



Office of the Inspector General

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration's Ability to Prevent and Detect Disability Fraud

Special Report

September 2014

OFFICE OF THE INSPECTOR GENERAL HISTORY AND MISSION

The *Inspector General Act of 1978* created independent and objective units to conduct and supervise audits and investigations relating to Federal agency programs and operations. The Office of the Inspector General (OIG) at the Social Security Administration (SSA) was established on March 31, 1995, pursuant to the *Social Security Independence and Program Improvements Act of 1994*.

The SSA OIG has the following responsibilities:

- Promote economy, efficiency, and effectiveness in the administration of SSA programs
- Prevent and detect fraud, waste, and abuse in SSA programs and operations
- Inform SSA and the Congress about deficiencies and recommend corrective action

To accomplish its statutory mission, the OIG directs, conducts, and supervises a comprehensive program of audits, evaluations, and investigations relating to SSA's programs and operations. The Inspector General is under the general supervision of the Commissioner of Social Security, but the Inspector General may not be prohibited from initiating, carrying out, or completing any audit or investigation, or from issuing any subpoena.

REPORT METHODOLOGY

This Special Report was prepared at the request of the Chairman of the Social Security Subcommittee of the Committee on Ways and Means, U.S House of Representatives. It was compiled by the OIG's Office of External Relations, with input from all OIG components, as well as external sources. It is neither an audit report nor an evaluation report, and was not prepared in compliance with generally accepted government auditing standards or with the *Quality Standards for Inspections and Evaluations* promulgated by the Council of the Inspectors General on Integrity and Efficiency. Rather, it is a survey of existing audit, investigative, and other work prepared for informational purposes only.

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INTRODUCTION & BACKGROUND

A Conspiracy in New York

Before dawn on a frigid morning this past January, 39 special agents from the Social Security Administration (SSA) Office of the Inspector General (OIG), along with investigators from the Manhattan District Attorney’s (DA) Office and officers from the New York City Police Department (NYPD), prepared to launch an arrest operation that was years in the making. Their targets were more than 100 people spread across 11 states—many of them former New York City police officers and firefighters—who had, for years, defrauded Social Security out of millions of dollars in disability payments.



Among the targets that day was Joseph Esposito, a former NYPD officer who had served the department for 17 years.

The 70-year-old Esposito, from the Long Island suburb of Valley Stream, New York, retired from the NYPD in 1990. Soon after, he filed for Social Security Disability Insurance (DI) benefits, alleging “mood disorders.” According to Social Security records, he subsequently received almost \$300,000 in benefits for himself,

another \$114,000 for his three children, and an additional \$13,000 for his wife.

For much of his retirement, as Esposito received thousands of dollars in Social Security disability benefits every year, he also recruited other recently-retired public safety workers to apply for DI—for their, and his own, financial gain.

He recruited former NYPD employees like Thomas Ponzo, Samuel Rushing, and Christopher Agoglia. The stories of these three men were not unique, but they were representative of the many people involved in this longstanding and widespread conspiracy uncovered by a multi-year OIG investigation.

- Ponzo, 51, of Nassau, New York, served the NYPD for 15 years and began collecting DI in March 2002.
- Rushing, 53, of Queens, served for 11 years and began collecting DI in January 2008.
- Agoglia, 51, of Brooklyn, served for 18 years and began collecting DI in April 2005.

For more than a decade, these three—with assistance from Esposito and other scheme facilitators—fraudulently collected a total of more than \$820,000 in DI payments. The former New York City public safety employees, like many others, upon retirement, conspired with Esposito and the other ringleaders to feign mental disabilities, submit disability applications with fabricated and/or exaggerated ailments like depression and anxiety, and ultimately collect government benefits for which they were not eligible. Many of the beneficiaries connected to the scheme went so far as to allege disabling mental conditions resulting from their work on and immediately after the terrorist attacks of September 11, 2001.

And when people like Ponzo, Rushing and Agoglia received an initial lump-sum payment from Social Security—retroactive to their approved date of disability 14 months earlier—Esposito was there to collect his and the other facilitators’ “finder’s fee”—as much as \$50,000 in cash.

Search warrants resulted in the discovery of \$650,000 in cash in a safe deposit box. In another case, a safe deposit box held \$43,000 in cash, 28 gold coins, and five platinum bars.

The investigation, which dates back to 2008, began after New York State disability examiners noticed similarities in several questionable disability applications from retired NYPD and New York City Fire Department (FDNY) employees. As New York Cooperative Disability Investigations (CDI)¹ investigators and analysts, together with SSA’s New York Region staff, dug deeper, it became apparent that the string of similar disability applications was part of a broader conspiracy. Uncovering the scheme required CDI and SSA staff to conduct an exhaustive review of thousands of pages of disability records, carry out hundreds of surveillances, and employ other complex investigative techniques.



Those efforts culminated with successful multi-agency arrest operations on January 7 and February 25, 2014, in which the Manhattan DA’s Office indicted a total of 134 people—the four scheme facilitators and 130 former disability beneficiaries. Those indicted stole about \$30 million in fraudulent Social Security disability benefits. Search warrants resulted in the discovery—and seizure—of millions in assets, including in Esposito’s case, \$650,000 in cash in a safe deposit box. In another case, a safe deposit box held \$43,000 in cash, 28 gold coins, and five platinum bars.

¹ CDI is a joint SSA and OIG anti-fraud initiative that investigates suspicious or questionable initial disability claimants to prevent potential improper payments.

As of September 2014, 71 of the defendants have pleaded guilty and have been sentenced. Ponzo, Rushing and Agoglia—arrested as part of the first sweep on that cold January morning—all pleaded guilty to grand larceny and were sentenced by a Manhattan Criminal Court Judge in July:

- Ponzo and Rushing were sentenced to 3 years' probation and ordered to repay \$395,298 and \$213,963 to Social Security, respectively.
- Agoglia was sentenced to a conditional discharge and ordered to repay \$211,392 to Social Security.

In August 2014, Esposito was the first of the four alleged ringleaders to plead guilty to concocting and operating the scheme. As part of a plea deal, Esposito agreed to testify against the other defendants in the case and to repay the government \$733,000, in exchange for a lesser prison sentence.



Cyrus R. Vance Jr., the Manhattan district attorney, held a news conference on Tuesday to announce the indictments. The photograph is from an online account of one of the defendants, who had applied for disability. Michael Appleton for The New York Times

It is a landmark case for the OIG; the individuals sentenced thus far have been ordered to repay more than \$14 million to Social Security. Though the investigation is ongoing and active, efforts have shifted and intensified to detect and prevent other widespread fraud conspiracies.

In a January 16, 2014 statement to the House Subcommittee on Social Security, Committee on Ways and Means, Inspector General Patrick O'Carroll said, "While this investigation and arrest operation is another example of the fine work of our investigators and our cooperative work with SSA and other law enforcement agencies, the revelation of the scheme is also a stark reminder of the vulnerability of Social Security's disability programs, when both applicants and facilitators are willing to steal from the taxpayers and from the beneficiaries who actually need and deserve these critical benefits."

Disability Benefits—A Historical Challenge

As early as 1938, the Social Security Advisory Council Report included a unanimous recommendation to provide benefits to disabled workers, citing social responsibility; however, reservations to the recommendation existed, including a warning from an actuary who stated, "unless a highly qualified medical staff examined each applicant, the cost of the [disability insurance] program would be higher than 'anything that can be forecast.'"²

² Edward. D. Berkowitz, Challenges Facing Social Security Disability Programs in the 21st Century, July 13, 2000.

Rhetoric about the government providing cash benefits to the disabled became reality in 1956, when President Dwight Eisenhower signed *Social Security Act* amendments to provide monthly benefits to permanently and totally disabled workers ages 50 to 64; the first disability payments were paid in January 1957. In the years prior, prolonged debates raised many concerns about government disability payments, at the core of which sat two pivotal administrative issues: the difficulty in determining disability and the potential program costs. And from the program's onset, the states and SSA experienced delays in processing times and failed to rehabilitate the majority of beneficiaries. In 2014, nearly 60 years after the inception of the DI program, and as the program has expanded to cover all disabled workers and their spouses and children, these issues remain major concerns for Social Security and Congress.

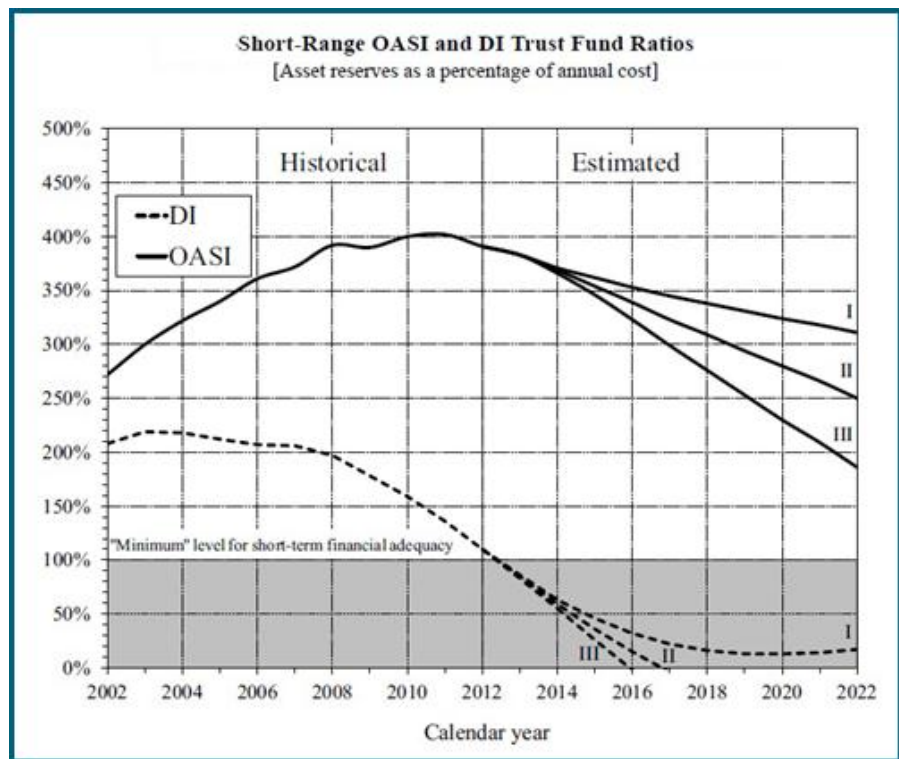
Solvency and Integrity

In recent decades, the baby boomer generation moved from less disability-prone ages (25 to 44) to more (ages 45 to 64), which led to increased DI applications, awards, and beneficiaries over the last 10 years. In 2014, the Agency is on track to pay nearly \$140 billion in DI to almost 11 million citizens across the country, including about 9 million disabled workers and 2 million spouses and children.

Meanwhile, the Board of Trustees of the Social Security Trust Funds in its 2013 Annual Report projected that the reserves in the DI Trust Fund, which have declined since 2009, will continue to decline until they're depleted in 2016. At that time, continuing income to the DI Trust Fund would be sufficient to pay only 80 percent of scheduled DI benefits.

Absent an act of

Congress, the *Social Security Act* does not permit further funding or allow SSA to make benefit payments from funds other than the Trust Funds. Consequently, if the Social Security Trust Fund reserves become depleted, current law would effectively prohibit SSA from paying full Social Security benefits. The Agency would then have to decide on the best course of action for paying beneficiaries.



Detecting Conspiracies

As SSA manages this workload, and as DI Trust Fund reserve depletion looms, the Agency and the OIG continue to investigate and learn from other disability conspiracies, most recently in Puerto Rico and Huntington, West Virginia.

- While the New York conspiracy was found to be an organized, facilitator-based scheme, the Puerto Rico cases appeared to involve more informal, “grassroots” efforts. In 2009, SSA forwarded an allegation to the OIG involving suspicious DI claims that involved nearly identical medical documentation. As a result, the OIG worked with the FBI and the Puerto Rico Police Department (PRPD), using traditional investigative techniques to uncover evidence of a conspiracy involving third-party facilitators and claimants submitting medical documentation that fabricated or exaggerated disabilities.



In August 2013, the OIG, the FBI, and the PRPD initiated an arrest operation in Puerto Rico that resulted in the arrests of 74 individuals—DI beneficiaries, physicians, and a non-attorney claimant representative who was a former SSA employee. As of September 2014, 27 defendants have been sentenced, with court-ordered restitution totaling more than \$873,000.

- In 2011, the OIG received an allegation from an anonymous source, asserting that an administrative law judge (ALJ) in Huntington, West Virginia conspired with an attorney to grant favorable decisions to disability claimants who were potentially ineligible for benefits. After the OIG opened an investigation and media publicized the issue, the ALJ in question was placed on administrative leave and later voluntarily retired from government service.

The investigation is ongoing, but the OIG has conducted numerous interviews, examined records and management information related to the ALJ’s decisions, and collected and analyzed thousands of documents related to the ALJ and the attorney.

