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Committee on Oversight and Government Reform
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Statement for the Record

**The Honorable Patrick P. O'Carroll, Jr.
Inspector General, Social Security Administration**

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Good morning, Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee. I have appeared before Congress many times to discuss the Social Security Administration's (SSA) disability programs, and how my office helps improve the effectiveness and integrity of those programs. I thank you for the invitation to testify today about these issues of critical importance to American taxpayers.

Increasing levels of disability claims and beneficiaries in recent years have challenged SSA's ability to deliver world-class service, creating workloads that strain resources, causing delays and backlogs, and leaving the Agency vulnerable to fraud and abuse. SSA must find ways to balance service initiatives, such as processing new claims and appeals, against stewardship responsibilities, to ensure that accurate determinations are made at every level and that current beneficiaries remain medically eligible.

Moreover, some individuals will withhold, exaggerate, or fabricate medical information to collect benefits that they are not eligible to receive. Sometimes, individuals involved with the disability claims process assist these fraudulent actions. It is critical that SSA and its Office of the Inspector General (OIG) be able to identify and prevent individuals and groups from defrauding the Government and these critical programs for personal gain.

Today I would like to discuss the efforts of my office to address both of these challenges: audits we've conducted and recommendations we've made to improve the integrity and effectiveness of the claims and appeals process; and current investigative initiatives that target widespread fraud schemes and identify vulnerabilities in the claims process.

Reviews and Recommendations

For many years, we have identified full medical continuing disability reviews (CDRs) and Supplemental Security Income (SSI) redeterminations as highly effective guards against improper payments and disability program fraud. Full medical CDRs are effective in reducing overpayments in the Disability Insurance (DI) program. SSA 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.

In a [March 2010 report](#), we determined that SSA's number of completed full medical CDRs declined by 65 percent from Fiscal Year (FY) 2004 to 2008, resulting in a significant backlog. We estimated SSA 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.

According to SSA, the Agency conducted 443,233 full medical CDRs in FY2012, up from 345,492 in FY2011. SSA's goal based on its FY2013 budget request was to conduct 650,000 full medical CDRs, but given the actual funding it received, the Agency has reported that it conducted 428,568. SSA expected a backlog of 1.3 million full medical CDRs to remain at the end of FY2013. This is an increase over the FY2012 year-end backlog of 1.2 million.

In recent years, SSA increased the number of full medical CDRs conducted, but does not have a formal plan to eliminate the backlog. In FY2014, SSA would like to conduct 1,047,000 full medical CDRs if it receives timely and sustained funding as outlined in the legislative proposal for a Program Integrity Administrative Expenses account, which would provide mandatory program integrity funding. We support this legislative proposal or any other mandatory funding for integrity activities.

Even when a CDR *is* conducted and the State Disability Determination Services (DDS) determines medical improvement, it does not always mean that SSA terminates benefits timely, or at all. In a [November 2012 report](#), we identified DI beneficiaries and their auxiliaries and SSI recipients who improperly received payments after their medical cessation determinations, for a projected total of about \$83.6 million in improper payments. We 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.

Also, we are currently assessing SSA's adherence to the medical improvement review standard (MIRS), and its impact 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 recent favorable determination and can perform work activities. However, if SSA mistakenly placed the individual on disability in the first place—if they were not disabled when the favorable determination was made—MIRS makes it difficult for SSA to take the person *off* disability, because under current law, there is *no medical improvement*. Based on our sample, it appears that some individuals would not be disabled under SSA's rules were MIRS not in place. Our report is still ongoing; we expect to issue it later this year.

In the SSI program, SSA conducts periodic redeterminations to determine whether recipients are still eligible for payments, and receiving the correct payment amount. In July 2009, we [reported](#) that the number of SSI redeterminations conducted by SSA had substantially decreased even though the number of SSI recipients had increased. Between FYs 2003 and 2008, redeterminations decreased by more than 60 percent. We estimated SSA could have saved an additional \$3.3 billion during FYs 2008 and 2009 by conducting redeterminations at the same level it did in FY2003.

Following our report, SSA significantly increased the number of redeterminations completed. Specifically, redeterminations increased approximately 252 percent since the low in FY2007 of 692,000 to almost 2.44 million in FY2013. SSA plans to conduct 2.6 million redeterminations in FY2014, which the Agency estimates will result in savings of \$5 for every \$1 spent on conducting them.

