held accountable. To this end, he worked closely with other agency components, including the Office of the General Counsel, to pursue appropriate actions. Generally, an informal feedback process worked, but in those cases where the ALJ did not comply and where appropriate, we pursued corrective action.

In the past several years, it has been necessary to seek removal or suspension of a number of ALJs. The agency strives to ensure that our ALJs adhere to the high standards expected of them, recognizing at the same time that we cannot and would not influence their decision in any particular case. Through the actions the agency brought to the Merit Systems Protection Board, we confirmed, among other issues, that when management addresses case processing it does not interfere with an ALJ's qualified decisional independence. We also confirmed that ALJs must adhere to the same standards of conduct as other federal employees. To date, the agency appropriately has sought the suspension or removal of over 20 ALJs through final MSPB decisions or resolution agreements resulting in separation from the agency. When it is necessary to remove an ALJ from service, the agency must complete a lengthy MSPB administrative process that lasts years and can consume over a million taxpayer dollars. Unlike disciplinary action for other civil servants, the law requires that ALJs receive their full salary and benefits until the case is decided finally by the full MSPB—even though the ALJ's conduct made it impossible for the agency to allow the ALJ to continue deciding and hearing cases or to interact with the public. We remain open to exploring options to address these matters, while continuing to provide the best service to the American public.

Conclusion

Over fifty years ago, Congress created the disability program to help some of our most vulnerable citizens. The program has served the American public well, and we would caution against calling its integrity into question based on the actions of a few individuals. The vast majority of our adjudicators care very much about making the right decision and being good stewards of the trust funds, and we are committed to helping them do their jobs effectively.

We deeply abhor any wrongdoing that detracts from confidence in our critical programs. As we have discussed, we have taken many actions to improve the integrity of our hearing process, and we remain committed to preventing and correcting issues that lessen our public service.

Some people seek to connect the former situation in Huntington to overarching concerns about the growth in the disability program. Despite the many opinions about the cause of the growth, as our Chief Actuary has repeatedly explained, the increased size and changed age distribution of the population under 65 is the main driver of long-term disability insurance (DI) program growth and was predicted many years ago.**9** For example, the aging of the baby boomer generation accounts for a large portion of the growth in DI awards, as does the fact that more women have joined the labor force and have become eligible for benefits.

We thank you for your interest in helping us improve our service and ensure ongoing confidence in our programs. We also ask for your support for the President's budget request, which will provide us with funding to continue to improve our hearings process, to improve the integrity of our disability programs, and to reduce improper payments by allowing us to conduct more continuing disability reviews and Supplemental Security Income redeterminations. With past support from Congress, we have made progress in both the administrative and program integrity arenas.

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1 These mandatory funds would replace the discretionary cap adjustments authorized by the Balanced Budget and Emergency Deficit Control Act of 1985, as amended by the Budget Control Act. These funds would be reflected in a new account, the Program Integrity Administrative Expenses account, which would be separate. and in addition to, our Limitation on Administrative Expenses (LAE) account. Under the proposal, the funds would be available for two years, providing us with the flexibility to aggressively hire and train staff to support the processing of more program integrity work.

2 With this increased level of funding, the associated volume of medical CDRs is 1.047 million, although it may take us some time to reach that level. By comparison, we conducted about 430,000 CDRs in FY 2013.

3 See section 205(u) of the Social Security Act.

4 The Supreme Court has recognized that we are "probably the largest adjudicative agency in the western world." Heckler v. Campbell. 461 U.S. 458, 461 n.2 (1983).

5 Some observers have raised concerns about the variations in ALJ allowance rates. Regardless of whether an ALJ's determinations fall inside or outside of the mean, we focus on the quality, timeliness, and policy compliance of the decision.

6 Our focus on reviewing ALJ denial decisions was driven, in large part, by the court's decision in ***Association of Administrative Law Judges, Inc. v Heckler***, 594 F. Supp. 1132 (D.D.C. 1984). That case concerned the "Bellmon Review Program" that targeted for review individual ALJs based solely on their allowance rates. Under the program, individual ALJs with allowance rates of 70% or higher were to have 100 % of their favorable decisions reviewed for accuracy. The court found that this focus on allowance rates was untenable under the law because it could have affected an ALJ's decision in an individual case.