Ongoing DI-related issues—increasing applications and awards coupled with decreasing trust fund reserves—have focused a spotlight on Social Security’s management of the DI program. The revelation of large-scale fraud schemes in New York and Puerto Rico has only intensified attention on SSA’s handling of DI awards and beneficiary review. More than ever, it is critical that SSA make timely and accurate disability payments to rightfully eligible beneficiaries, while ensuring that those beneficiaries are regularly reviewed to determine they remain eligible to receive government payments.

A Congressional Mandate

Said Congressman Sam Johnson, Chairman of the Subcommittee on Social Security, on January 16, 2014: “[The disability] program cannot afford more fraud. It is only a matter of time when Congress may be asked to bailout this program with the retirement side having to come to the rescue. And if that is the case then all taxpayers and beneficiaries will shoulder the burden of this crime wave.”

At that hearing, Congressman Johnson requested from the OIG a formal review of SSA’s management of the DI program, with a focus on fraud identification and prevention.

This report will present findings from the review undertaken by the OIG in response to the Chairman’s request. This report will identify the degree to which SSA does or does not have the infrastructure, systems, policies, or culture in place to adequately identify potential fraud or manage and respond to fraud risks, particularly with respect to conspiracies like those discussed above, in which a small number of bad actors can drain the DI Trust Fund of tens of millions of dollars.

In particular, this report will cite OIG audit findings and recommendations and insight from criminal investigative work to identify and explain fraud vulnerabilities; it will also document ongoing and future SSA and OIG efforts to address those vulnerabilities. Finally, the report will examine efforts to improve these systems and processes, and identify what needs to be done to detect and prevent the next large-scale disability fraud scheme, as well as thousands of individual fraud cases.

We have spoken with auditors and investigators, and with prosecutors frustrated with SSA’s vulnerabilities and limitations. We have reviewed thousands of pages of audit and investigative material, and drawn on the institutional knowledge gained in the first 20 years of this OIG’s existence to offer the observations and suggestions on the pages that follow.

We have also analyzed SSA’s approach to addressing fraud. We have reviewed its response to Chairman Johnson’s request that SSA detail its anti-fraud efforts early this year and studied SSA’s actions in the months since, including but not limited to the resurrection of the National Anti-Fraud Committee, the evolution of the Disability Claims Processing System, the fast-tracking of predictive analytics, and the Agency’s minimization of the scope of the fraud problem. The Acting Commissioner and others have consistently and inaccurately cited a 2006 OIG report as the “best-available evidence” that the rate of fraud in the disability program is less than one-tenth of one percent. We are currently updating that 2006 report, and expect that our findings will give us more insight into fraud and abuse in the disability programs.

“This program cannot afford more fraud... all taxpayers and beneficiaries will shoulder the burden of this crime wave.”

–Congressman Sam Johnson

THE DISABILITY CLAIMS PROCESS

The disability claims process comprises, for purposes of this report, three stages in which fraud and fraud conspiracies can occur. First, the initial application, in which an applicant files a claim for DI benefits and a decision is made whether to deny or allow that claim; second, the administrative appeals process, in which applicants request reconsideration of a denied claim; and third, post-entitlement, in which individuals are receiving DI benefits, but may conceal from SSA factors affecting their continued eligibility. We will examine each of these three stages in turn to identify vulnerabilities that create fraud risk, and in particular, create a risk of fraud conspiracies.

THE INITIAL APPLICATION STAGE

How it Works

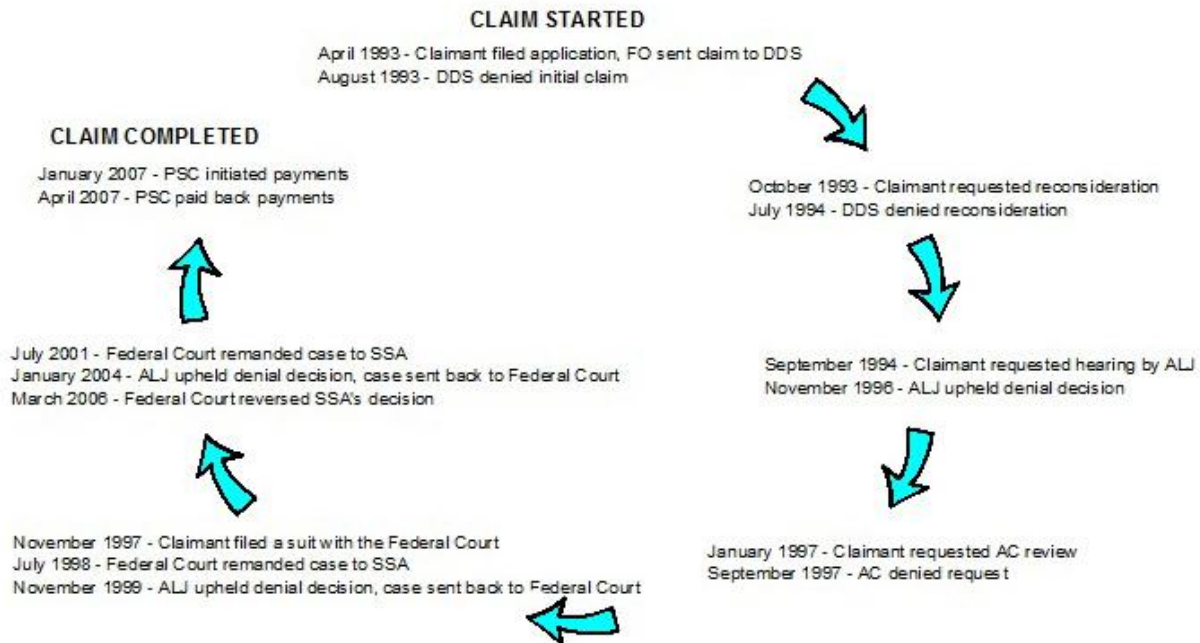
When Social Security receives an initial application for disability benefits—in a field office (FO), online, or through a teleservice center—SSA determines whether the individual meets the non-disability criteria for benefits, including verifying factors such as sufficient earnings. If so, SSA forwards the claim to a disability determination services (DDS)³ agency in the state where the applicant resides.

DDS in each state or other responsible jurisdiction obtain and evaluate evidence from medical and other sources to determine whether a claimant is disabled under the definition set forth in *the Social Security Act* (Act). Once the DDS makes a determination (denial or allowance), it sends the claim back to the FO for final processing or to the Disability Quality Branch (DQB) for review prior to final processing.⁴

³ The DDS is generally a state-run agency that makes disability determinations for SSA. SSA has direct oversight over the DDS budget, but it has no oversight of DDS employees and limited oversight of DDS claims through quality reviews.

⁴ DQB selects half the DDS allowances and a statistically valid sample of DDS denials. In the DQB, a Federal quality reviewer reviews each sample case to determine whether the record supports the determination and whether the evidence and determination conform to SSA policies and procedures.

If the claimant disagrees with the initial disability determination, he or she can file an appeal. In most cases, there are four levels of appeal, including: (1) reconsideration⁵ by the DDS, (2) a hearing by an ALJ, (3) review by the Appeals Council, and (4) review by the Federal Courts.



*Chart Note: PSC stands for Payment Service Center

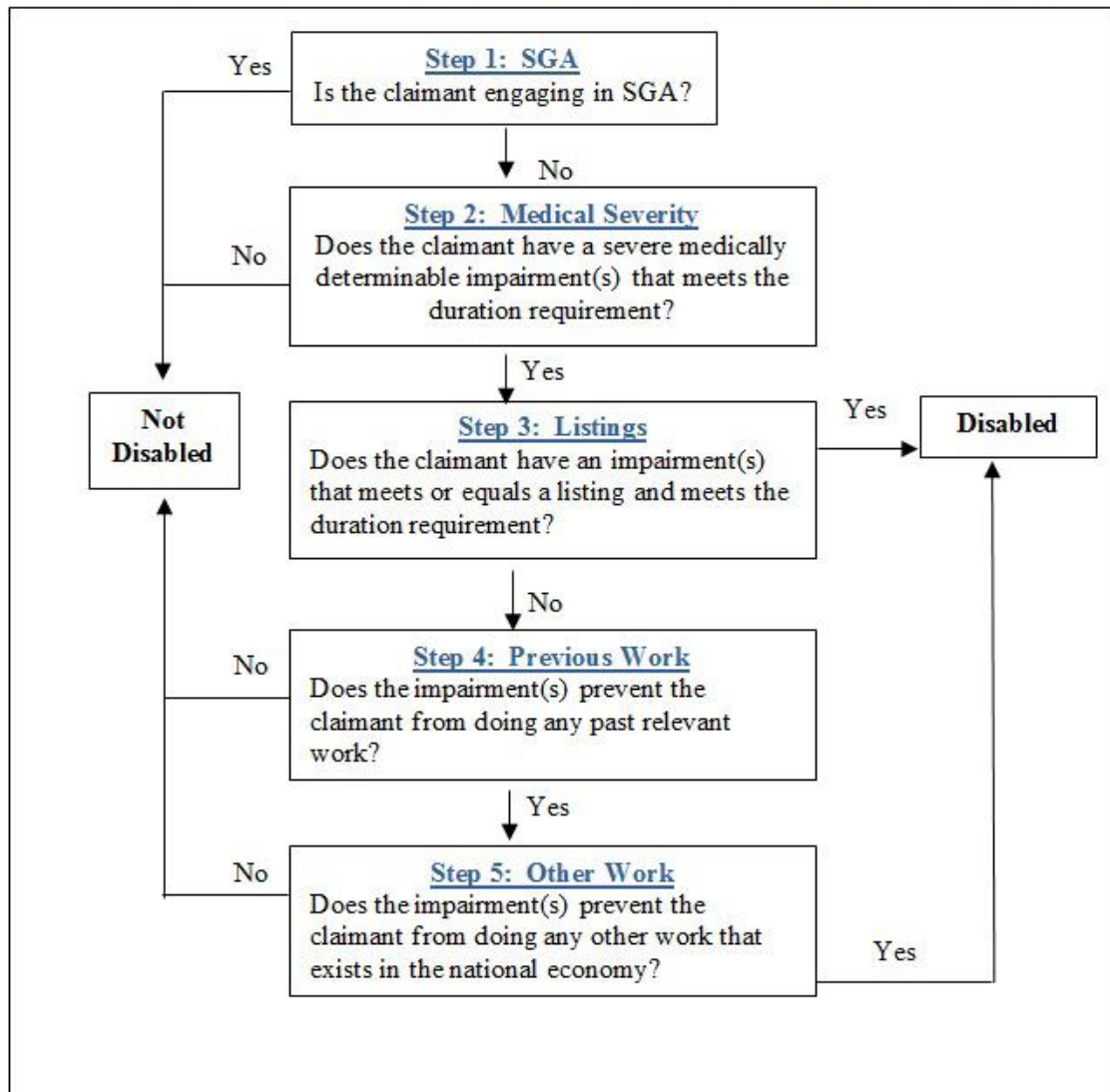
The Act considers an adult disabled if he or she is unable to engage in any substantial gainful activity (SGA)⁶ because of a medically determinable physical or mental impairment (or combination of impairments) that can be expected to result in death, or that has lasted, or can be expected to last, for a continuous period of not less than 12 months.

⁵ The reconsideration step of the appeals process is eliminated for DDSs participating in the Disability Redesign Prototype (Alabama, Alaska, California—Los Angeles North and Los Angeles West Branches, Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York and Pennsylvania).

⁶ For Calendar Year 2014, SSA generally considered earnings of \$1,070 per month to reflect SGA.

SSA follows a five-step sequential process for evaluating disability in adults, which generally follows the definition of disability in the Act. As soon as SSA can make a decision at a step, the analysis stops, and SSA makes a decision.

SSA's Five-Step Sequential Evaluation Process for Determining Disability for Adults



In fiscal year (FY) 2013, DDSs completed about 3 million initial claims for disability and reconsidered about 800,000 denied claims.⁷

⁷ SSA, *The Social Security Administration's Financial Report for Fiscal Year 2013*, December 2013.

VULNERABILITIES AT THE INITIAL APPLICATION STAGE

In an era in which private businesses are consistently employing cutting-edge technology to improve service efficiency and integrity, government agencies like SSA attempt to keep pace. Consistent with its historical emphasis on service over stewardship, the Agency has tapped into technological advances to improve how it connects with and serves its customers through online channels; however, internally, as it relates to maximizing IT capabilities to process disability applications and prevent fraud and improper payments, significant additional effort and investment is necessary.

Social Security Lacks Sufficient Front-End Fraud Identification and Prevention

The New York and Puerto Rico fraud schemes revealed that numerous individuals, with the assistance of the same attorney, claimant representative, or other facilitator, could apply for DI, allege similar physical and/or mental impairments, provide similar fabricated or exaggerated medical documentation certified by a common physician or medical facility, and then receive DI.

The Agency's dated systems, combined with the diverse and unintegrated systems of 54 DDSs⁸, provide little protection against the cookie-cutter approach to large-scale DI fraud conspiracies such as those in New York and Puerto Rico, where only vigilant DDS analysts were finally able to detect signs of a scheme after millions of dollars were paid to fraudulent beneficiaries.

