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PREVENTING DISABILITY SCAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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CONTENTS

	Page
Advisory of February 26, 2014 announcing the hearing	2

WITNESSES

PANEL 1:

The Honorable Carolyn Colvin, Acting Commissioner, Social Security Administration, Testimony	11

PANEL 2:

J. Matthew Royal, Vice President and Chief Auditor, Unum Group, Chattanooga, Tennessee, Testimony	43
William B. Zielinski, Deputy Commissioner of Systems and Chief Information Officer, Social Security Administration, Testimony	48
Alan R. Shark, Fellow, National Academy of Public Administration, Testimony	58

MEMBER QUESTIONS FOR THE RECORD

The Honorable Carolyn Colvin	82

PUBLIC SUBMISSIONS FOR THE RECORD

Coalition Against Insurance Fraud	89
Consortium for Citizens with Disabilities	91
IBM	96
James Goodman	106
Michael Gilbert	109
National Organization of Social Security Claimants' Representatives	113

PREVENTING DISABILITY SCAMS

WEDNESDAY, FEBRUARY 26, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON SOCIAL SECURITY,
Washington, DC.

The subcommittee met, pursuant to call, at 10:01 a.m., in Room B–318, Rayburn House Office Building, the Honorable Sam Johnson [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Johnson Announces Hearing on Preventing Disability Scams

B–318 Rayburn House Office Building at 10:00 AM
Washington, Feb 19, 2014

U.S. Congressman Sam Johnson (R–TX), Chairman of the House Committee on Ways and Means Subcommittee on Social Security, today announced a hearing on ways to prevent conspiracy fraud in the Social Security Disability Insurance program. **The hearing will take place on Wednesday, February 26, 2014 in B–318 Rayburn House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

According to the Social Security Administration (SSA), 11 million beneficiaries received $139.4 billion in Social Security Disability Insurance (SSDI) benefits in fiscal year 2013. Currently, 160 million workers contribute to Social Security. The 2013 Social Security Trustees report projects that revenues will be sufficient to pay only 80 percent of SSDI benefits beginning in 2016. The SSDI program is under increased scrutiny after a Senate investigation and two investigations uncovered significant incidents of fraud costing taxpayers millions.

On September 19, 2013, the Subcommittee on Social Security held a hearing on an SSDI fraud conspiracy in Puerto Rico. In August of 2013, authorities in Puerto Rico arrested more than 70 individuals charged in the conspiracy, including several doctors and a former SSA employee. Under the alleged scheme, the former SSA employee would help a claimant file an SSDI application and, with the assistance of a conspiring doctor, provide fraudulent medical evidence that would result in benefits for individuals who did not, in fact, meet the legal eligibility standard for disability benefits. The hearing examined the details of the scheme, the SSA's oversight of the SSDI program in Puerto Rico, as well as the agency's overall efforts to detect, prevent and prosecute fraud.

In October of 2013, the Senate Homeland Security and Governmental Affairs Committee released the results of a bipartisan investigation detailing inappropriate conduct and collusion between a Kentucky law firm, an SSA Administrative Law Judge in Huntington, West Virginia and local doctors. The investigation revealed that inappropriate collusive actions were taken to approve disability benefits and highlighted years of ineffective oversight by the SSA.

Following an announcement by the New York County District Attorney's Office regarding the indictment of 106 defendants for their alleged involvement in a criminal conspiracy, the Subcommittee held a hearing on January 16, 2014, focusing on the details of the New York scheme that cost taxpayers approximately $23.2 million. In exchange for individual cash payments of up to $50,000, four facilitators helped coach 102 SSDI applicants, including many retired police officers and firefighters, on how to falsely demonstrate symptoms of mental disorders in order to fraudulently obtain disability benefits. At the hearing, Subcommittee Chairman Johnson asked the Acting Commissioner of Social Security to present Congress with a full report, within 30 days, detailing the agency's efforts to combat fraud conspiracies targeting the SSDI program, plans for future initiatives and recommendations for legislation.

In announcing the hearing, Social Security Subcommittee Chairman Sam Johnson said, **"When criminals are able to take advantage of Social Security's disability program due to its outdated policies and pay-first chase-later culture, taxpayers and those who count on the vital program end up paying the price. That's wrong! If Social Security wants to regain the public's confidence, it must commit itself to preventing fraud from happening in the first place. It's time for Social Security to protect precious taxpayer dollars. That's why last month, I asked Acting Commissioner Colvin for a plan detailing the immediate actions Social Security is taking to prevent further disability fraud. Hardworking taxpayers want, need, and deserve real action. I look forward to hearing her ideas and those of our other experts**."