In our September 2013 review, [SSI High-error Profile Redeterminations](#), however, we found that SSA was not completing all of the redeterminations identified as having the highest risk of likely overpayment. Each year, SSA identifies the number of high-error profile redeterminations it will complete based on the dedicated program integrity funding it expects to receive in its budget appropriation. Since SSA is uncertain of this amount at the beginning of the year, SSA intentionally selects more high-error profile redeterminations than it plans to complete. SSA's method for assigning redeterminations as high-error is based on the anticipated dedicated program integrity funding and the amount SSA allocates to redeterminations. Therefore, when actual dedicated program integrity funding is at or lower than expected, some high-error profile redeterminations selected are not completed.

For example, in FY2011, the dedicated program integrity funding SSA received resulted in the Agency not completing up to 201,000 high-error profile redeterminations selected. If SSA had completed all these redeterminations, we estimate that it would have identified at least \$228.5 million in additional improper payments, both overpayments and underpayments. We recommended that SSA continue to increase the number of the high-error profile redeterminations conducted as resources allow, and SSA agreed to do so.

In September 2011, we issued a follow-up report, [*Childhood Continuing Disability Reviews and Age-18 Redeterminations*](#), in which we found that SSA had not completed 79 percent of childhood CDRs and 10 percent of age-18 SSI redeterminations, within the timeframes specified in the *Social Security Act*. SSA requested and received special funding for FY2009 to FY2012, but while the number of age-18 redeterminations increased, the number of childhood CDRs conducted declined.

We estimated that SSA paid about \$1.4 billion in SSI payments to approximately 513,300 recipients under 18 that it should not have paid; and that SSA would continue paying about \$461 million annually until reviews are completed. We recommended that SSA conduct all childhood CDRs and age-18 redeterminations within legally required timeframes, and SSA agreed to do so to the extent that its budget and other priority workloads allowed.

For many years, we have also focused considerable audit resources on challenges SSA faces at the hearings level of the claims process. A number of years ago, we issued a review, [*Administrative Law Judge Caseload Performance*](#), in which we analyzed existing case disposition statistics across the entire ALJ corps, and evaluated the effect of these production levels on the Office of Disability Adjudication and Review's (ODAR) ability to process incoming hearing requests and reduce the backlog of cases within five years. Without recommending any specific production level, we presented options to SSA and recommended that the Agency develop a performance accountability process that does not infringe on ALJ qualified decisional independence but allows ALJ performance to be addressed when it falls below an acceptable level.

We have continued to focus on ODAR and ALJ performance in our recent audit work as well. In February 2012, we issued a Congressional Response Report, [*Oversight of Administrative Law Judge Workload Trends*](#), in which we focused on the productivity of 24 ALJs—the 12 with the highest allowance rates, and the 12 with the lowest allowance rates. Most SSA staff we interviewed attributed the variance in allowance rates to ALJ decisional independence and discretion when interpreting the law, as well as the demographics of the hearing office service area population. In this report, we also found that SSA management teams at the hearing offices and regions monitored ALJ productivity but did not monitor allowance rates.

Most recently, in a January 2013 report, [*Identifying and Monitoring Risk Factors at Hearing Offices*](#), we found that although ODAR had created 19 ranking reports that measured hearing office performance using individual risk factors, the Agency had not established a process to rank performance using a *combination* of risk factors. Therefore, in an ongoing audit (currently in draft and with SSA for comment), *Analysis of Hearing Offices Using Key Risk Factors*, we have developed a model that measures variances among multiple risk factors. The model analyzes performance and outcome data among ALJs in the same office and uses five ALJ-related risk factors: (1) allowance rates, (2) dispositions, (3) rate of on-the-record (OTR) decisions, (4) dismissal rates, and (5) average processing time.

Though the Agency's current monitoring process identifies some potential workload problems, such as ALJ-specific issues, our model offers a way to evaluate the performance of individual hearing offices. Using our model and FY2012 workload data, we are identifying hearing offices with the highest and lowest variance scores. We believe outlier hearing offices provide ODAR managers with indications of potential processing issues (high variance) as well as potential best practices (low variance). We plan to recommend that SSA:

- determine if our methodology would assist in monitoring hearing office performance, understanding that the number and nature of the risk factors can be adjusted to meet Agency needs; and
- ensure that ODAR's early monitoring system combines 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.

In FY2014, we are continuing our audit focus on reducing improper payments in SSA's disability programs; in fact, nearly half of our planned reviews address disability program integrity in some way. Among those reviews, we will assess whether SSA:

- could use Medicare information to identify beneficiaries who are receiving disability benefits but may be deceased or not truly disabled;
- is collecting prior overpayments on an individual's record when that person becomes re-entitled to benefits at some point in the future; and
- is appropriately addressing wages earned by disabled beneficiaries *after* their alleged disability onset date but *before* a favorable hearing decision. Such earnings may be an indication that an individual does not, in fact, meet the guidelines for benefit eligibility.