In both cases, SSA lacked the IT infrastructure and front-end analytics tools necessary to screen applications for "potential fraud warnings" and then to review or investigate further before approving; for example, flagging a string of disability claims from applicants in the same geographic area with a common claimant representative and similar alleged disabilities. Watchful SSA and DDS employees ultimately caught the patterns present in the fraudulent claims in New York and Puerto Rico, but not before the Agency approved those claims and made millions of dollars of payments to the beneficiaries.

Private insurance firms, such as the U.S.-based Unum Group, use predictive analytics to continuously monitor disability insurance claims for potential fraud.

Predictive analytics is the practice of extracting information from existing data sets to determine patterns and predict future outcomes and trends. It forecasts what might happen in the future.



⁸ The issue of DDS systems and their integration will be discussed under the next vulnerability.

In February 2014, before the Subcommittee on Social Security, J. Matthew Royal, Unum’s vice president and chief auditor, explained:

“Unum’s predictive model is a custom-built, internal model that integrates claims data from many sources. It analyzes multiple data points simultaneously to identify subtle variations and patterns among the data elements indicative of possible fraud. By using predictive analytics, fraud analysts can review thousands of claims to determine if additional investigation is warranted.”

“By using predictive analytics, fraud analysts can review thousands of claims to determine if additional investigation is warranted.”

– J. Matthew Royal, Unum Vice President and Chief Auditor

Strong fraud-risk management not only inspires public confidence in benefit-paying programs, but it can also contribute to significant program recoveries and projected savings. For example, the Commonwealth of Massachusetts is using predictive analytics to combat fraud in Medicaid payments; the system supports investigations by providing real-time risk assessments of health claims, according to a February 2014 *Government Computer News* report:

“By shifting away from a ‘pay-and-chase’ model, investigators have been able to recover \$2 million in improper payments and have avoided paying hundreds of thousands of dollars in fraudulent claims during the first six months of operations, said Joan Senatore, director of the Massachusetts Medicaid Fraud Unit.”

In the aftermath of the New York and Puerto Rico fraud schemes, SSA publicly announced intentions to increase its use of predictive analytics to deter and prevent disability fraud. For several years, SSA has used predictive analytics in its disability programs to prioritize which claims to select for continuing disability reviews (CDRs) and Supplemental Security Income (SSI) redeterminations. These tools allow the Agency to focus its resources on reviewing cases with the highest likelihood of being overpaid or beneficiaries no longer being disabled. The Agency also uses predictive analytics to select claims for quick disability determinations (QDD)⁹ or compassionate allowances.¹⁰ However, until recently, SSA had not embraced predictive analytics to identify claims with a high likelihood of being fraudulent.

⁹ When an individual files an application for disability benefits, he/she must tell SSA about his/her impairment, how it limits his/her ability to function, his/her medical sources, age, education, past work, etc. All of this information (whether collected in person, by telephone or online) is keyed into or downloaded into SSA’s Electronic Disability Collect System (EDCS). When the SSA Field Office transfers the case to the DDS for processing, the QDD predictive model runs and pulls data from selected fields in EDCS. The QDD model cleans up and spell-checks the unstructured data and then sends everything to the scoring engine, which rates over 40,000 items.

¹⁰ SSA OIG, *Compassionate Allowance Initiative* (A-01-10-21080), August 2010.

SSA EFFORTS

Predictive Analytics

This year, SSA began an initiative to develop predictive analytics to detect disability fraud. This project entails two phases:

Phase I: A 90-day “proof of concept” phase, completed in May 2014, set forth an objective to use data analytics to prove **known** fraud using disability claims data from the New York, Puerto Rico, and West Virginia schemes. According to the Agency, it achieved an 81, 91 and 86 percent match rate, respectively, in identifying claims in each fraud scheme. As part of its analysis, SSA looked at similar characteristics and groupings (that is, claimant representative, medical source, etc.) among disability claims.

Phase II: A 180-day phase to use predictive analytics to uncover **unknown** fraud using similar criteria deployed in Phase I, is ongoing. In addition, SSA is looking to build a fraud risk-scoring model, as well as determine the feasibility of establishing a joint anti-fraud organizational model composed of several SSA components. SSA is currently working with three vendors: Northrup Grumman and SaS on the use of the predictive analytics tool, and Accenture regarding a joint anti-fraud unit.

Fraud Prevention Units

In 2014, SSA established Fraud Prevention Units (FPU), with the first specialized anti-fraud unit in the New York Region. This anti-fraud initiative is comprised of about 20 dedicated disability examiners assigned to the Region’s Disability Processing Branch. The FPUs’ purpose is to review and identify suspicious disability claims, as well as handle related redeterminations.

SSA added additional units in Kansas City, which became operational in August, and San Francisco, which became operational in July. These three units will provide coverage and support for the Eastern, Midwest, and Western regions, respectively.

Disability examiners assigned to these units will conduct their normal disability claims duties; however, the units will be activated to provide support to the OIG during disability fraud investigations involving facilitators, or in furtherance of an impending disability fraud investigation.

According to SSA, the FPU would initially review and analyze cases identified through data analytics. If the FPU identifies suspicious activity, it would refer those cases to the OIG.

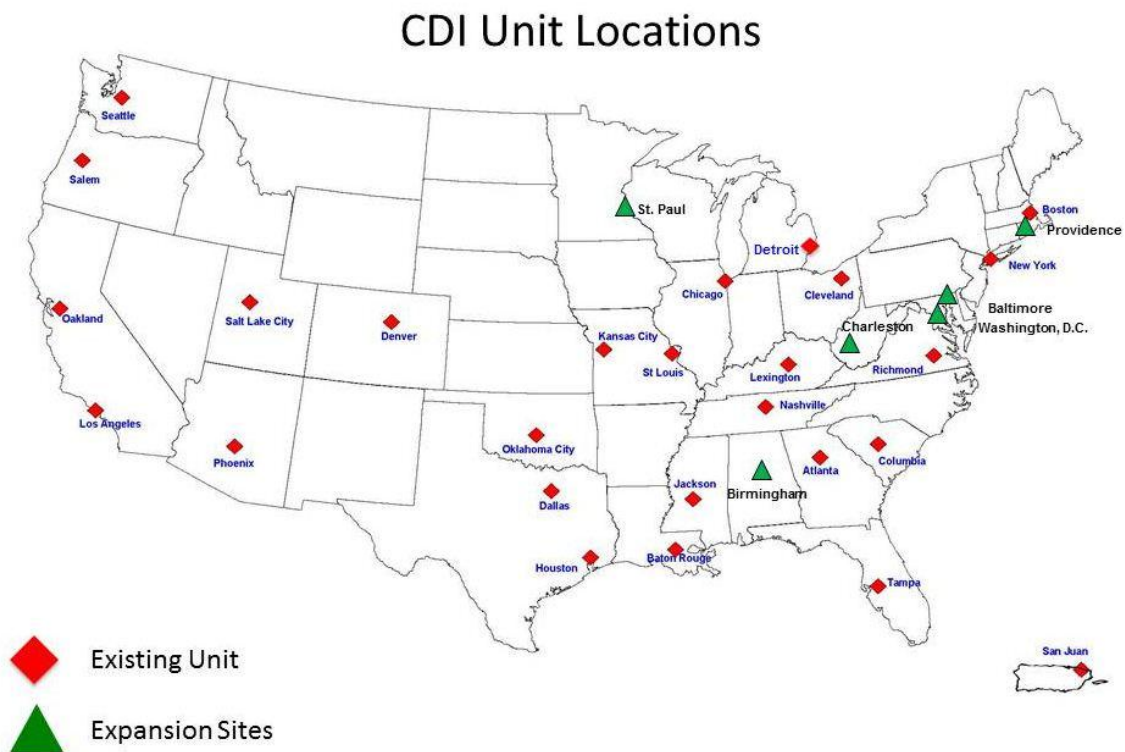
OIG EFFORTS

Cooperative Disability Investigations Units

Combating the myriad of ever-evolving fraud schemes requires a cache of proven tools; one such tool is the CDI program. This anti-fraud initiative, established jointly by SSA and the OIG, in conjunction with DDS agencies and State or local law enforcement, is one of the most effective guards against disability fraud. In FY 2013, CDI program efforts contributed to \$340 million in projected savings to SSA's disability programs.

Since its inception, the program has contributed to more than \$2.8 billion in projected SSA savings. Beginning in FY 1997, with five units, CDI now totals 26 units in 22 states and the Commonwealth of Puerto Rico. The most recent CDI unit opened in Detroit in August 2014. Employing the expertise of their respective agencies, the CDI team generally consists of an OIG special agent serving as the team leader, DDS disability examiners and SSA employees who are programmatic experts, and State or local law enforcement officers. CDI Units receive benefit claims identified as suspicious by the DDS or SSA and, where appropriate, investigate the claims to gather additional information to help the disability examiner make a more informed decision.

CDI program expansion, approved in 2014, includes adding State or local law enforcement investigators to existing units, and establishing six additional new units—increasing the program to 32 units by the end of FY 2015.



Disability Fraud Pilot

Expanding upon the CDI program, another OIG anti-fraud initiative is the Disability Fraud Pilot (DFP). This anti-fraud effort was implemented in July 2013 within the Chicago and San Francisco SSA regions. The pilot serves as an augmentation to expand upon the role of existing CDI Units. The DFP consists of five dedicated OIG special agents working in conjunction with the local CDI Units to investigate fraud allegations focusing on third-party facilitators, such as medical providers, claimant representatives, and others, alleged to be abusing SSA's disability programs by engaging in fraudulent practices.

Initially, the pilot involved four locations; subsequently, a fifth location was added. The pilot will continue until the end of FY 2014; then, based on the success of investigations conducted during the pilot, as well as an evaluation of its effect on the disability process, the Inspector General will consider expanding this initiative across all 10 of the OIG's field divisions.

As of September 2014, the OIG is currently investigating about 25 cases as a result of research and analysis from the DFP.

Ongoing, Planned Reviews

The OIG has contracted with Grant Thornton to complete a fraud risk assessment of Social Security's benefit programs; it is expected to be issued in the first quarter of FY 2015.

Also, in an effort to quantify the amount of fraudulent payments in the disability programs, the OIG also is working on an update to its 2006 report, *Overpayments in the Social Security Administration's Disability Programs*. SSA has repeatedly stated that the estimated rate of fraud in the disability programs is "less than 1 percent," and it has cited this 2006 report when doing so. However, the report was conducted to estimate the rate of disability *overpayments*, not fraud; overpayments can occur for a number of reasons, fraud being one of those reasons.

Of a sample of 1,562 beneficiaries, the OIG noted five cases that appeared prosecutable, and they were referred to the OIG's Office of Investigations. But an additional 287 beneficiaries in the sample (more than 18 percent) were found to have been overpaid, or had their benefits stopped because they were no longer eligible, or both. The OIG didn't pursue a determination as to whether those 287 beneficiaries might have committed *some type* of fraud that would've resulted in another outcome. Thus, it is misleading to use the five cases from this single audit report as the basis to estimate the overall rate of disability fraud at less than 1 percent.

The update to the 2006 report should provide more information on overpayments associated with disability fraud and abuse.

The OIG is currently investigating about 25 cases as a result of research and analysis from the Disability Fraud Pilot.

Social Security Lacks a Comprehensive Record Profiling Systems

SSA has several systems dedicated to improving its ability to process disability applications and maintain a claimant's record over time. However, none of the existing systems provide adequate tools for detecting and investigating fraud.

THE ELECTRONIC DISABILITY FOLDER

As part of the disability claims process, SSA utilizes its electronic disability folder to store claims records. The Agency began using this tool about 10 years ago and currently still receives and stores medical records as scanned images in this electronic folder. Prior survey work conducted by OIG auditors has found that medical records are usually scanned images of handwritten documents and do not contain searchable fields, thus it is difficult and time-consuming to perform records queries to group records.

By not having a comprehensive records profiling system or a comprehensive searchable system of records... the Agency is at a significant disadvantage in fraud detection, and particularly in the detection of fraud conspiracies.

Specifically, the lack of such systems extended the amount of time needed to investigate records of claimants in the New York and Puerto Rico cases, perhaps by years. The ailments and conditions, which were used repeatedly by claimants who were coached by the facilitators, were not easily or quickly discovered during manual review.

Furthermore, based on prior work conducted by OIG auditors, information in the electronic disability folder has a number of issues regarding its usability to conduct data analysis to identify and/or prevent fraud involving collusion among medical providers, claimant representatives, or Agency employees. Examples of such issues include:

Varied Names for the Same Treatment Source. The name of a treatment source could be entered into the electronic disability folder in a variety of ways. For example, the same source name may show up multiple times in SSA's records with slight spelling variations and extra characters, such as periods, commas, spacing, etc. Additionally, the source could appear under the physician's name and again under the name of the clinic or hospital where he or she treated the claimant.

Most Treatment Sources Listed Were Not Doctors. Most of the treatment sources in SSA's records associated with claimant representatives listed a hospital, not the physician. As a result, it is difficult to determine the treating physicians, based on record reviews. This would require staff to review each electronic disability folder (millions of them) to identify the specific treating physician in each document of medical records.