7 Our focus on reviewing ALJ denial decisions was driven, in large part, by the court's decision in ***Association of Administrative Law Judges, Inc. v Heckler***, 594 F. Supp. 1132 (D.D.C. 1984). That case concerned the "Bellmon Review Program" that targeted for review individual ALJs based solely on their allowance rates. Under the program, individual ALJs with allowance rates of 70% or higher were to have 100 % of their favorable decisions reviewed for accuracy. The court found that this focus on allowance rates was untenable under the law because it could have affected an ALJ's decision in an individual case.

8 Because the AC reviews these cases before the agency effects the ALJ decisions, these reviews may affect case outcomes. Either the AC may remand the reviewed case to the hearing office for further development or issue a decision modifying the original hearing decision.

9 This is a different type of review from the one described earlier. Unlike that review, this type of review occurs after the agency effects the ALJ decisions. Therefore, these reviews do not change case outcomes.

10 See Statement of Stephen C. Goss, Chief Actuary, SSA, before the House Committee on Ways and Means, Subcommittee on Social Security (Mar. 14, 2013), available at http://www.ssa.gov/legislation/testimony_031413a.html

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SSA RESPONSE TO RECOMMENDATIONS
How Some Legal, Medical, and Judicial
Professionals Abused Social Security Disability
Programs for the Country's Most Vulnerable:
A Case Study of the Conn Law Firm
Staff Report
Committee on Homeland Security and Governmental Affairs
United States Senate

October 7,2013

ALJ Consideration of Prior Agency Decision. Judge Daugherty ignored information provided in prior decisions denying benefits and overturned those decisions by relying on information provided by Mr. Conn and his network of doctors that the claimant was disabled. The agency should ensure initial decisions made by the Department of Disability Services ("DDS") to deny benefits are well documented, with specific evidence on why the claimant did not meet the agency's definition of disability. The agency should consider allowing the ALJ to contact the DDS examiner who made the prior decision in the presence of the claimant's representative to ask about the reasons for the prior denial. The ALJ would remain responsible for providing a ***de novo*** review of the claim.

Response: We agree that all disability decisions should be well documented, with specific evidence supporting the decision. We require adjudicators at all levels to clearly docwnent and rationalize the evidentiary basis of their adverse decisions. All State DDSs now document

initial and reconsideration determinations with eCAT, our electronic case analysis tool that provides a detailed disability determination explanation that is retained in the case file. We think it would be far more expedient for ALJs to review the eCAT than to contact DDS adjudicators directly, and we will issue reminders to ALJs to review the eCAT DDS explanation.

Strengthen ALJ Quality Review Process. Judge Daugherty's approved decisions were not subject to further review or the scrutiny of the appellate process, since his awards of benefits were not appealed by the claimant. It is important the agency strengthen and expand the review of ALJ award decisions by the Quality Division of the Office of Appellate Operations, and that Congress provide adequate funding for that effort. The agency should conduct more reviews during the year and improve ways of measuring the quality of disability decisions. Such information should be made available to Congress.

Response: We agree. For many years, the Appeals Council was not adequately funded to perform its oversight responsibilities. In 2007, when we committed to reducing the hearings backlog, we did not want to sacrifice quality in the process. Therefore, we provided some resources for the Appeals Council to implement quality assurance initiatives and improve ALJ training. Our first step was to collect meaningful data that are the foundation of our reviews. As such, we created the Division of Quality in the Appeals Council that began quality reviews in September 2010. In fiscal year (FY) 2012, we reviewed a random sample of about 7,000 hearing decisions, which is up from nearly 3,700 reviews in FY 2011. In FY 2013, having lost staff in DQ, we did fewer own motion reviews-about 6,100-but maintained post-effectuation focused reviews, which help us to delve into potential problematic areas like those in the Huntington Hearing Office.

Without adequate funding or hiring capability, it is projected that overall staffing levels at the Appeals Council will decrease by 10-20 percent in the next few years. At the same time, we expect the number of filings with the Appeals Council on our mandated workloads-handling Federal court work and claimant appeals of ALJ decision-will increase. We must provide timely responses to claimants on requests for review and respond to courts within mandatory deadlines. Additionally, processing appeals is an important feedback tool for ALJs and is the means of collecting invaluable data used by the DQ.