FOCUS OF THE HEARING:

The hearing will examine the Acting Commissioner's plan and legislative recommendations for preventing conspiracy fraud. The Subcommittee will also hear the recommendations of public and private sector experts to stop disability fraud schemes before benefits are awarded and to deter criminals from attempting to cheat the system.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, March 12, 2014**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days' notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman JOHNSON. Good morning. Appreciate you all being here today.

As part of my ongoing efforts as chairman to rout out fraud, waste, and abuse in the Social Security Disability Insurance program, we are here on behalf of the 11 million people with disabilities and their families and hardworking taxpayers, Americans demanding action now from Social Security. We need answers on how it will prevent conspiracy fraud in the Social Security Disability Insurance program.

In September 2013 and more recently in January, this subcommittee held two hearings on disability conspiracy fraud occurring in Puerto Rico and New York City. Just yesterday, we learned about 28 more indictments in the ongoing New York conspiracy investigation, including 16 former New York police officers and 5 New York firefighters. To date, almost $30 million has been stolen from taxpayers in this case alone.

Last October, the Senate Homeland Security and Governmental Affairs Committee released the shocking results of their bipartisan investigation detailing abusive conduct and collusion between a law firm, a Social Security Administrative Law Judge, and local doctors in West Virginia in approving benefits.

Two themes run through all these alarming cases. First, these cases involve professionals, a shadowy industry of doctors, lawyers, and enablers, such as former Social Security employees, who know it pays to break the law, some of them.

I hope you got rid of them.

Second, while frontline employees ultimately detected these conspiracies, preventing fraud from occurring in the first place was not a priority for Social Security's leadership. Catching bank robbers before they get the cash is a lot easier than trying to recover stolen money later. That is just common sense.

During last month's hearing, Commissioner Colvin told us that she considered it a success that Social Security staff discovered the fraud in Puerto Rico and New York. And we appreciate that. Let me be clear: That is not how I define success. More importantly, I don't think that is how those who count on these benefits or the taxpayers who support the program would define success either. Success is not discovering massive fraud; success is preventing it in the first place. Preventing fraud is what Social Security has to start doing right now.

And at the January 16th hearing, I asked Acting Commissioner Colvin to give us a plan on ways to help stop organized fraudsters. I have since met with the Acting Commissioner and appreciate that she delivered that plan to us before the 30-day deadline and look forward to discussing it today.

Further, I have asked the Social Security Inspector General to do a full investigation of Social Security's management and their failure to prevent fraud conspiracies, such as Puerto Rico and New York. The IG's report will be important in determining whether Social Security is truly committed to preventing fraud conspiracy.

Also with us today is a panel of public- and private-sector experts with their recommendations on preventing fraud.

In the past, Congress has sent Social Security billions of taxpayer dollars in extra funding to make sure those on the rolls deserve to be there. That is not only expensive but also an ineffective and inefficient way to find the fraudsters on the dole. It also doesn't find the crooks that help them get their illegal checks. Enough is enough. Money alone won't change Social Security's culture of pay first and chase later. Social Security's credibility is on the line.

Further, how can Social Security even begin to ask for bigger budgets from hardworking, struggling taxpayers when, since the recession began in 2008, it paid out $244 million in employee bonuses, when it spends close to $15 million each year for employees to do union work instead of Social Security work, and when it is spending over $5 million fixing the damage of the Puerto Rico case, with more spending to follow in the New York case?

I would like to add for the record that Social Security will receive full funding to conduct continuing disability reviews. But the bottom line is that preventing fraudsters from getting on the rolls in the first place will only happen if Social Security makes a complete and genuine commitment to end this pay-first-and-chase-later culture. Crimes against the program cheat hardworking Americans and honest beneficiaries. It must stop now. Americans want, need, and deserve no less.

I now recognize our Ranking Member, Mr. Becerra, and my friend for his opening statement.

Mr. BECERRA. Mr. Chairman, thank you very much.

And I note that this is our third hearing about conspiracies to steal from Social Security.

In our first two hearings, we heard what the Social Security Administration did to stop fraud. Their frontline employees detected the suspicious pattern, their investigators followed up, and hundreds of people have now been indicted.

Today, we need to talk about what Congress should be doing to support the Social Security Administration and to protect Social Security.

I hope, Commissioner, that you will be blunt with us about what we in Congress need to do about the fraud and errors that SSA can't prevent unless Congress steps up to the plate.

At our hearing on the New York conspiracy, we learned that over 100 people have been indicted for fraud, partly because SSA Special Agent Peter Dowd came up with a creative idea. He thought of checking to see whether the retired police officers who SSA suspected had submitted fraudulent evidence still had licenses to carry concealed weapons—licenses which would not be issued if the applicant suffered from mental impairments.