Going forward, we are also conducting or will conduct multiple reviews focused on improving SSA's hearings process:

- We are currently conducting an audit, *Trends Associated with Cases Decided by High-Denial Outlier ALJs*, in which we are analyzing subsequent actions on high-denial ALJ decisions, as well as subsequent actions on denials made by other ALJs in the high-denial ALJ's hearing office.
- *Quality Review of On-the-Record Decisions*: OTR decisions—where no hearing was necessary because the documentary evidence alone supported a fully favorable decision—accounted for about 1 of every 5 allowances in FY2012. We will assess the reasons OTR cases were decided upon receipt at the hearing office but not approved earlier at the DDS level.
- *Relationships Between Medical Providers and Represented Claimants*: We will look at trends in medical source information provided by claimants and their representatives at the hearing level to identify any questionable relationships that may merit additional Agency attention.

Puerto Rico Disability Conspiracy

Of course, our audits and evaluations of SSA's disability programs are only one side of the integrity coin. We also conduct thousands of criminal investigations per year of potential disability fraud, resulting in hundreds of criminal convictions as well as benefit terminations and court-ordered restitution. As you may be aware, during August 21-23, we conducted an extensive arrest operation in Puerto Rico, as part of a complex disability fraud investigation. Working with the FBI and the Puerto Rico Police Department, we arrested 75 individuals, including medical providers, beneficiaries, and a non-attorney claimant representative—who is also a former SSA employee.

These arrests came as the result of a thorough and far-reaching investigation, involving surveillance and undercover operations. We also worked closely with SSA's New York Regional Office to review disability claim files. Our investigation found evidence that individuals were submitting nearly identical medical reports for claimants who shared a common employment history with a company that was experiencing significant downsizing. As this matter is still an active criminal investigation, and the judicial process is ongoing, I am limited in the details that I can share publicly. However, one implicated beneficiary recently pled guilty, and faces up to five years in prison. Also, we continue to receive calls to a special telephone hotline we established to receive tips and other information connected to the investigation; and we anticipate that some of these calls will generate new investigative leads.

OIG's Integrity Initiatives

We have long placed a high priority on allegations of so-called "third-party facilitator" fraud, where doctors, interpreters, social workers, attorneys, or even judges, conspire to submit or approve fraudulent disability claims. As a result of the Puerto Rico operation and other cases, we have undertaken a review of all facilitator-fraud allegations received from SSA or DDS personnel in the last five years. This review is one facet of the work being undertaken by the OIG's Disability Fraud Pilot, which commenced in July. The pilot consists of an SSA Associate Chief Administrative Law Judge, a Deputy Assistant Inspector General for Investigations, and additional OIG investigative and audit personnel, all working to identify and develop allegations of facilitator fraud throughout the country.

Through a variety of means, including data mining, the pilot seeks to identify high-dollar, high-impact cases involving third-party facilitators conspiring with claimants to defraud SSA. The pilot team will explore ways to compile and analyze data that could give us insight as to how to proactively identify those disability claims that might be fraudulent or might involve a corrupt facilitator or even an employee. We are working with ODAR to analyze management information already available to that office, to identify irregularities in administrative law judge performance, claimant representative fees paid, or any other factor that could indicate potential fraud or misconduct.

The pilot is scheduled to run through September 2014, and we will consider expanding the initiative after that, based on the success of investigations conducted during the pilot and an evaluation of the effect the pilot has on the disability process. The pilot is operating as an extension of our Cooperative Disability Investigations (CDI) program, which has for over 15 years been successful in preventing fraud at all levels of the disability claims process. SSA and OIG jointly established the CDI Program in FY1998, working with State DDSs and State or local law enforcement agencies, to pool resources and expertise to investigate suspicious disability claims.

Each CDI Unit comprises

- an OIG special agent who serves as the Team Leader,
- employee(s) from that State's DDS and SSA, who act as programmatic experts, and
- State or local law enforcement officers.

Tapping the skills and expertise of each member, the CDI Units receive claims identified as suspicious by the DDS and, where appropriate, investigate these claims using traditional investigative techniques. The CDI program's primary mission is to obtain evidence that can resolve questions of fraud *before* benefits are ever paid; however, they also evaluate and investigate in-pay beneficiaries, often referred by SSA or a DDS to a CDI Unit during or as the result of a CDR.