We remain committed to our quality assurance initiatives and strengthening the DQ. We plan to demonstrate our commitment to the maximum extent possible, despite the significant stafting cut in OAO caused by a lack of funding.

Reform the Medical-Vocational Guidelines. Almost all of Judge Daugherty's cases reviewed by the Committee were decided based on the outdated medical-vocational guidelines, which have not been changed since 1980. Those guidelines should be reviewed to determine the reforms needed to update the guidelines to reflect current life expectancy and related ability. Additional studies should be conducted to evaluate whether the current guidelines utilize the proper factors and if they appropriately reflect a person's ability to work.

Response: The medical-vocational rules found in our regulations are rooted in the statutory definition of disability and its requirement that we consider age, education, and work experience in conjunction with residual functional capacity.

We constantly strive to improve our ALJ hearings and are guided by the principles that they must be fair, accurate, and efficient. We are continuing to evaluate if any changes to the medical-vocational rules would enable us to better to meet these goals.

Prohibit Claimant Use of Doctors with Revoked or Suspended Licenses. In some cases, the Conn law firm provided medical opinions from a doctor whose licenses had been suspended or revoked in another state. The agency should prohibit claimants from submitting opinions by doctors whose services, under its existing rules, the agency itself could not accept.

Response: The Social Security Act (Section 223(d)(5)(B)) requires us to "consider all evidence available" in determining if an individual qualifies for disability benefits. Existing law does not permit us to reject existing evidence submitted by a claimant on the basis of the provider's suspended or revoked license. We are continuing to evaluate the issue of medical source licensure and how any potential changes to the current approach would impact the integrity and efficiency of disability decisions.

Strengthen ALJ Analysis of Medical Opinions. Almost all of Judge Daugherty's decisions were based on a medical opinion provided by an attorney-procured medical professional. Many times those opinions were in direct conflict with other evidence in the claimants' files. SSA should provide specific training with regard to how ALJs should use these types of opinions.

Response: We agree that our adjudicators could always use additional training in knowing how to evaluate potentially conflicting evidence. Such evidence could include medical evidence the claimant provides or we gather from treating sources, a report that the claimant submits from an examining source, a report that we request from an examining source, a medical source statement, or the testimony from a medical

or vocational expert. Resolving discrepancies in medical evidence can be challenging, and some adjudicators overdevelop or under-develop the record. In 2012, we trained ALIJs on how to evaluate and weigh "medical source statements" from "acceptable medical sources." We defined these terms and discussed the proper approach in weighing medical source statements. We provided ways to articulate the reasons for the weight given to these statements, emphasizing the need to do so in clea,. concise, and accurate language and the need to avoid stock phrases in applying analysis.

Also in 2012, we trained ALJs on how to articulate the rationale in the written decision for every part of the residual functional capacity (RFC) finding, including articulating RFC findings function by function. In addition, we trained ALJs on how to consider not only the objective medical evidence but also how to treat history, opinions, and other factors described in 20 CFR 404.1529, 416.929, and SSR 96-7p. We will consider how we can involve ALJs in determining how to improve tools in this area, such as consulting with ALJs who are currently on detail to the Office of Appellate Operations' Division of Quality.

Focused Training for ALJs. The Oflice of Appellate Operations, Quality Division, should provide training to all ALJs regarding adequate articulation in opinions of legal determinations. This training should emphasize the proper way to analyze and address these issues as required by law, regulation and agency guidance, including how to address obesity and drug and alcohol abuse.

Response: We agree. We conduct reviews to identify common errors in hearing decisions. The results of these reviews thus far show that common errors include the failure to adequately develop the record, lack of supporting rationale, and improper evaluation of opinion evidence. We use this information to develop and implement focused mandatory training for our ALJs and to provide feedback on policy guidance and litigation issues. Since 2012, we have provided training on residual functional capacity, evaluating medical source statements, assessing credibility, effective questioning and writing, dismissals, vocational expert evidence, and overpayments. We have training on childhood disability and drug addiction and alcoholism scheduled for 2014.