Special Agent Dowd worked for SSA's Cooperative Disability Investigations Unit in New York. Since this CDI program began, CDIs have successfully pursued over 30,000 fraud cases, saving taxpayers over $3½ billion. But what if the New York scheme had unfolded in 1 of the 29 States that don't have a Special Agent Dowd because SSA can't afford to staff a CDI unit in those States?

At our hearing on the Puerto Rico conspiracy, we learned that the ringleaders were caught because of the vigilance of frontline staff who evaluate applications. Medical consultant Dr. Vicente Sánchez was the first to report the suspicious medical evidence to SSA, and program analyst Susan Palais and Maria Lora conducted numerous case reviews to spot the trends that helped SSA find the fraud.

Tips from frontline SSA workers account for nearly two-thirds of fraud investigations and most successful prosecutions. But what if the Puerto Rico scheme happened now, after Republican budget cuts significantly reduced the number of trained examiners like Susan Palais and Maria Lora?

Mr. Chairman, too many frontline SSA employees and investigators played key roles in exposing fraud in New York and Puerto Rico for me to name them all during my 5 minutes. I ask unanimous consent, however, to include their names in our hearing record.

Chairman JOHNSON. Without objection.

[The information follows:]

Names of Front-line Staff With Critical Roles in Stopping Recent Puerto Rico and New York Fraud Conspiracies

DDS Medical Consultant Dr. Ascisclo Marxuach

DDS Medical Consultant Dr. Vicente Sanchez

DDS Systems Manager Juan Ocasio

DDS Systems Manager Javier Ortiz

District Manager and former Disability Processing Unit Manager Diane Maldonado

Disability Program Administrator Annie Malave

Program Analyst Susan Palais

Program Analyst Maria Lora

Area Office Supervisor Awilda Montalvo

Assistant Regional Administrator Yvonne Bastide

Lead Disability Processing Specialist Kathleen Fitzpatrick

Lead Disability Processing Specialist Michael Warner

Deputy Assistant Regional Commissioner Frank Barry

Center for Disability Deputy Director Jose Colon

Special Agent-in-Charge Edward Ryan

Assistant Special Agent-in-Charge John Grasso

Assistant Special Agent-in-Charge Anthony Piazza

Resident Agent-in-Charge Sharon McDermott

Special Agent Peter Dowd

Special Agent Manuel Rivera

CDI Team Leader Angel Rodriguez

Management Support Specialist Jaimie Arce

CDI Specialist Amanda Rios

CDI Specialist Karen Velez

Hundreds of other Social Security employees, contractors, and investigators, as well as state, local, and federal prosecutors also played an important role in bringing the conspirators to justice.

Mr. BECERRA. SSA is required to periodically review whether beneficiaries are too disabled to work. In 2011, SSA reviewed about 350,000 targeted beneficiaries to see if they were still medically eligible for disability benefits and found that a small percentage were not. Social Security's Chief Actuary estimates that those reviews will eventually save taxpayers $5.4 billion, a return on our investment of $13 for every $1 spent.

But what about the 1.3 million cases SSA couldn't review? Since 2011, our colleagues on the Republican side in the House have pre-

vented over a million case reviews by blocking program integrity funding authorized by the Budget Control Act.

Let me be clear: Those failures to protect Social Security aren't the SSA's fault. In 2012, Social Security paid 56 million Americans over $600 billion in earned benefits. SSA had a 0.22 percent overpayment rate. That is less than one-half of 1 percent overpayment rate.

This low error rate didn't happen by accident. It happened because the SSA has conscientious, well-trained staff. But since 2011, Social Security has lost thousands of highly trained employees to budget cuts. Ultimately, Congress is responsible for protecting Social Security, and Congress needs to do its job.

Over Social Security's lifetime, American workers have contributed over $14 trillion to Social Security. The Social Security Trust Fund currently has a $2.7-trillion surplus—money American workers have contributed and that they will need when they retire. In exchange for their contributions to Social Security, American workers get real economic security. They know that they and their families will be protected when they can no longer work.

For 77 years and through 13 recessions, including the 2008 Wall Street recession, Social Security has paid Americans their benefits that they have earned on time and in full. That means it is vitally important that we prevent fraud, waste, and errors that could drain the trust funds and prevent us from paying Americans the benefits they earned and depend on to pay their bills.

Mr. Chairman, today, I am introducing legislation to help SSA protect Social Security while still paying every American his or her earned benefits on time and in full. I am pleased to be joined by my colleagues on the Democratic side of this subcommittee. My proposal provides SSA with the new tools it needs to fight fraud and prevent errors.