Also, SSA's systems do not track physicians in a searchable field, another limitation of the electronic folder. DDS examiners track who they contact to obtain and pay for medical records, which is usually a medical records department, and not necessarily a specific physician. Also, each of the 54 DDS agencies has its own version of a case processing system and a medical records vendor file that is a separate state-owned file (not an SSA-owned file) the office uses to request and pay for medical records.

eCAT

SSA in recent years rolled out the electronic Claims Analysis Tool (eCAT), a Web-based application designed to document the analysis made by a disability adjudicator and to ensure all relevant Agency policies are considered during the adjudication process. OIG has found that eCAT promoted the consistent application of Agency policy and resulted in better documented determinations.¹¹ However, the tool does not serve as the records-management system SSA needs in place to properly and effectively search claims for specific characteristics.

SSA EFFORTS

SSA has one of the largest repositories of electronic medical records in the world; therefore, making any changes to its systems requires significant resources and time. SSA is currently developing the Disability Claims Processing System (DCPS) to replace the separate DDS case processing systems with one system.¹² However, the project has experienced complications and taken longer than anticipated. In fact, the OIG is at this time conducting both an audit and an investigation at the request of the Social Security Subcommittee into the complications encountered and SSA's response to those complications. If these complications are overcome and the system is rolled out nationally and performs as intended, SSA will have one nationwide medical records vendor file to maintain.



¹¹ SSA OIG, *The Effects of the Electronic Claims Analysis Tool* (A-01-11-21193), July 2011.

¹² SSA OIG, *Identifying Requirements for the Disability Case Processing System Based on Findings from Prior Audits* (A-44-10-20101), November 2010.

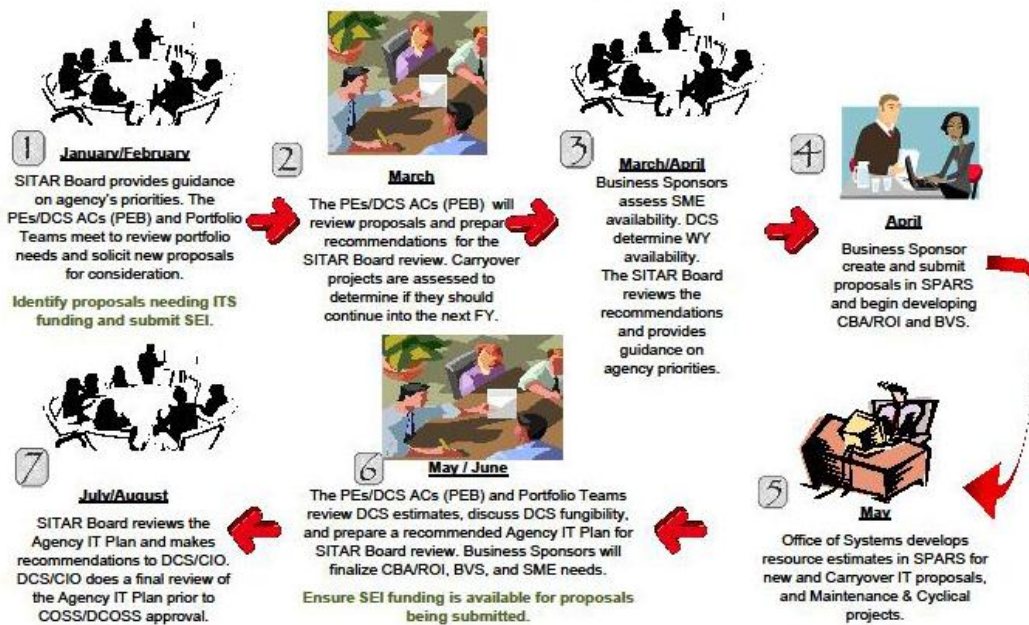
Concerns have also been raised that some claimants may withhold medical evidence that could be unfavorable to their claims; SSA has proposed revising regulations to require claimants to share or submit all evidence known to them that relates to their disability claim—both favorable and unfavorable. SSA also has proposed to require that a representative must assist the claimant to obtain the information or evidence that the claimant must submit.

OIG EFFORTS

The OIG has two DCPS reviews planned—*Update on the Disability Case Processing System* and *Information Captured in the Disability Case Processing System*. The reviews will determine whether SSA effectively managed project costs and achieved performance goals, and whether the data the system captures can support management analysis and fraud detection.

However, to make any major adjustments to DCPS at this stage, SSA would need to submit a formal Strategic Information Technology Assessment and Review (SITAR) proposal to modify its systems to collect additional information.

SSA IT Planning Process



Portfolio Teams meet periodically to discuss the health of the IT Plan and new proposal submissions.
SITAR Board reviews the Health of the IT Plan and approves adjustments to the IT Plan on a quarterly basis.

Prepared by DCS Planning Staff – January 2013

Social Security Does Not Track Data on All Claimant Representatives

Social Security claimants may choose to appoint an attorney or a qualified non-attorney to represent him or her in filing for benefits, as long as the appointed person is not disqualified or suspended from acting as a representative before SSA, or other agencies, or prohibited by law from acting as a representative.

The OIG has found that having a representative who assisted with the claims slightly increased the likelihood of an allowance. Conversely, claims where no representatives were involved generally had a lower allowance rate.¹³

A comprehensive tracking and review process on all claimant representatives could potentially have alerted SSA of the fraud schemes in New York and Puerto Rico earlier.

SSA does not have the infrastructure or a system to properly track the activity of non-attorneys, other claimant representatives, physicians, or medical providers. The Agency has a copy of the required form, the *SSA-1696: Appointment of Representative*, from all claimant representatives, however, SSA only tracks claimant representatives who receive payments directly from the Agency through their fee agreement or petition process. There are, moreover, many claimant representatives who are not paid directly by SSA—for example, those paid by a hospital or insurance company or those who waive their fees.¹⁴

The New York and Puerto Rico fraud schemes exposed the damaging effects third-party facilitators can inflict on the disability programs; in the New York scheme, the indicted beneficiaries were all represented by the same attorney, alleged similar ailments, and submitted medical documentation certified by the same physicians.

A comprehensive tracking and review process on all claimant representatives could potentially have alerted SSA of the fraud schemes in New York and Puerto Rico earlier, and the ability to compare and research electronic claimant forms and documents could have triggered a flag for the repeated use of the same facilitator or representative or even signaled the frequency of recurring impairments with verbatim descriptions.

SSA EFFORTS

This year, SSA began initiatives to link its different claimant and claimant representative systems to better track claimant representative activity.

¹³ SSA OIG, *Claimant Representatives at the Disability Determination Services Level* (A-01-13-13097), February 2014.

¹⁴ SSA OIG, *Claimant Representatives Barred from Practicing Before SSA* (A-12-07-17057), September 2007.

In the past, the OIG has raised concerns about SSA's screening of claimant representatives to identify those barred by any Federal or State Court or Federal program. The OIG found instances in which sanctioned representatives were representing claimants after being disqualified. Also, in some instances, the name of the representative listed on the SSA-1696 form did not agree with how the name appeared in SSA's Case Processing and Management System (CPMS).¹⁵

OIG EFFORTS

The OIG's Disability Fraud Pilot is performing data analysis and generating investigations from available claimant representative data. The OIG has also planned reviews that assess potential risk factors associated with the claimant representatives directly paid by the Agency and determine whether SSA is properly processing and timely resolving conduct issues related to claimant representatives.

Social Security Must Monitor and Strengthen Online User Authentication Controls

SSA has tapped advances in technology to reach and serve the public by allowing people to access their services online to conduct business, and even to file for DI benefits via the Internet claim (iClaim) process and the *my Social Security* online portal. The OIG, however, in recent years has investigated several cases of electronic DI fraud involving multiple victims.

For example, as the result of a single OIG criminal investigation, a Miami man in July 2014 pleaded guilty to using personal identifying information to establish online accounts on the SSA website, for already-existing retirement or disability beneficiaries to redirect payments to accounts he controlled. Law enforcement identified almost 950 fraudulently established *my Social Security* accounts, all with similar fraudulent email addresses. The fraudulent claims resulted in more than \$700,000 in fraudulent Social Security retirement and disability payments.¹⁶ This represents one of tens of thousands of allegations of fraudulent attempts to establish *my Social Security* accounts received by the OIG in the past year and a half.

In an effort to curtail fraudulent Internet activity, SSA has blocked suspect IP addresses from accessing *my Social Security* and direct deposit information. The OIG plans to evaluate the effectiveness of SSA's controls over iClaim applications.

¹⁵ SSA OIG, *Claimant Representatives Barred from Practicing Before SSA* (A-12-07-17057), September 2007.

¹⁶ U.S. Attorney's Office, Southern District of Florida, July 22, 2014.

Social Security's Disability Policies Should Reflect Advances in Medicine and Technology

LISTING OF IMPAIRMENTS

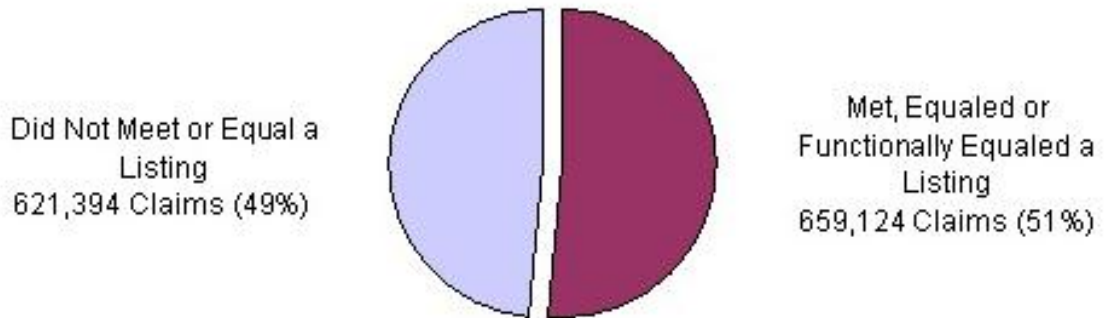
Since 2000, the OIG and the Government Accountability Office (GAO) have issued several reports about the Listing of Medical Impairments that SSA uses in developing disability claims and defining the applicant's medical impairment. These reports have concluded that SSA does not regularly update the Listing of Medical Impairments.¹⁷ These outdated listings do not reflect recent medical and technological advances; thus the listings may not be as effective a screening tool as they have been in the past. For that reason, in 2003, SSA implemented a new process to update and monitor the listings at least once every five years.¹⁸

Status of the Medical Listings as of August 2014			
Listing	Last Revision	Expiration Date	Current Status
Respiratory System	October 7, 1993	January 30, 2015	NPRM February 4, 2013.
Mental Disorders	September 18, 2000	January 2, 2015	NPRM November 11, 2010.
Musculoskeletal System	February 19, 2002	July 31, 2015	
Skin Disorders	July 9, 2004	January 30, 2015	NPRM November 10, 2009.
Growth Impairment	July 26, 2004	January 30, 2015	NPRM May 22, 2013.
Neurological	December 15, 2004	July 31, 2015	NPRM May 1, 2014.
Hematological Disorders	December 15, 2004	July 31, 2015	NPRM November 19, 2013.
Genitourinary Impairments	September 6, 2005	January 30, 2015	NPRM February 4, 2013.
Cardiovascular System	April 13, 2006	July 31, 2015	NPRM April 16, 2008.
Digestive System	December 18, 2007	January 30, 2015	
Immune System	June 16, 2008	June 16, 2016	NPRM March 25, 2014.
Malignant Neoplastic Diseases	December 2000	November 5, 2017	NPRM December 17, 2013.
Endocrine System	June 7, 2011	June 7, 2016	
Multiple Body Systems	April 5, 2013	April 5, 2018	
Special Senses and Speech	April 29, 2013	April 29, 2018	

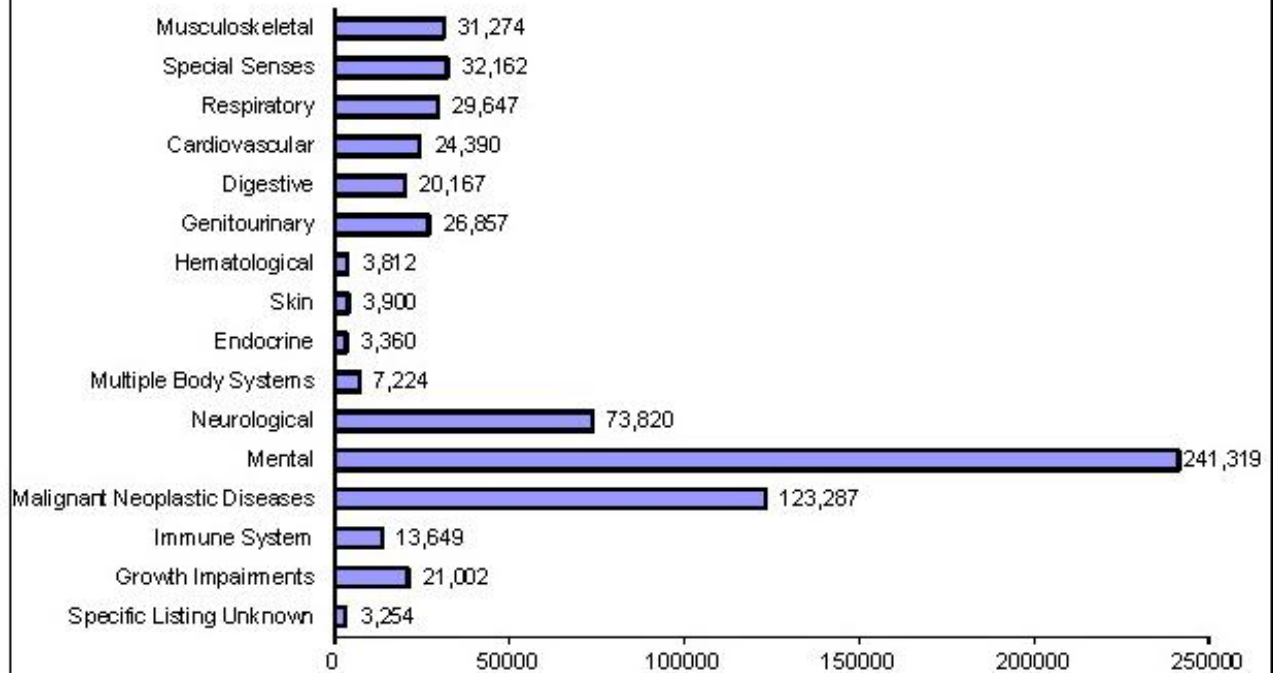
¹⁷ SSA OIG, *Status of the Social Security Administration's Updates to the Medical Listings* (A-01-99-21009), August 2000; GAO, *Re-Examining Disability Criteria Needed to Help Ensure Program Integrity*, August 2002.