Office of Disability Adjudication and Review

Anti-Fraud Activities

Over the last three years, we have implemented procedural changes, new controls, electronic system changes, management practices, and improved data collection and analysis. While these improvements are paying off, we remain vigilant and continue to review national data for trends and fact patterns that suggest policy non-compliance or fraud.

Corrected weakness in business process:

In 2011, we strengthened our long-standing case assignment policy by updating our national case assignment system to prevent Administrative Law Judges (ALJ) from assigning cases to themselves.

Capped the number of cases an ALJ may be assigned:

In 2011, we put a control in place to cap the maximum number of cases a judge can be assigned at 1,200 cases per year. We reduced that number to 960 cases per year in 2012. Effective fiscal year (FY) 2014, we reduced the cap to 840 cases per year.

Improved and expanded review of hearing level cases:

The Appeals Council (AC) reviews decisions and orders issued by ALJs and Senior Attorney Adjudicators (SAAs). The AC may review a hearing level decision or dismissal of a hearing request at the request of a party to the action or, pursuant to 20 CFR 404.969 and 416.1469, on its own motion. Through the exercise of its authority to review cases, the AC is responsible for ensuring that the final decisions of the Commissioner are proper and in accordance with the law, regulations, rulings, and agency policy.

Consistent with this authority, the AC reviews unfavorable ALJ cases. In FY 2013, the AC reviewed 176,251 requests for review for claimants who were unsatisfied with the ALJ decision (usually a denial or partially favorable decision). The action the AC takes on these appealed cases provides feedback to ALJs, helping them know if their determinations are policy compliant.

While the AC's regulatory authority extends beyond handling requests for review, for many years, limited resources and rising backlogs caused the AC to suspend pre-effectuation reviews (reviews of hearing-level cases before they are effectuated). Since 2010, the AC focused on improving electronic case processing systems and management information, thus freeing resources to reinstate these pre-effectuation reviews on unappealed favorable hearing decisions.

The AC acknowledged that while it had data from unfavorable cases due to its handling of requests for review, without data from favorable decisions, we have an incomplete picture of whether adjudicators are complying with agency policy. To address this vulnerability, in FY 2010, the AC established the Division of Quality (DQ). In its first three years, the DQ implemented the random sample case selection provisions of the regulations which permitted the DQ to consider a random sample of unappealed hearing decisions for possible own motion review.

These reviews address concerns in particular claims, but they also support consistent, legally sufficient, and policy compliant decision-making throughout the disability adjudication process. Reviewers analyze the adjudication of each case beginning with the initial application, collect concrete data about recurrent issues in decision making, make suggestions for improvements in policies and procedures, and identify training opportunities for adjudicators and other agency employees involved in the adjudication process.

In addition to the pre-effectuation case reviews, since FY 2011, the DQ has conducted post-effectuation focused quality reviews (FQR) with the overarching goals of identifying recurrent decisional issues that can be addressed through training, policy clarification, procedural changes, and software as well as providing feedback to judges, senior attorneys, and hearing offices to improve their adjudication. Subjects of completed FQRs include hearing offices, ALJs, physicians, senior attorney advisors, claimant representatives, decisions in which ADHD was identified, and abandonment dismissals of hearing requests.

During these focused reviews, DQ looks for potential fraud issues such as the frequent appearance of one representative before an ALJ or the frequency of reports from one medical source that may be questionable. As the result of these reviews, DQ has referred a number of cases to the Office of Inspector General (OIG) for investigation of potential fraud or improper situations.

Modernization of hearing process:

SSA has implemented one of the largest electronic processing and record keeping systems in the world. This technology has allowed us to conduct 180,000 video hearings annually, and our video hearings process has been cited as a Federal agency best practice for all Federal agencies, by the prestigious Administrative Conference (ACUS) of the United States. We have implemented an electronic business process to ensure uniform practices in all offices. Our electronic systems provide the infrastructure for far better monitoring of hearing office work, from both a policy consistency and anti-fraud perspective. We are also assisting the Veterans Administration with their implementation of an electronic disability processing system.