As our recent experience demonstrates, there is no getting around the hard fact that one of those tools has to be adequate resources. SSA needs more tools to go after the people who violate positions of trust and rob Social Security, whether they are doctors, lawyers, translators, or even Social Security employees.

Mr. Chairman, you and I have discussed working together to fight fraud, prevent errors, and support the Social Security Administration, and I want to continue that process. We have worked on some tough issues together in the past, and I believe we can solve this one too. And for that reason, I am pleased that we are doing this hearing, and I appreciate that you are helping us move forward this issue of fighting fraud within Social Security.

With that, I will yield back the balance of my time.

Chairman JOHNSON. Thank you.

Chairman JOHNSON. As I said in our last hearing, I would like to work with you. Preventing fraud ought not to be a partisan issue, and I don't think it is, at least the way you and I see it. I look forward to reviewing the provisions in your bill.

As is customary, any Member is welcome to submit a statement for the hearing record.

Chairman JOHNSON. Before we move on to our testimony today, I want to remind our witness to please limit your oral state-

ment to 5 minutes. However, without objection, all the written testimony will be made a part of the hearing record.

We have two witness panels today. In the first panel, we have the Honorable Carolyn Colvin, Commissioner of Social Security Administration.

And they call you Acting, but I think you are Commissioner.

Ms. COLVIN. Thank you.

Chairman JOHNSON. So, welcome. Please go ahead.

STATEMENT OF THE HONORABLE CAROLYN COLVIN, ACTING COMMISSIONER, SOCIAL SECURITY ADMINISTRATION

Ms. COLVIN. Thank you. Chairman Johnson, Ranking Member Becerra, Members of the Subcommittee, good morning. I am Carolyn Colvin, the Acting Commissioner of the Social Security Administration. I thank you for continuing the conversation about our antifraud efforts.

Like you, Mr. Chairman, I am outraged and personally offended whenever anyone attempts to defraud the American people. We strive to preserve the public's trust in our programs, and we have no tolerance for fraud. Every day, our employees honor these principles, and I am very proud of them.

To those who would cheat us, let me emphasize: We will find you, we will seek the maximum punishment allowable under the law, and we will fight to recover the money you have stolen from the American people.

Regrettably, there will always be people who try to steal. Recognizing this, we comprehensively train our field office and disability determination services employees to detect fraud. Because of this training, our dedicated DDS employees in New York City and Puerto Rico identified suspicious patterns in some disability claims and referred these cases to our OIG for investigation. Our employees remain our first and best line of defense against cheats. Last fiscal year, they referred almost 23,000 cases to the Office of the Inspector General.

We know that we cannot prevent all fraud schemes any more than we can stop all crime. We can, however, deter and prosecute fraud. As the recent cases show, we tirelessly seek to bring to justice anyone who tries to cheat American taxpayers. While any level of fraud is unacceptable, the low level of fraud in our disability program speaks to our efforts. The best available evidence from OIG shows that the level of actual disability fraud is below 1 percent.

We recognize that criminals continuously devise more complex and sophisticated methods to steal. Thus, with new tools now available, we are expanding our use of data analytics to enhance our ability to detect possible fraud. Data analytics should increase our ability to find questionable patterns in disability claims and prevent payment of fraudulent claims.

Even the post powerful data analytics, though, will only produce leads that employees still must investigate. We are also collaborating with private insurers and other Federal agencies to learn new ways to combat complex and sophisticated fraud schemes. We will expand our successful antifraud training to all SSA employees, specifically focusing on lessons learned from real-life examples.

Time and time again, this training has paid off. To illustrate, a field office employee in Texas suspected that a disability beneficiary was working but not reporting his income. The employee referred the case to OIG, who determined that the beneficiary concealed his employment and conspired with his company to pay his wages in his wife's name. The beneficiary, his wife, and the company were all sentenced.

The Cooperative Disability Investigation, or CDI, program is our best disability fraud prevention tool. For instance, a man in his 30s alleged a mental impairment that made him nervous around others. A CDI unit investigated after receiving a tip that the man worked as a model and actor. The CDI unit discovered that he was working as a model and regularly appeared on a television show. The casting director described the man as happy, upbeat, and very sociable. His claim was denied.

We will add seven CDI units by the next fiscal year. We will also expand the capacity of a number of current CDI units by increasing the number of law enforcement investigators in them. According to the OIG, for every dollar spent on a CDI unit, we save $17.

We are also establishing a central and specialized fraud unit, which will consist of disability examiners with considerable experience in potential fraud cases. They will review suspect cases and help develop further analytical tools.