¹⁸ SSA OIG, *The Social Security Administration's Listing of Medical Impairments* (A-01-08-18023), March 2009.

Chart 1: FY 2013 Initial and Reconsideration Allowances



Number of Initial and Reconsideration Claims Allowed Under Each Listing in FY2013



DICTIONARY OF OCCUPATIONAL TITLES AND O*NET

Since the early 1960s, SSA has used the occupational descriptions in the Dictionary of Occupational Titles (DOT) to determine if a claimant is able to perform former work or to do any work available in the national economy. The DOT was developed by the Department of Labor (DOL) in 1939, and it underwent its last major revision in 1977. In recent years, DOL replaced the DOT with the Occupational Information Network (O*NET), an online detailed resource of current job descriptions, however, neither the DOT nor O*NET was designed to be used for SSA's disability process.

As of 2014, SSA is working with the Bureau of Labor Statistics to test occupational data collection methods that could lead to the development of a new Occupational Information System (OIS) tailored for use in the disability programs. The new OIS would replace the outdated DOT; however, SSA acknowledges that many development and implementation challenges exist in this critical and complex undertaking.

SSA EFFORTS

In April 2014, before the Subcommittee on Energy Policy, Health Care and Entitlements, House Committee on Oversight and Government Reform, Marianna LaCanfora, SSA's Acting Deputy Commissioner for Retirement and Disability Policy, said the Agency is still at work and on track with these complex reviews and updates. SSA is currently working with the Disability Research Consortium and the Library of Congress in a literature review to look at how other disability systems factor in age, education and work history. The Agency intends to update the vocational grids, used to establish disability and to identify other work that a claimant could perform. The OIG plans to audit SSA's efforts to replace the DOT in the disability adjudication process.



Social Security Should Consider Consulting Claimant Social Media Activity During Reviews

Reviewing public social media information posted by disability applicants has proven to be a valuable tool in the OIG's criminal investigations of potential disability fraud; for example, social media played a critical role in the New York disability fraud investigation, as disability claimants were seen in photos on their personal accounts, riding on jet skis, performing physical stunts in karate studios, and driving motorcycles. That information on its own did not build the entire case for investigators, but the social media review was a crucial step in the evidence-gathering process.

SSA does not allow its employees or DDS employees to consult this information during adjudication of a claim. Allowing them to do so would require new policy, guidance, training, and oversight.

SUMMARY

SSA is committed to training new and current employees to be watchful of questionable or suspicious disability claims. Currently, disability examiners in 22 states can refer suspect claims to CDI Units for further investigation; the CDI program has proven to be effective in detecting and preventing disability fraud and played a critical role in the New York disability fraud investigation.

The Agency has actively expanded its anti-fraud initiatives this year, establishing three Fraud Prevention Units and kick-starting efforts to apply predictive analytics to the disability application process. Still, for SSA, which pays more than \$850 billion in benefits to 65 million people every year, an investment in state-of-the-art software to properly store and analyze claims records to ensure payment integrity and accuracy is a necessary cost of business.

While SSA also needs systems that can track claimant representative information and activity, the Agency should focus efforts on righting the DCPS project, which might assist with recording claimant information that could be used to detect and prevent fraud.

SSA is working with several outside organizations to review disability policy with respect to current advances in medicine and technology. While this is a complex and lengthy undertaking, updated policy in the 21st-century economy could serve as an effective screening tool in the application process.

THE APPEALS STAGE

As previously outlined, if a disability claimant is dissatisfied with the initial DDS determination, the claimant may request that the DDS reconsider it. A claimant may then request a hearing before an ALJ if he or she is dissatisfied with the reconsideration determination. In 10 states, though, the reconsideration step has been eliminated, making a hearing before an ALJ a claimant's first step of appeal in some areas.

When the claimant does not waive his or her rights to appear at the hearing, the ALJ reviews information obtained from questioning the claimant, his or her representative, and witnesses. In addition, the ALJ reviews the evidence on file and any additional evidence submitted for consideration. The ALJ then issues a decision.¹⁹

SSA's Office of Disability Adjudication and Review (ODAR) comprises 169 hearing offices, five national hearing centers, and one national case assistance center.

In FY 2013, ODAR reported 824,989 hearing receipts; 1,525 ALJs made 793,580 hearing decisions, with an average case processing time of 382 days. In conducting this work, ALJs, managers, and staff are expected to adhere to ODAR's policies and procedures to ensure each claimant has a fair hearing. The Agency expects its managers to monitor the quality of the hearing process, direct sufficient resources to key workloads, and address allegations pertaining to deviations from proper case handling. ALJ hearings are non-adversarial; while the claimant has the right to be represented at the hearing, the DDS is not represented.

A May 2011 *Wall Street Journal* article, which identified ALJ outliers based on their disposition and allowance rates, focused on the activity of an ALJ in Huntington, West Virginia. This article coincided with an OIG investigation into the ALJ in question and his extremely high allowance rate. The OIG investigation, coupled with media and congressional scrutiny on the ALJ and his office, has thrust SSA oversight of ALJs and their activity into the spotlight.



¹⁹ A claimant may request the Appeals Council (AC) to review his or her case if dissatisfied with the ALJ's decision. If the AC agrees to review the case, it will consider the evidence on file, any additional evidence submitted by the claimant and the ALJ's findings and conclusions. The AC will then: (1) uphold or reverse the ALJ's decision or (2) remand the case to the ALJ to issue a new decision, to obtain additional evidence or to take additional action. If still dissatisfied, the claimant may file a suit with a Federal District Court, then the U.S. Circuit of Appeals, and ultimately the Supreme Court of the United States.

“OUTLIER” JUDGES

In the Huntington case, one private attorney representing numerous SSA claimants allegedly regularly collaborated with several medical providers and a particular ALJ, leading to a significant amount of questionable disability allowances for the attorney’s clients. Although ODAR had previously taken steps toward improving its monitoring of ALJs, this alarming allegation spurred even more focus on this critical issue. In June 2011, the Subcommittee on Social Security requested that the OIG provide information on ALJs who were significant outliers either in terms of their productivity or their decisional outcomes.

Using FY 2010 data, the OIG found 1,398 ALJs issued between one and 3,620 decisions. While the average decisional allowance rate for ALJs (with 200 or more decisions) in FY 2010 was 67 percent, it ranged from a low of 8.6 percent to a high of 99.7 percent nationwide. In OIG surveys, hearing office staff attributed the variance in allowance rates to ALJs’ decisional independence and discretion when interpreting law, as well as the demographics of the hearing office service area population.

Other factors that could affect ALJ allowance rates, according to hearing staff, included

- the amount of evidence in the file and how the case was developed,
- DDS allowance rates and case development,
- use of medical and vocational experts,
- pressure from management to complete a certain number of cases,²⁰ and
- the claimant’s credibility as well as related evidence.

The OIG review found a wide variance in ALJ decisional outcomes and identified 24 “outlier” ALJs—12 with the highest allowance rates and 12 with the lowest allowance rates. Among the 24 outliers, one ALJ with a high allowance rate had a disproportionate number of cases (59 percent) with a single claimant representative, which was an indication of a potential problem with case rotation. Within hearing offices, policy calls for cases to be assigned on a rotating basis; therefore, one ALJ should not be assigned a disproportional number of cases from one claimant representative. Normally, based on the circumstances of this office, the number of cases for one ALJ from a single claimant representative would be about 11 percent.²¹

²⁰ Several ALJs reported that some of their peers felt pressure to meet SSA’s 500-to-700 decision benchmark, and they may have allowed more cases because allowances are easier to process than denials. In an October 2007 Memorandum, ODAR’s Chief ALJ identified expectations regarding the services ALJs provide to the public. Primarily, he asked ALJs to issue 500 to 700 legally sufficient decisions each year; act on a timely basis; and hold scheduled hearings unless there is a good reason to postpone or cancel. SSA considers the 500 minimum decisions a goal, not a quota.

²¹ SSA OIG, *Oversight of Administrative Law Judge Workload Trends* (A-12-11-01138), February 2012.

OIG interviews with hearing office staff, as well as data analysis, identified exceptions to case rotation, such as dismissals, on-the-record (OTR) decisions²², and a disproportionate number of cases heard by one ALJ with a single claimant representative that may indicate continuing issues with workload assignment. The prior ability of ALJs to select and/or reject cases, subjectively, or to self-assign cases, might have fostered opportunities for collusion and conspiracy among judges and claimant representatives.²³

In 2011, though, ODAR’s Acting Chief ALJ issued a memorandum with new restrictions on case assignments and reassignment. Following the memorandum was an update to the Case Processing and Management System (CPMS), restricting the authority to assign cases from the master docket to the Hearing Office Chief ALJ, the Hearing Office Director, and group supervisors.

OVERSIGHT OF JUDGES

In 2013, the OIG reported that ODAR had created 19 ranking reports that measured hearing office performance using a single risk factor, such as a report on average processing time or pending cases per ALJ. However, ODAR had not established a process to rank hearing office performance using a combination of risk factors.

Hearing Office Ranking Reports

Report Name	
Average Processing Time	Pending per ALJ
Average Age of Pending	Percentage of Dispositions Less than 180 Days
Continuance Rate	Percentage of Dispositions over 270 Days
Decision Writing Pending Days	Percentage of Dispositions over 365 Days
Decision Drafted per Month per Decision Writer	Postponement Rate
ALJ Dispositions per Day per ALJ	Productivity Index
Dispositions to Receipt Ratio	Pulling Pending Days
Held per ALJ per Day	Scheduled per ALJ per Day
Held to Schedule Rate	Total Receipts per Day per ALJ
Number of Cases Pulled per Resource	

²² An OTR decision is a favorable ruling by an ALJ prior to a hearing, based on medical records provided to the ALJ.

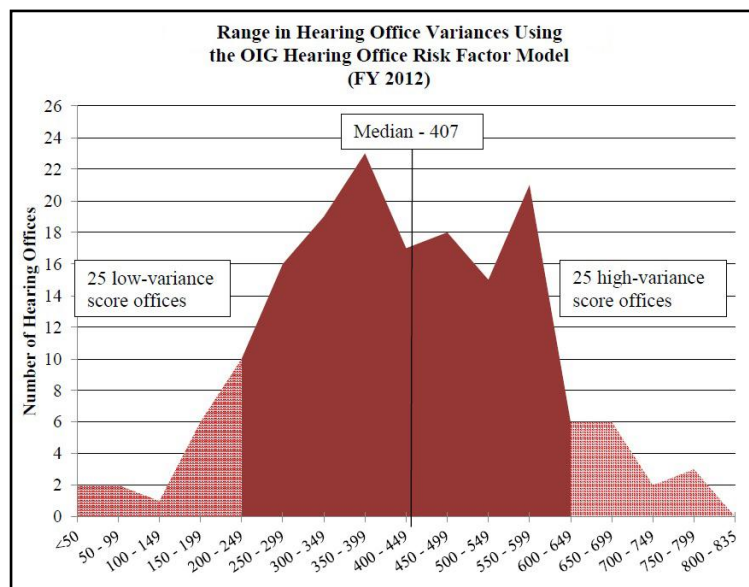
²³ An OIG review of FY2011 and FY2012 data found that just four hearing offices had case-rotation issues throughout the period that were primarily related to their remote sites. The OIG also determined that the number of hearing offices with case-rotation issues declined over the previous 18-month period; managers at the offices credited the improvement to, among others things, increased management oversight and changes in ALJs. SSA OIG, *Hearing Office Case Rotation Among Administrative Law Judges* (A-12-12-11274), March 2013.

In FY 2011, ODAR began developing an early monitoring system to measure ALJ performance based on a combination of risk factors, such as number of dispositions, number of on-the-record decisions, and frequency of hearings with the same claimant representative. A quality division then reviewed potential issues identified in the ALJ monitoring system to ensure compliance with established policies and procedures.