Using data and technology to uncover anomalies:

We now have increasing amounts of data to detect areas of policy non-compliance by adjudicators. Software and data analytics are revealing patterns that suggest policy-compliance weaknesses or other concerns to include possible fraudulent practices. We are using the data to provide better feedback to adjudicators to improve policy compliance. In addition, we work very closely with our OIG and our Office of General Counsel (OGC) to share our findings of possible fraudulent practices.

Data show that quality is improving. This improvement is not happenstance but the result of several changes from the way we hire, to the way we train, to the way we give feedback.

Improved new ALJ hiring processes:

Since 2007, we have strengthened our hiring process through our own background checks, reference checks, and comprehensive interviewing.

Improved training is making ALJs more policy compliant:

We have improved the training we provide to our ALJs to help ensure that our hearings and decisions are consistent with the law, regulations, rulings, and agency policy. Since FY 2007, our new ALJs have undergone rigorous selection and have participated in a two-week orientation, four-week in-person training, formal mentoring, and supplemental in-person training.

Newly hired ALJs receive four weeks of face-to-face training on national disability policies and practice conduct of a hearing. We then bring these new ALJs back for supplemental face-to-face training at the one-year mark. Multiple agency components including the OGC and our policy components are involved in developing and delivering training.

We retrain approximately 300 ALJs each year. We also provide quarterly continuing education to all judges, senior attorneys, and writers in the hearing offices on error-prone topics. As part of the quarterly training, hearing office judges, senior attorneys, and writers meet after the training to further discuss the topic, and we provide talking points for managers to facilitate that discussion.

Timely feedback is making hearing office decisions more policy compliant:

In 2011, we created a new management information tool, known as "How MI Doing," that permits both ALJs and line employees to compare their productivity and quality statistics against other hearing office employees, regional employees, and all employees nationally. This tool also gives ALJs timely feedback on remands from the AC including reasons for remand and will soon include related training topics for improvement.

While management is providing the support for adjudicators that leads to these results, it is the adjudicators themselves who have responded positively to the feedback. Perhaps for the first time, we have a feedback loop that allows adjudicators to actively participate in improving their work and in telling us about disagreements or problematic areas through the AC Feedback Initiative.

For denial decisions, we have seen ever-increasing concordance between ALJ decisions and the AC. We now have increasing amounts of data to detect areas of policy non-compliance on allowances, and we are using that data to provide better feedback to adjudicators to improve policy compliance.

We are holding our judges accountable:

The vast majority of our ALJs are conscientious and hard-working employees who take their responsibility to the public very seriously. For these ALJs, we can rely on agency measures including training to address any performance issues they may have. Generally, the informal process works. In those rare cases where the ALJ does not comply, as required and where appropriate, we pursue disciplinary action.

Over 20 ALJs have separated from the agency through final MSPB decisions or resolution agreements. Nearly all of these cases have involved serious conduct issues. In the last few years,

we had an ALJ who failed to inform us, as required, that he was also working full-time for the Department of Defense. Another ALJ was arrested for committing a serious domestic assault. More recently, an ALJ failed to follow his managers' orders to process his cases. We removed these ALJs after completing the MSPB disciplinary process.

We note, however, that this process is lengthy--lasting several years--and can consume over a million dollars of taxpayer resources. In each of these cases, unlike disciplinary action against all other civil servants, the law requires that ALJs receive their full salary and benefits until the case is finally decided by the full MSPB--even though the agency could not in good conscience allow these ALJs to continue deciding and hearing cases. We remain open to exploring different options to address this matter, while ensuring the qualified decisional independence of ALJs.

We are not insular in our approach:

We have consulted with ACUS on a number of challenging and controversial issues including the duty of candor, closing the record, treating source rule, and expansion of AC own motion review. ACUS provides us with a perspective to ensure that we have a strong and thoughtful policy basis for our decisions.

Personnel Changes:

We have a strong new management team running the Huntington hearing office. This team has implemented many best practices in the office and is sharing its knowledge and best practices with other offices.