CDI currently consists of 25 Units in 21 States and, as of August 2013, the Commonwealth of Puerto Rico. In FY2013, the CDI program reported \$340.2 million in projected savings to SSA's disability programs and \$246.4 million in projected savings to non-SSA programs such as Medicare and Medicaid. Since the program was established, CDI efforts have resulted in \$2.5 billion in projected savings to SSA's disability programs and \$1.6 billion in projected savings to non-SSA programs. Following are recent examples of CDI successes:

- The Oklahoma City CDI Unit investigated a 56-year-old woman who applied for disability benefits claiming an injured wrist, elbow, and shoulder. In her claim, she alleged weakness and pain on the left side of her body, and a limited ability to walk. She also claimed she was required to use a walker and needed help with personal care. During a consultative examination, the woman exhibited no mobility in her left leg and decreased mobility of her back. She was using a walker and wearing a soft neck collar. The woman could not move her neck, and refused to remove the neck collar.

When CDI investigators interviewed the woman at her residence, however, she was not wearing a neck collar or using an assistive device to walk. She was able to sit, stand, and walk without the use of a walker. She told investigators she was working about 20 hours a week as the manager of a donut shop. The woman complained about her left shoulder hurting, but she appeared to move her shoulder and arm freely. Investigators later observed the woman while she worked at the donut shop, and as she ran errands throughout the city. Her last stop of the day was a gym, where she swam and used the whirlpool. At no point did she use a walker or wear visible braces on her arms or neck, and she walked with a normal gait. The Oklahoma DDS denied the woman's claim.

- The Salem, Oregon CDI Unit investigated a 51-year-old woman who applied for disability benefits alleging ADHD and headaches. Though born in the United States, she claimed not to speak English when dealing with SSA. After undergoing multiple evaluations, it was determined that she met a disability listing of Mild Mental Retardation. The claim was submitted as a proposed allowance, but was reviewed by a quality assurance branch. The reviewer noted inconsistencies between the claimant's reported functioning, her 25-year employment history, and other medical records. The claim was sent back to the Oregon DDS for review, and the DDS referred the case to the CDI Unit.

CDI investigators discovered that the claimant owned and managed several rental homes, and was a well-known businesswoman in her small town, having operated a second-hand store and a taco truck before starting her current restaurant business, a walk-up Mexican food stand located a few blocks from an SSA office. CDI investigators located over a dozen witnesses in the local community who had both professional and personal dealings with the woman, who they considered to be a fluent English speaker. In addition, she had filed numerous eviction orders—in English—related to her rental properties.

The Oregon DDS denied the woman's claim, and our Office of Counsel assessed a civil monetary penalty of \$3,000 against her for the false statements she made in connection with her claim.

The CDI program has enjoyed great support from SSA as well as from your colleagues in Congress. We continue to look for opportunities to expand CDI across the country, given available resources and ability to secure law enforcement partners in specific locations.

It is also important to highlight our Civil Monetary Penalty (CMP) Program. My Office of Counsel has the delegated authority to enforce section 1129 of the *Social Security Act*, which authorizes a CMP

against anyone who makes false statements, representations, or omissions in connection with obtaining or retaining benefits, among other offenses. After consultation with the Department of Justice, we are authorized to impose penalties of up to \$5,000 for each false statement, representation, conversion, or omission. A person may also be subject to an assessment, in lieu of damages, of up to twice the amount of any resulting overpayment.

We are committed to increasing the number of such cases successfully resolved each year to punish wrongdoing in cases where criminal prosecution has been declined and to deter Social Security-related fraud. In FY2013, we successfully resolved 280 cases and imposed more than \$15 million in CMPs.

For example, in one recent case, a woman, who was the representative payee for her disabled daughter, conspired with her own mother to fraudulently obtain SSI. When the woman started a lucrative job that would have rendered her daughter ineligible for SSI, the woman's mother (the child's grandmother) told SSA that the disabled child had moved in with her, when in fact, the child resided with her own mother. The woman and her mother then shared the significant amount of money in SSI that they wrongfully received. We imposed a total CMP of \$78,980 against the grandmother and imposed a CMP of \$81,000 against the mother, who masterminded the scheme.

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

SSA faces many challenges to its efforts to maintain the integrity and effectiveness of its disability programs. It is critical that the Agency, even in this fiscal environment, allocate sufficient resources to ensure that only individuals eligible to receive benefits are able to do so. My office is committed to working closely with SSA and your Subcommittee to help the Agency achieve this goal. Thank you again for the invitation to testify today, and I'd be happy to answer any questions.