While this ALJ monitoring process assisted management with its oversight of the hearings process, the OIG found ODAR would enhance this process by creating an early monitoring system that evaluates *multiple* risk factors relating to hearing office performance. A hearing office risk factor report would allow ODAR to place the issues identified in an ALJ early monitoring system into context, and would give ODAR managers more information relating to management controls in each hearing office.²⁴

Later, the OIG developed a model that analyzed individual hearing office performance and measured variances among multiple risk factors. The model analyzes performance and outcome data among ALJs in the same office and uses five risk factors: (1) ALJ allowance rates, (2) ALJ dispositions, (3) ALJ OTR decision rates, (4) ALJ dismissal rates, and (5) ALJ average processing time.

Using the model and FY 2012 workload data, the OIG identified hearing offices with the highest variance scores (possible outliers) and lowest variance scores (possible best practice offices). Outlier hearing offices could provide ODAR managers with indications of potential processing issues as well as potential best practices. The review of the hearing offices with the 10 highest variance scores identified an outlier ALJ who had a significant number of dispositions and OTR decisions with a single claimant representative. The OIG referred this case to ODAR management for additional review.



The OIG model would have identified the Huntington, West Virginia hearing office as an outlier office in FY 2010.

²⁴ SSA OIG, *Identifying and Monitoring Risk Factors at Hearing Offices* (A-12-12-11289), January 2013.

The OIG has recommended that ODAR's early monitoring system should combine existing information on ALJ OTR decisions and case rotation to identify any ALJ who issues a high percentage of OTR decisions with the same claimant representative.²⁵

The OIG's oversight of potential outlier judges is ongoing, with a review that will identify ALJs who have both high productivity *and* high allowance rates on their cases. The OIG will also examine OTR decisions processed by hearing offices within 100 days and the Agency's efforts to reduce the number of postponed hearings.

DECISION REVIEWS

The U.S. Congress created the administrative hearing process and the quasi-independent ALJ position to ensure public confidence in the adjudication process and in decisions on disability appeals. However, the restricted authority granted to SSA limits its oversight of ALJ productivity and decisions.

SSA is authorized to review ALJ decisions, but is also restricted by law in how the reviews are conducted. Specifically, SSA regulations state that in pre-effectuation reviews, where the ALJ's decisions are subject to change, that neither SSA's random sampling procedures nor its selective sampling procedures will identify ALJ decisions for review based on the identity of the decision maker or his or her office.²⁶ The *Administrative Procedures Act* and other ALJ-related statutes would need to be changed to modify SSA's authority to conduct pre-effectuation reviews of specific ALJ decisions.

Instead, SSA is limited to performing post-effectuation reviews of specific ALJs decisions, and typically, ALJ decisions are not changed after those reviews. SSA's role in the review process is to determine whether the ALJ followed SSA's policies and procedures, and if not, provide training for the ALJ, and if warranted, issue directives for compliance.

SSA, in conducting these pre- and post-effectuation reviews of ALJs' decisions, uses the results to identify changes that are needed in its policies and procedures, and to develop training for ALJs and hearing office staff.²⁷

²⁵ SSA OIG, *Analysis of Hearing Offices Using Key Risk Factors* (A-12-13-13044), December 2013.

²⁶ During pre-effectuation reviews, the AC has 60 days to decide whether to take an "own motion" review of a claimant's case, and the decision is subject to change based on the review results. SSA performed about 17,000 "own motion" reviews from 2011 to 2013.

²⁷ SSA OIG, *The Social Security Administration's Review of Administrative Law Judges' Decisions* (A-07-12-21234), March 2012.

In November 2013, before the Subcommittee on Energy Policy, Health Care and Entitlements, House Committee on Oversight and Government Reform, Glenn Sklar, ODAR's Deputy Commissioner, mentioned the obstacles SSA faces in disciplining ALJs:

“Agency managers may take certain corrective measures, such as informal counseling or issuing a disciplinary reprimand. However, the agency cannot take stronger disciplinary measures against an ALJ, such as removal or suspension, reduction in grade or pay, or furlough for 30 days or less, unless the Merit Systems Protection Board (MSPB) finds that good cause exists.”

The Huntington case ... sparked interest in ALJ oversight and raised questions related to SSA's reviews of ALJs and its ability to confront ALJs with conduct, performance, and policy compliance issues.

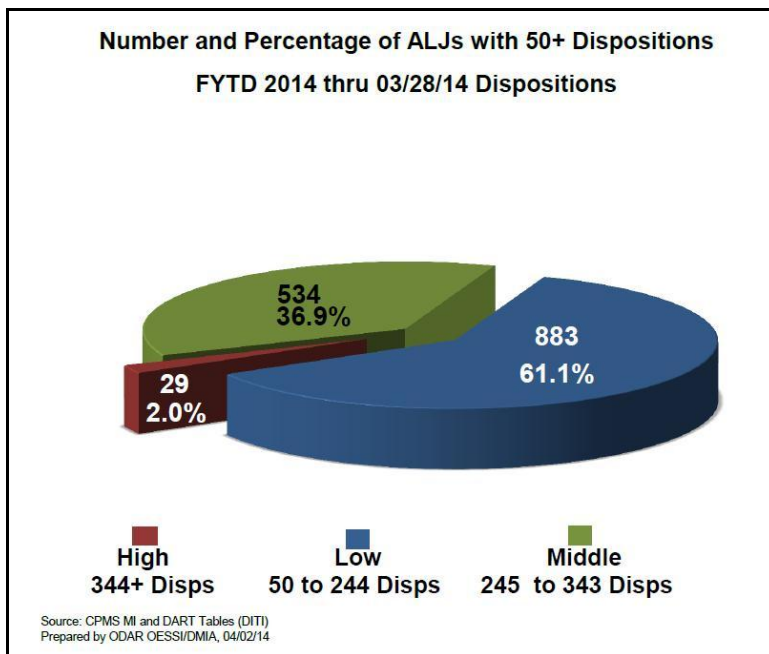
The Huntington case was, arguably, the by-product of a culture of invincibility among the ALJ corps, resulting not only from its judicial independence, but from decades of poor case law and inattention. But it sparked interest in ALJ oversight and raised questions related to SSA's reviews of ALJs and its ability to confront ALJs with conduct, performance, and policy compliance issues.

In recent years, the tide has shifted somewhat dramatically toward accountability, as the Agency has taken a methodological approach toward inappropriate conduct, poor performance, and failure to follow policy. SSA has brought a number of successful cases against ALJs before the MSPB, resulting in case law that requires ALJs to behave appropriately, demonstrate good public service, and follow Agency policy.²⁸

²⁸ ODAR has renewed emphasis on ALJ training, to ensure that ALJs comply with law, regulations, and policies. ODAR trains ALJs on the agency's rules and policies, with a focus on the limits of an ALJ's authority in the hearing process, including the ALJ's obligation to follow the agency's rules and policies.

Additional efforts to promote policy compliance include a pilot of the Electronic Bench Book (eBB) for adjudicators. Similar to eCAT for disability examiners, the eBB is a policy-compliant Web-based tool that aids in documenting, analyzing, and adjudicating a disability case in accordance with SSA regulations. The OIG has a review planned that will examine eBB's effect on the hearings process.

The ALJs did not give ground easily, contesting not only those cases, but contesting the dispositional goal set by then-Chief ALJ Frank Cristaudo, which was a non-binding goal of completing 500 to 700 cases annually, in a quality-conscious and legally defensible manner. Although the goal was challenged in Federal court, the case was dismissed and is currently on appeal. Meanwhile, the majority of ALJs are meeting that goal. This SSA chart reflects ALJ dispositions for the first half of FY 2014:



To ensure that ALJs are issuing an acceptable number of high quality and accurate decisions,²⁹ and complying with Agency policy, ODAR has committed to harnessing the wealth of information it collects, turning it into actionable data. ODAR now collects a significant amount of data from the Appeals Council concerning the application of agency policy in hearing decisions.

Using these data sets, ODAR provides feedback on decisional quality, giving adjudicators real-time access to their remand data. The feedback tool "How MI Doing?" gives ALJs information about their Appeals Council remands, including the reasons for remand, but also information on their performance in relation to other ALJs in their office, their region, and the nation.

ODAR also established the Division of Quality (DQ) in FY 2010. Prior to the creation of the DQ, ODAR did not have the resources to examine ALJ allowances. Since FY 2011, the DQ has conducted pre-effectuation reviews on a random sample of ALJ allowances every year.

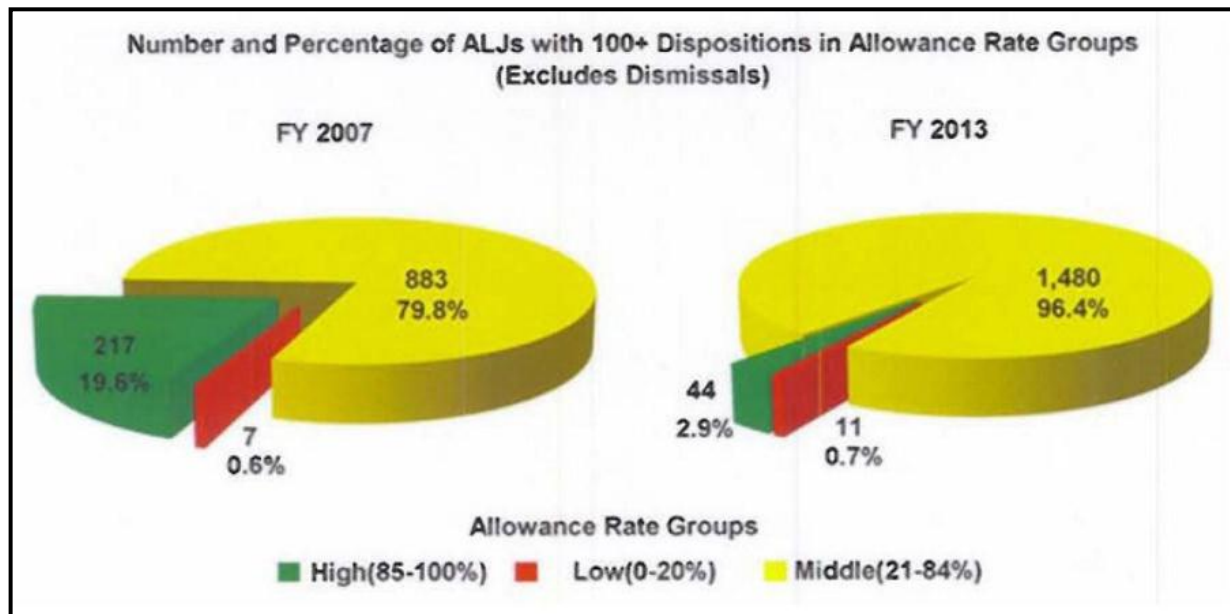
²⁹ SSA has placed a cap on the numbers of cases each ALJ can be assigned annually, currently 840. SSA OIG, *Request for Review Workloads at the Appeals Council* (A-12-13-13039), March 2014.

The DQ also performs post-effectuation focused reviews looking at specific issues—hearing offices, ALJs, representatives, doctors, and other participants in the hearing process. Because these reviews occur after the 60-day period within which a claimant must appeal the ALJ decision, the reviews do not result in a change to the decision, so the regulatory restrictions regarding random and selective sampling do not apply.

In a critical change from prior practice, the DQ is now reviewing not only denials, but allowances, eliminating what could have been an off-kilter incentive for ALJs to pay cases, as they would receive no further scrutiny. This new review process, coupled with existing reviews of denied cases, has created a truer illustration of ALJ decision-making and allowed the Appeals Council to amass large datasets documenting where ALJs are most likely to make mistakes.

SSA has also added two new types of ALJ reviews: focused reviews, which look at closed cases for policy compliance, and a selective sampling procedure, which encourages the Agency to use data to identify error-prone areas.

Deputy Commissioner Sklar has pointed to ALJ performance statistics to support ODAR’s efforts on quality control. In FY 2007, 19.6 percent of ALJs allowed more than 85 percent of their cases; in FY 2013, that percentage dropped to 2.9 percent of ALJs, in effect decreasing the number of “outliers” like the judge identified in West Virginia.



USE OF MEDICAL AND VOCATIONAL EXPERTS

The medical expert (ME) program is designed to provide expert witnesses for ODAR cases pending before an ALJ. MEs include physicians and mental health professionals. These individuals, who provide impartial expert opinions at the hearing level of the claims process, testify at hearings or provide written responses to interrogatories on disability claims. A regional ME program coordinator is required to recruit people who are qualified to serve as credible expert witnesses, screen the credentials and background of applicants, and provide a list of available MEs to hearing offices in that region. The OIG plans to evaluate the Agency's ME screening process to ensure that SSA staff are complying with policy, and that issues regarding questionable experts are appropriately flagged, investigated, and resolved.

ALJs may also request vocational experts (VE) to testify at hearings. The ALJ decides whether to receive the VE opinion at the hearing, by telephone, by videoconference, or in response to written interrogatories. While the *Social Security Act* does not specifically require that the ALJ obtain VE testimony, it requires consideration of matters within the VE's expertise, such as whether the claimant can engage in substantial gainful activity in the national economy.