We enhanced our communications plan:

Our front-line employees often have the best opportunity to identify problems in our business process and fraud. Deputy Commissioner Sklar has consistently and repeatedly messaged that employees must "say something" if they "see something" and that our managers must "do something if they hear something." To support this effort and to give employees an expanded ability to report concerns directly, we created dedicated email boxes to tell us about possible weaknesses in our business processes and ideas for improvement, as well as providing another place to report concerns about fraud, waste, or abuse. Headquarters staff review the incoming emails, ensuring that we are addressing them, including any necessary referrals to OIG.

Deputy Commission Sklar required all ODAR managers to certify their review of a recent Senate Committee on Homeland Security and Governmental Affairs report that highlighted several vulnerabilities and weaknesses in our programs. Managers certified that they are not aware of any similar issues or have reported any concerns to the OIG.

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Leaning In: Government's Push to Leverage Big Data

Gauging 'Data to Knowledge to Action' in Government

In 2014, the public sector is working to overcome challenges inherent in managing high volume, high velocity data streams, and make better use of the tools and techniques designed to help agencies capture, store, manage and analyze big data as it flows through agencies, every day.

In the private sector, many organizations are already leveraging big data analytics to interpret consumer behavior, detect fraud and make predictions about the future. Increasingly, agencies are starting to understand the use of big data analytics has the potential to transform government and society. "Hidden in the enormous volume, variety and velocity of data as it streams through government agencies today, is important information, facts, relationships, indicators and pointers that previously couldn't be discovered, or simply didn't exist," Jeanne Holm, Evangelist for Data.gov.

Federal oversight organizations are working to motivate federal agencies to start leveraging big data. Big data refers to data that comes from automated sensors, user-generated content from social media, the web and software logs, cameras, information-sensing mobile devices, aerial sensory technologies, genomics, medical records and other sources. These large data sets can be challenging to store, search, share, visualize and analyze. "Using the right tools and techniques, agencies can leverage this data from interactions and other channels to inform how processes work, and formulate better procedures and services that can streamline operational processes," said Wo Chang, Digital Data Advisor, National Institute of Standards and Technology (NIST).

The White House Office of Science and Technology Policy (OSTP) and Networking and Information Technology R&D program (NITRD) rolled out 28 big data collaborative partnerships last November, aimed at stimulating private sector collaboration in big data initiatives. 'Data to Knowledge to Action' is the latest effort built to expand the Obama Administration's Big Data initiative launched in March 2012. The Administration's goal is to ensure big data analytics is widely deployed to address key operational process challenges and unearth new discoveries based on the empirical evidence that results from using actual data, rather than other more traditional forms of analysis. Some private and public sector arenas already gaining benefits from big data analytics include environmental, earth, medical and astronomical sciences, cyber security, forensics, fraud detection, social media analytics, logistics, transportation, weather forecasting, natural resource exploration and conservation and predictive damage assessments. Security data can be used to analyze activities and metrics associated with risk management, incident detection, regulatory compliance, investigations and forensics. And the healthcare arena, the National Institutes of Health (NIH) has a Big Data to Knowledge (BD2K) initiative working to develop standards, tools, and other solutions that can make use of massive amounts of data generated by the health and medical research community.

> *"Using the right tools and techniques, agencies can leverage this data from interactions and other channels to inform how processes work, and formulate better procedures and services that can streamline operational processes..."*
>
> *- Wo Chang, Digital Data Advisor, National Institute of Standards and Technology (NIST).*

continued from "Leaning In..." on page 1

Tools and Technologies

To help reduce the many complexities involved in leveraging big data, organizations are turning to a variety of tools and techniques to help filter data more efficiently. Take for example, the growing need to analyze data in real-time. In-memory computing is one technique that allows organizations to take advantage of existing hardware to bring massive amounts of data into memory for quicker analysis of large data sets. "As the cost of RAM has dropped to where a gigabyte costs under a dollar, bringing more data into RAM enables users to quickly analyze and use more information to fuel real-time decision-making," said Chris Steele, Chief Solutions Architect for Software AG.

Another useful analytic tool is data visualization, which makes it easier to highlight key findings and/or anomalies as they arise. Data visualization is used to help internal program experts quickly see patterns or factors that lie outside the norm, to help aid daily operational decision-making. "Government needs this type analytic capability to help assist those in the military to quickly see on a large data map how to achieve mission goals, or serve those citizens impacted by disasters," said Michael Ho, vice president of professional services for Software AG.

Regardless, whether government initiatives are enlisted to heighten intelligence, share information in defense of U.S. interests, detect fraud or terrorists, or enable government institutions to improve constituent services, increase accountability or open data for greater accessibility, agencies must examine how to leverage such analytic techniques. According to Data.gov's Holm, big data analytics should be central to agency mission goals. "By accurately measuring the effectiveness of each interaction, government agencies can bring greater legitimacy and accountability to programs and services, which translates to lower costs and more efficient operations."

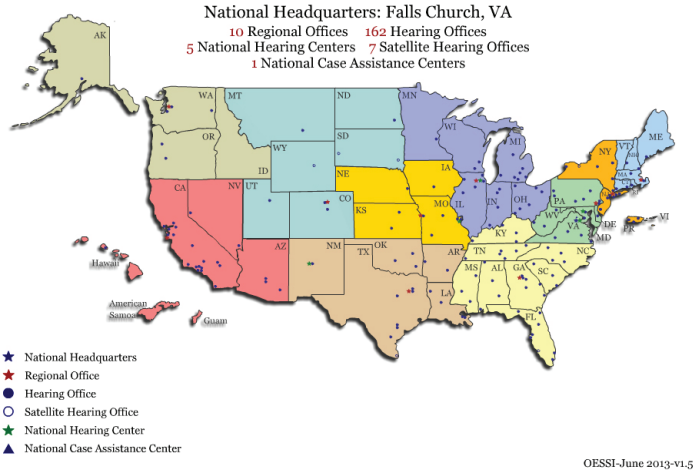
SSA Leverages Big Data Analysis to Advise Disability Appeals

The Social Security Administration's (SSA) administrative appeals operation, under the Office of Disability Adjudication and Review (ODAR) is one of the largest administrative judicial systems in the world. ODAR is charged with analyzing disability claims, as they roll through the appeals process. SSA issues more than half a million hearing and appeal dispositions each year, and appeals judges render the agency's final decision in over 100,000 cases per year.

As can be imagined, an enormous amount of data is collected for and about each appeal claim as it winds through the steps involved in filing, adjudicating, hearing, and the rendering of a final appeal decision, as required for each case. Approximately three years ago, SSA's ODAR team started working to gain more intelligence from the data collected about each claim. "We wanted to know more about the policy errors that existed, and how to develop training and high quality feedback to reduce errors and better inform operational decisions," said Jim Borland, Assistant Deputy Commissioner for the Office of Disability Adjudication and Review.

> *"We wanted to know more about the policy errors that existed, and how to develop training and high quality feedback to reduce errors and better inform operational decisions."*
>
> *- Jim Borland, Assistant Deputy Commissioner for the Office of Disability Adjudication and Review*

Map of ODAR's Field Office Sites throughout the United States



continued from "SSA Leverages Big Data..." on page 2

As with any analytic feedback process, each adjustment made in the appeals process has led to new and better results. SSA's ODAR now captures key claims data, visualizes the results, analyzes those results and delivers feedback to managers and appellate judges, so the organization can change the policy, system, or advise personnel to take corrective steps based on what the data uncovers.

The ability to analyze large and complex data sets using case analysis tools, data visualization, clustering analysis and multiple variable models allows ODAR to efficiently tackle the complex challenges faced daily in adjudicating disability appeals. Overall, ODAR has gained more consistency and accuracy in the processing of all appeals, along with the ability to process more claims, more quickly as well.

How it's Done

In total, there are approximately 2,000 different outcomes to be derived from 2,000 different points in the disability appeals process. If claims adjudicators skip any portions of the decision tree, they can make errors that slow or negatively impact claim appeals, explains Judge Gerald Ray, Deputy Executive Director, Office of Appellate Operations, ODAR.