The OIG previously found that ODAR did not have a unified national strategy to advertise for VE services. Hearings offices have advertised for VE services mainly by word of mouth and online. A lack of SSA outreach may lead to a more limited pool of qualified candidates and deprive potential candidates of an opportunity to participate in the program.³⁰

SUMMARY

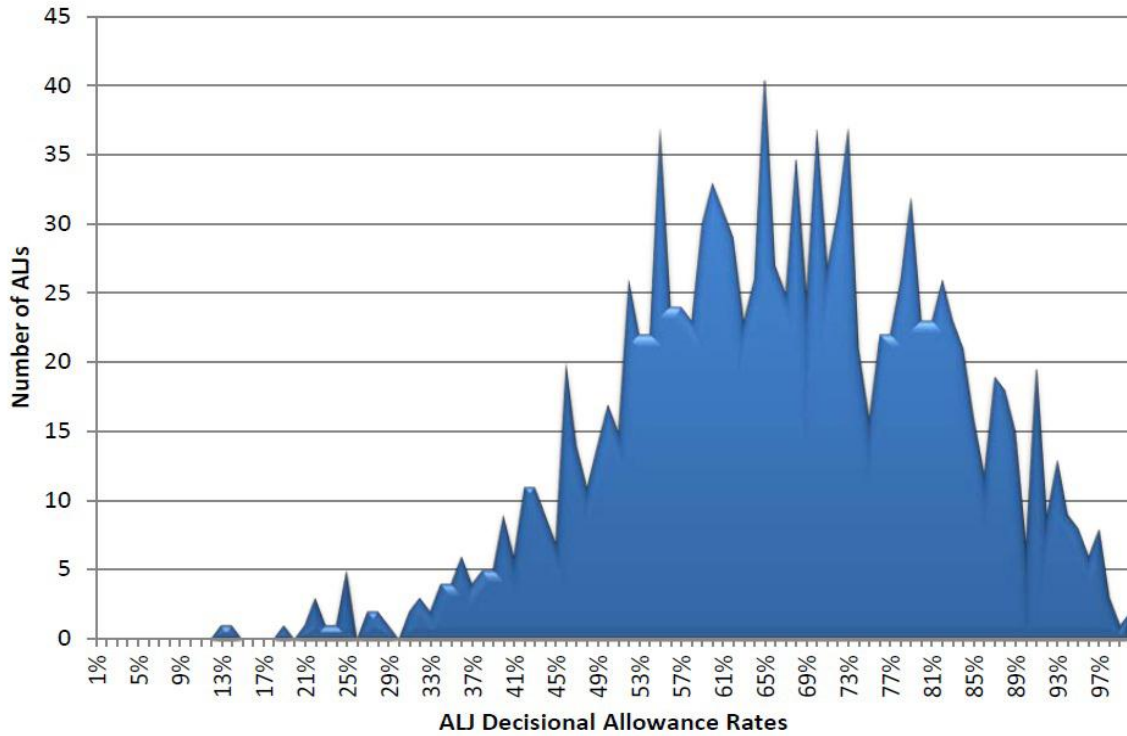
ODAR's commitment to improving the quality of ALJs' decisions is commendable and encouraged; in the charts on Page 33, ALJ allowance rates in FY 2013 have pushed toward the center and track closer to a normal bell curve than in FY 2010.

To further its oversight of hearing offices and ALJs, SSA should:

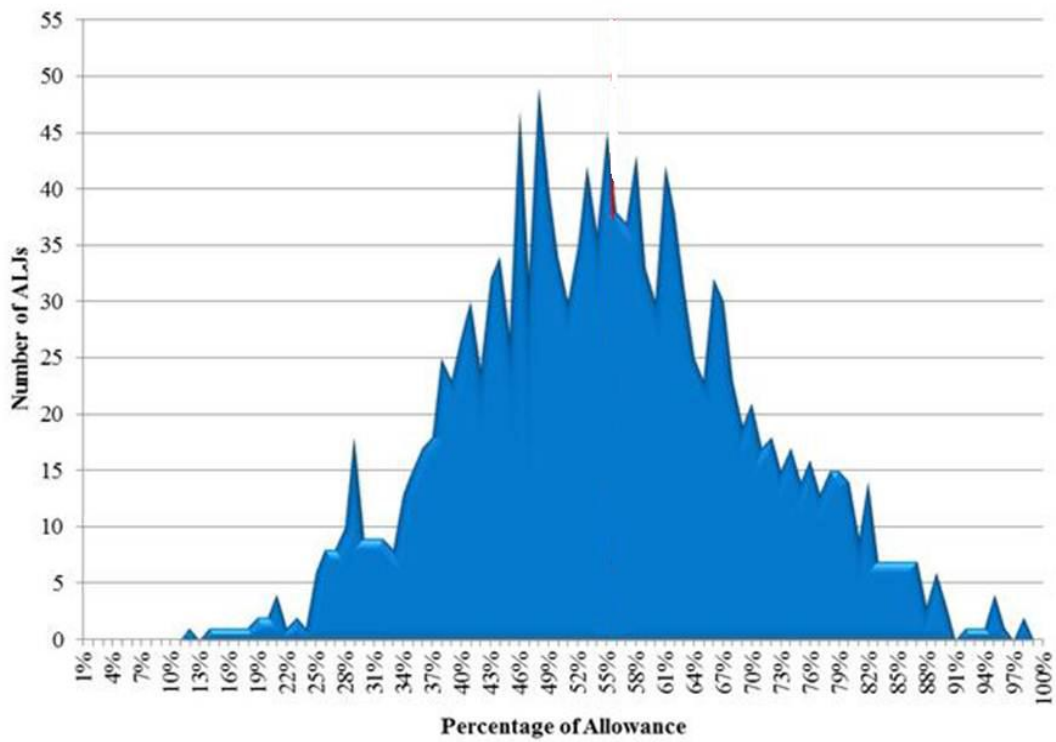
- Develop routine computer matching to identify high-allowance ALJs and any connections to the same claimant representatives and/or doctors/medical facilities.
- Develop a software tool that can review medical records and other claim information in SSA's systems for patterns, such as similar phrases describing the alleged disability impairment(s).
- Establish a process to rank hearing offices using a combination of risk factors to identify potential outlier offices and judges.

³⁰ SSA OIG, *Availability and Use of Vocational Experts* (A-12-11-11124), May 2012.

FY 2010 ALJ Decisional Allowance Rates
 (Relates to 1,256 ALJs with at least 200 dispositions)



FY2013 ALJ Decisional Allowance Rates
 (Relates to 1,477 ALJs with at least 200 dispositions)



INTEGRITY REVIEWS

This report, thus far, has focused on various vulnerabilities present at the initial application and hearings stage of the disability process, which left Social Security susceptible to the fraud schemes uncovered in New York and Puerto Rico and investigated in Huntington, West Virginia. While it is critical that SSA and the OIG work to solve those vulnerabilities and increase its reviews and analysis of claims at the initial application and hearings stages, other management and policy issues exist that, if addressed, could contribute to the overall improvement of the integrity of the disability process.

CONTINUING DISABILITY REVIEWS

For many years, the OIG has identified full medical continuing disability reviews (CDRs) as highly effective guards against improper payments and disability program fraud. After an individual is determined to be disabled, SSA is required to conduct periodic CDRs to determine whether the individual continues to be disabled. However, SSA generally cannot find an individual's disability has ended without finding medical improvement has occurred. Diaries are set for

- six to 18 months when improvement is expected,
- up to three years when improvement is possible, and
- five to seven years when improvement is not expected.

If SSA determines the person's medical condition has improved such that he or she is no longer disabled according to its guidelines, it ceases benefits. The Agency estimates that every \$1 spent on medical CDRs yields about \$9 in savings to SSA programs as well as Medicare and Medicaid over 10 years.³¹

SSA employs a profiling system that determines the likelihood of medical improvement for disabled beneficiaries. SSA selects the records of those beneficiaries that have been profiled as having a high likelihood of improvement for a full medical review by DDS. Beneficiaries profiled as having a medium or low likelihood of medical improvement are sent a mailer questionnaire to respond to.³² A vast majority of low-scoring cases can be completed at this point and do not require a full medical review; but if there is an indication of medical improvement, SSA sends the case for full medical review.

In 2010, the OIG determined that SSA's number of completed full medical CDRs declined by 65 percent from FYs 2004 to 2008, resulting in a significant backlog. The OIG estimated that SSA

³¹ SSA, *Annual Report on CDRs*, September 2013.

³² SSA completed more than 1.1 million mailer CDRs in FY 2013.

would have avoided paying at least \$556 million during calendar year 2011 if SSA had conducted the medical CDRs in the backlog when they were due.³³

According to SSA, in FY 2013, the Agency completed 428,658 medical CDRs; more than 115,000 of these, or about 27 percent, resulted in an initial cessation of benefits.³⁴

Program Integrity Funding, Spending, and Workloads, FYs 2002 Through 2013

Fiscal Year	Dedicated Program Integrity Funding (Millions)	Program Integrity Spending (Millions)	Mailer Only CDRs Completed	Full Medical CDRs Completed	Number of Redeterminations Completed
2002	\$630	\$976	729,242	856,849	2,311,499
2003	\$0	\$922	701,870	669,385	2,449,674
2004	\$0	\$891	923,670	681,010	2,278,566
2005	\$0	\$757	985,096	530,381	1,724,875
2006	\$0	\$523	1,020,725	316,913	1,070,822
2007	\$0	\$417	557,215	207,637	692,485
2008	\$0	\$555	845,915	245,388	899,507
2009	\$504	\$715	785,023	316,960	1,389,931
2010	\$758	\$879	631,615	324,567	2,248,163
2011	\$756	\$909	1,063,405	345,492	2,223,097
2012	\$756	\$979	961,069	443,233	2,407,836
2013	\$743	\$1,098	1,146,947	428,568	2,436,705

MEDICAL CDR BACKLOG

The medical CDR backlog stood at 1.3 million at the end of FY 2013. This year, the OIG evaluated SSA’s progress in completing program integrity workloads, in light of the Agency’s annual congressional appropriations and dedicated funding for program integrity efforts like CDRs. The OIG determined:

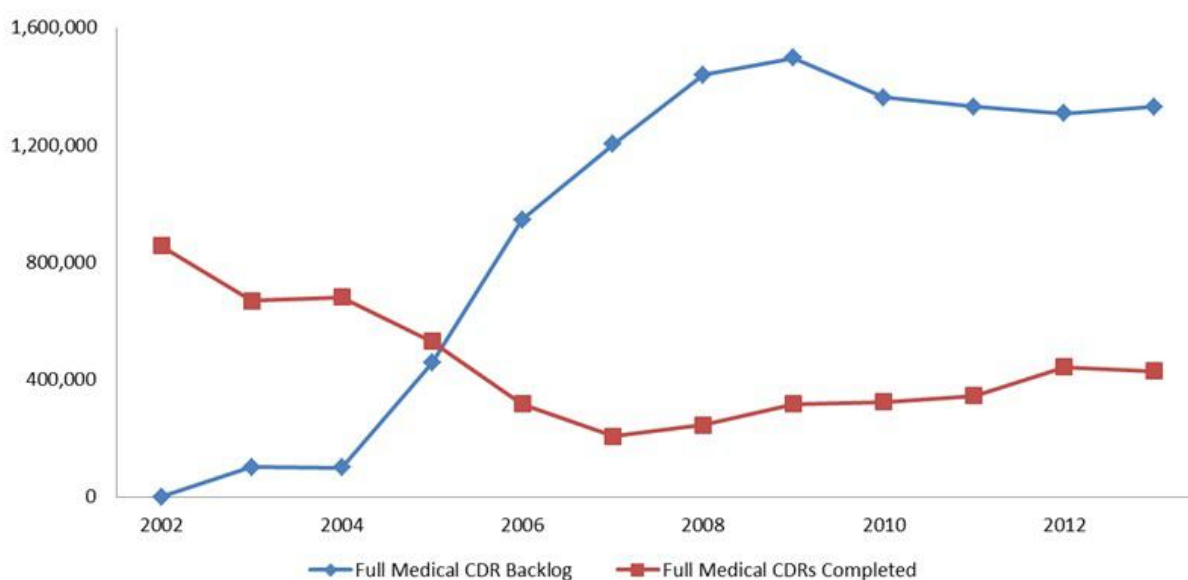
- In FY 2002, SSA received \$630 million in dedicated funding for program integrity work; that year, the Agency completed 856,849 medical CDRs.

³³ SSA OIG, *Full Medical Continuing Disability Reviews (A-07-09-29147)*, March 2010.

³⁴ This number does not take into consideration the number of cessations that will be upheld on appeal. SSA estimated that about 67 percent of the 96,012 CDR cessations in FY 2011 would be upheld on appeal, for example.

- From FYs 2003 to 2008, SSA did not receive any dedicated funding for program integrity; CDR workloads decreased, and the CDR backlog grew significantly.
- Since FY 2009, SSA has received dedicated program integrity funding; the Agency began increasing its program integrity workloads, but despite recent improvements, it has completed less program integrity work than it had in the past.
- For example, in FY 2013, SSA received \$743 million in dedicated program integrity funding, but completed about half the number of medical CDRs it completed in FY 2002 with less integrity funding.
- For FY 2014, under the *Consolidated Appropriations Act of 2014*, SSA received about \$1.2 billion in dedicated program integrity funding, and recent information received from the Agency suggests that it plans to complete 510,000 medical CDRs.

Full Medical CDR Backlog and Completions, FYs 2002 Through 2013



SSA has reported it would need \$11.8 billion in funding over the next 10 years to eliminate the medical CDR backlog by FY 2018 and prevent its recurrence through FY 2023. Under this scenario, SSA should identify tens of billions of dollars in lifetime Federal benefit savings.

However, to eliminate the backlog and achieve these savings, as SSA has reported, it would require program integrity funding in excess of that planned under the *Budget Control Act of 2011* (BCA), which was to provide SSA's integrity funding through FY 2021.

The BCA funding level would provide SSA \$10.3 billion for medical CDRs over the next 10 years, which should also enable SSA to identify tens of billions of dollars in lifetime Federal benefits savings and reduce the backlog dramatically by the end of FY 2018, though the backlog would grow in subsequent years. Therefore, SSA may only be able to reduce the CDR backlog temporarily based on the Agency's plans for integrity workloads under different funding

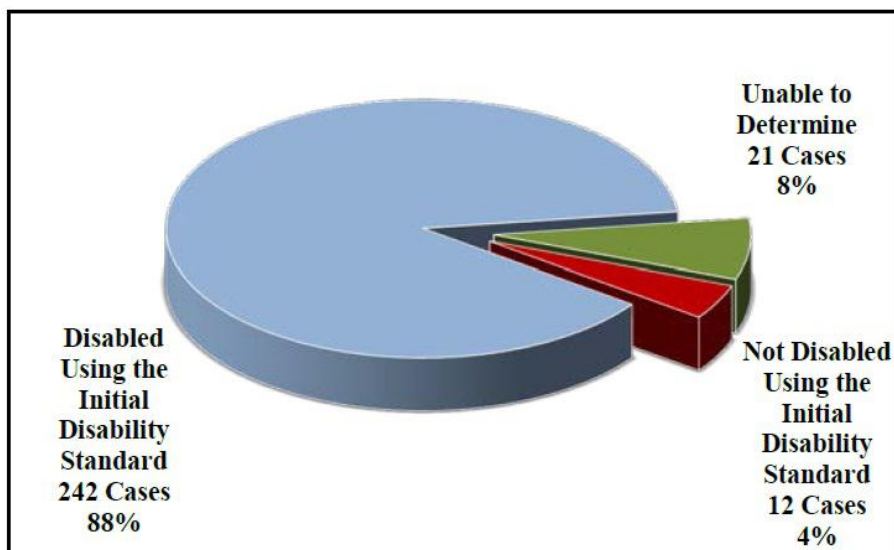
scenarios. The OIG has consistently recommended that SSA prioritize the use of available resources toward CDR workloads so it does not miss opportunities to realize potential savings.³⁵

THE MEDICAL IMPROVEMENT REVIEW STANDARD

The OIG has also reviewed SSA’s adherence to the medical improvement review standard (MIRS) and its effect on the beneficiary rolls. During a CDR, SSA follows MIRS—mandated by the *Social Security Disability Amendments of 1984*—to determine if a beneficiary’s impairment has improved since his/her most favorable determination and can perform work activities.

However, if SSA’s decision to place the individual on disability was questionable in the first place—for example, if the allowance was not fully supported or documented but not clearly in error and the individual’s condition has not changed—MIRS makes it difficult for SSA to cease the individual’s benefits, because under current law, there is no medical improvement.

This year, the OIG reviewed a sample of cases of adults with a CDR continuance, because of “no medical improvement,” and asked SSA to review the cases again using the Initial Disability Standard (which is used during a claimant’s initial application for disability), rather than MIRS, and determine whether benefits would have been continued. The review found that about 4 percent of cases *would not be considered* disabled under the Initial Disability Standard.



³⁵ SSA OIG, *The Social Security Administration’s Completion of Program Integrity Workloads* (A-07-14-24071), August 2014.

The OIG estimated that SSA will pay about \$269 million in benefits until the next CDR due date to about 4,000 adult beneficiaries who would not be considered disabled if MIRS were not in place and SSA instead used its Initial Disability Standard during a CDR. The National Association of Disability Examiners (NADE) has stated that MIRS impedes decision-making during the CDR process; NADE has recommended possible revisions to MIRS, including a brand new review of a beneficiary at the CDR stage.

There are several exceptions to MIRS—for example, if evidence shows a claim was mistakenly approved, SSA can cease benefits. However, the OIG could not adequately review MIRS exceptions in a recent audit because of miscoded cases; in other words, cases were coded as MIRS exceptions, when in fact, they were not.³⁶

NADE has also recommended additional training on MIRS exceptions, and SSA is accordingly updating its CDR training, to include guidance on MIRS and its exceptions and evaluating medical evidence.³⁷

TIMELY TERMINATION OF BENEFITS

Unfortunately, even when a CDR *is* conducted and the DDS finds medical improvement, it does not always mean that SSA terminates benefits timely, or at all. The OIG identified DI beneficiaries and their auxiliaries who improperly received payments after their medical cessation determinations, for a projected total of about \$83.6 million. The OIG recommended that SSA enhance its systems to perform automated terminations following medical cessation decisions. Although SSA has not yet implemented this change, it has agreed to do so.³⁸ The OIG has a future review planned to examine systems improvements implemented to address this issue.

WORK CDRS

Although disabled beneficiaries are required to report work activity, they do not always do so. Therefore, SSA uses its Continuing Disability Review Enforcement Operation (CDREO) to compare earnings reported on its Master Earning File (MEF)³⁹ to the benefit rolls. CDREO

³⁶ SSA OIG, *The Medical Improvement Review Standard during Continuing Disability Reviews* (A-01-13-23065), May 2014.

³⁷ NADE President, Jennifer Nottingham, *Examining Ways Social Security Can Improve the Disability Review Process*, April 9, 2014.

³⁸ SSA OIG, *Termination of Disability Benefits Following a Continuing Disability Review Cessation Determination* (A-07-12-11211), November 2012.

³⁹ The MEF is a repository of earnings information maintained by SSA.

identifies potentially unevaluated substantial earnings that were reported on the MEF and that may affect benefit entitlement, and alerts SSA to review the earnings. SSA must perform a work-related CDR when earnings indicate the beneficiary has returned to work at the SGA level.

The OIG recently reviewed a sample of DI beneficiaries in current pay status with earnings reported on the MEF between 2007 and 2011 that may have affected their entitlement to benefits. From the sample, the OIG estimated that about 119,500 disabled beneficiaries were overpaid approximately \$1 billion because of work activity.

SSA did identify about \$870 million of these overpayments to about 107,500 beneficiaries; the OIG estimated SSA did not detect about \$146 million in overpayments to about 13,900 beneficiaries.

The Agency reported that it has established dedicated staff to target its oldest work CDR cases for completion; it has also prioritized enforcement alerts by the amount of earnings, so staff works cases with highest earnings to minimize overpayments. Just as the Agency focuses on completing medical CDRs on time, it should also allocate resources to timely perform work-related CDRs and assess all overpayments resulting from work activity.⁴⁰

SUMMARY

CDRs are highly effective guards against improper payments and disability program fraud. SSA must make all efforts to allocate resources to clear the continuing disability review backlog and stay current on all CDR workloads. The OIG supports any legislative proposal or other mandatory funding to complete these valuable integrity activities, as well as considerations of policy revisions to ensure the CDR process is effective in ensuring that only eligible individuals continue receiving benefits and are receiving the correct payment amounts.

⁴⁰ SSA OIG, *Work Continuing Disability Reviews for Disabled Beneficiaries with Earnings* (A-01-12-12142), May 2014.

CONCLUSION

Since the revelation of the Puerto Rico and New York disability schemes, SSA has made efforts to improve fraud prevention and detection. In addition to ongoing initiatives already addressed in this report—the establishment of Fraud Prevention Units, the expansion of the CDI program, and the development of predictive analytics tools—the Agency has reinstated the National Anti-Fraud Committee, expanded anti-fraud training to all employees, and strengthened the administrative sanctions process.⁴¹

These and other anti-fraud efforts are admirable, considering SSA’s heavy everyday workloads and its ongoing quest to balance customer service and program stewardship. However, as the Agency attempts to integrate these “baseline” efforts into its normal business process, major fraud vulnerabilities still exist and must be addressed with broad systems enhancements and significant policy changes.

How SSA plans to address these vulnerabilities and limit disability fraud and abuse should be a part of the Agency’s long-term planning and budget process. Earlier this year, Acting Commissioner of Social Security Carolyn Colvin reported to the Subcommittee on Social Security that the Agency does not track spending on anti-fraud activities. Going forward, that must change.

The OIG, for several years, has identified “Strategic and Tactical Planning” as a major management challenge for SSA, saying, “SSA needs long-range plans that address its long-term challenges, including a rising workload, a decrease in experienced staff, overly complex program policies, and a rising need to provide more services electronically.”⁴² The GAO has also urged SSA leadership to develop and maintain continuity in its strategic planning leadership: “SSA generally views long-term planning as a secondary responsibility and is more focused on addressing short-term, tactical issues.”⁴³

While SSA develops a long-term plan to address current and future challenges, it must make fraud prevention a priority; it can do this by investing in effective anti-fraud tools and, in turn, promoting an Agency culture that has zero tolerance for fraud and is committed to ensuring all benefit allowances are accurate and supported with proper evidence.

⁴¹ When the OIG is unable to pursue a case for fraud conviction or civil monetary penalty, SSA employees can impose administrative sanctions (temporary bans from receiving benefits) on individuals who give false or misleading information or who fail to report material information.

⁴² SSA OIG, *Fiscal Year 2013 Inspector General Statement on SSA’s Major Management and Performance Challenges* (A-02-14-14056), December 2013.

⁴³ GAO, *Long-Term Strategy Needed to Address Key Management Challenges*, May 2013.

Therefore, SSA should:

- **Invest in predictive analytics tools to identify claims more likely to be fraudulent.** SSA should have current integrity tools in place that routinely analyze disability claims and medical records to identify and flag claims for further review, if they exhibit the trends and patterns present in claims known to be fraudulent.
- **Invest in a comprehensive searchable system of records to identify and review trends in claims with common characteristics.** To flag and investigate suspicious or questionable claims, SSA needs the ability to match and analyze claims with the same claimant representatives and doctors/medical facility; as well as to search for similar impairments, wording, and phrases in disability applications or medical records.
- **Modernize disability policy to reflect advances in medicine and technology.** The Agency is addressing this complex policy project by consulting with organizations like the Administrative Conference of the United States and the Institute of Medicine; SSA must continuously monitor and update the listing of medical impairments and vocational guidelines so they can be effective screening tools in the disability process.
- **Continue oversight of performance and productivity of hearing offices and Administrative Law Judges.** By regularly monitoring and reviewing hearing offices and ALJs, SSA can identify potential at-risk outliers. SSA should routinely review its data to identify judges with high-allowance rates and determine if patterns exist and allowances are connected to the same claimant representatives or doctors/medical facility.
- **Make all efforts to allocate resources to clear the continuing disability review backlog and stay current on all CDR workloads.** SSA estimates that every \$1 spent on medical CDRs yields about \$9 in savings to SSA programs; the OIG supports any legislative proposal or other mandatory funding to complete these valuable integrity reviews.

SSA has consistently promoted its increased anti-fraud efforts in the past year, but these efforts do not go far enough to address the fact that the Agency's outdated and unintegrated systems and policies have not been able to prevent or easily identify widespread fraud schemes. The OIG's recommendations to prevent similar large-scale schemes in the future will require significant investment, planning, and support from Agency leadership.

The OIG recognizes that SSA provides a tremendous service to its beneficiaries, but more must be done to ensure the integrity of taxpayer dollars that fund the critical programs that so many Americans depend on each and every day.

Furthermore, as SSA officials have many times this year—over the OIG's objections—touted a “less than 1 percent” fraud rate in the disability programs, the Agency must understand that

schemes like the one the OIG uncovered in New York—with more than 100 people indicted and more than \$30 million stolen—fuel public opinion that Social Security’s disability programs are easily exploited. SSA should not downplay large-scale fraud; it must acknowledge that the threat of another massive scheme is real, and that criminals will always look for the next vulnerability, poking and prodding until they find a weak spot in the system to attack.

The work will not be quick, easy, or inexpensive. But it is work that has to be done to protect the disability programs, now and in the future.

The OIG, of course, is an invested partner with SSA in this endeavor, and we remain committed to doing everything we can—through program audits, fraud investigations, and legislative and policy reviews—to help detect and prevent fraud, waste, and abuse in all of Social Security’s programs.

The OIG’s dedicated employees come to work every day across the country with a single mission: to improve the integrity and efficiency of all Agency operations. How SSA does business—with evolving systems and policies—may change over time, but the OIG’s priorities will not.