In simplest terms, ODAR had to first deconstruct each point in the appeals process to be able to seek out errors as they cropped up along the path that disability claims may take in appeals. The original tool built helped give ODAR gain insight into quality problems in the adjudication process. Data visualization techniques were used, such as heat mapping, to highlight key 'outliers' or data points that fall outside the norm, as they arose in analysis. Then, a subset of cases with similar problems are reviewed to uncover what caused the anomaly and to provide feedback to the ODAR personnel who are then re-trained to help correct the problem. In some situations, Ray said it was clear nearly everyone was making the same mistake. That led the ODAR team to examine whether an SSA policy was too broad or difficult to clearly understand. Armed with measured data insights, SSA's ODAR team has been able to adjust specific policies to help adjudicators become compliant, dramatically reducing errors in claims processing. ODAR also enlisted outside help from the Administrative Conference of the United States (ACUS), an independent federal agency dedicated to improving administrative processes through applied research, providing nonpartisan recommendations for improvement of agency procedures. ODAR enlisted help from ACUS to conduct surveys and other research to help indicate where changes in specific SSA laws and regulations may improve compliance and further reduce errors in the appeals adjudication process.

> *"In many cases, complex data analysis is undertaken to help 'tease out' what the team doesn't yet know about its adjudication processes."*
>
> *- Judge Gerald Ray, Deputy Executive Director, Office of Appellate Operations*

One of the primary goals of ODAR's big data research was to improve training. In this effort, the ODAR team has explored in detail, how adults learn. ODAR now leverages methods including intrinsic motivation, which ties learning about complex things to the context needed to help each person better understand why a specific rule works as it does. Through all of these efforts, SSA's ODAR team has seen a dramatic improvement in caseload quality. There are fewer appeals and fewer cases returned due to errors. Productivity has also increased as the staff has been retrained to work within continually improving parameters. In the past, ODAR officials acknowledged, certain highly complex cases would languish. "Now, there's training available for how to deal with each step in those difficult cases to help move those claims through the adjudication process as well," Ray explained.

As ODAR's efforts have evolved, the team has started investigating the use of data outside the agency to ensure everyone is treated the same, in accordance with U.S. laws. Utilizing information from the Census Bureau, for example, along with other agencies, ODAR is able to uncover more about how to help claimants return to work. In one type of analysis, certain key characteristics are examined, such as the type of impairment, to ensure all citizens with the same or similar disabilities are being treated consistently, at the local, regional and national level. "ODAR's work now is largely focused on seeking patterns in the way types of cases are adjudicated to ensure all claimants are treated the same, no matter where they might live," Borland said.

In many cases, complex data analysis is undertaken to help 'tease out' what the team doesn't yet know about

continued from "SSA Leverages Big Data..." on page 3

its adjudication processes, Ray explained. This type of analysis requires advanced computational statistics and mathematic capabilities. One such computation took seven days on a high performance computer that processed 9.5 billion transactions. The SSA ODAR team's work continues to refine data models and identify additional analysis data points to help spot and analyze any outliers.

The use of more complex, large data sets for analysis is something that Borland and Ray agreed they haven't seen elsewhere yet in their interactions with other agencies.

Lessons Learned

One of the biggest lessons learned has been that collaboration between mathematicians/data scientists and in-house program experts is essential to making sense of the outcomes derived from data. "The calculations add up to nothing more than numbers without insights from internal experts," Ray explained.

Another important tip: Keep auditable data and performance metrics data separate from the business intelligence data used for analysis. At SSA, copies of data from production systems are placed into a data warehouse for access by the analytic team. Borland also advises agencies to keep control over the data and develop in-house expertise to help analyze the data. He explained, "We don't want our internal high priority analysis to be put on the 'to do list' of some outside expert who must prioritize our work, along with other jobs. We must be able to decide our own priorities, and not wait for advice from others."

ODAR's efforts are expanding to those SSA officials who work with initial claims, as well. SSA is building a new system designed to leverage big data analysis to help process initial claims more efficiently. This organization will also be examining data for problems that arise as new disability claims cases are filed. According to Borland and Ray, by applying the law, policy or procedure correctly, the entire process gets better and the overall quality of any internal processes improves. The ODAR team has learned that it's possible to apply this model and improve the quality of anything, just by capturing the data up front to improve the process.

Ultimately, ODAR's adjudicators come to work to do a good job. They entered into public service for this reason. "They want to know how to do their jobs better," Borland said. "It's important not to penalize anyone for errors, but instead to help retrain personnel so the same error isn't repeated again."