Additionally, we will expand our fraud prosecution unit. We have placed a number of our own attorneys in U.S. attorneys' offices to serve as fraud prosecutors. Since fiscal year 2003, they have secured over $60 million in restitution and more than 1,000 convictions. We are doubling the number of fraud prosecutors.

As I have noted, all of these efforts require additional resources. We appreciate the additional funding that you gave us this fiscal year; however, without adequate sustained funding going forward, we may be unable to achieve all that we can in our antifraud activities. We need your support to ensure that we can continue to enhance our antifraud efforts.

In short, we have long been committed to combating fraud. Although the level of fraud in our disability program is low, no amount of fraud is tolerable. Fighting fraud is an ongoing and evolving process, and we continue to adapt our antifraud strategies.

Routing out fraud is a team effort. We need people who suspect something to say something. If you suspect fraud, please call OIG at 1–800–269–0271.

Thank you. I am very happy to answer any questions you may have.

Chairman JOHNSON. Thank you, ma'am. Appreciate your testimony.

[The prepared statement of Ms. Colvin follows:]

COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

UNITED STATES HOUSE OF REPRESENTATIVES

FEBRUARY 26, 2014

STATEMENT FOR THE RECORD

CAROLYN W. COLVIN
ACTING COMMISSIONER
SOCIAL SECURITY ADMINISTRATION

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

Thank you for this opportunity to continue discussing our anti-fraud efforts and our partnership with the Office of the Inspector General (OIG) to root out disability fraud wherever it may occur. I am Carolyn Colvin, the Acting Commissioner of Social Security (SSA).

At our last hearing on this topic, you asked us to review and report on our practices in light of the recent fraud cases in New York and Puerto Rico and to discuss with you any changes to those practices. Today, I will you share with you the highlights of our review.[1]

Our Anti-Fraud Efforts

We are committed to preserving the public's trust in our programs. We have no tolerance for fraud, and I reiterate to those who would defraud Social Security: We will find you; we will prosecute you; we will seek the maximum punishment allowable under the law; and we will fight to restore the money you've stolen to the American people. We have expended significant resources in our anti-fraud efforts and in support of the Inspector General, who is responsible for "provid[ing] leadership and coordination ... to prevent and detect fraud and abuse."[2] Our efforts are working: The indictments in the New York City and Puerto Rico fraud cases likely would not have occurred without the vigilance of our dedicated SSA and Disability Determination Service (DDS) employees.

It is regrettable that people will try to take advantage of our programs; however, that is the reality. Thus, we have developed expertise on fraud identification and referral through comprehensive training. All SSA field office and DDS employees receive extensive training on fraud detection. This training includes identifying fraud scenarios--including "middleman fraud" such as what allegedly occurred in Puerto Rico and New York City. Because of this training, our dedicated frontline DDS employees in New York City and Puerto Rico were able to identify suspicious patterns regarding certain disability claims, and we referred these cases to the OIG for investigation. In fiscal year (FY) 2013, we made over 22,500 disability fraud referrals to the OIG; the OIG opened about 5,300 cases based on these referrals. To date, the OIG has referred over 100 of these cases to United States Attorneys' Offices for criminal prosecution.

We work closely with the OIG to support its anti-fraud activities. Each SSA regional office has a Regional Anti-Fraud Committee – chaired by an OIG Special Agent-in-Charge and the Regional Commissioner– that meets to discuss and promote anti-fraud initiatives. In addition, we have dedicated resources and staff, including experienced disability examiners and medical consultants, to support the OIG, law enforcement, and prosecutors with their investigation of possible fraud cases. For example, following the fraud referrals in Puerto Rico, our New York Regional Office established a unit responsible for helping the OIG and prosecutors analyze disability cases and identify other disability claims in Puerto Rico that potentially were

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[1] *See* www.ssa.gov/legislation/other.html#a0=2.
[2] *See* Inspector General Act of 1978, Pub. L. 95-452, § 2.

connected to the alleged conspiracy. Our partnership with the OIG and others was instrumental in facilitating the indictments.

Our most successful collaboration with the OIG is the Cooperative Disability Investigation (CDI) program – our premier disability fraud investigation and prevention tool. Each CDI Unit consists of an OIG Special Agent who serves as the Team Leader, State DDS and SSA employees who are programmatic experts, and State or local law enforcement officers. CDI units investigate individual disability applications to identify applicants, beneficiaries, and third parties who participate in disability fraud. CDI units may present the results of these investigations to Federal or State prosecutors for criminal prosecution or civil action, as well as to the Office of the Counsel to the OIG for the imposition of civil monetary penalties. Currently, we have 25 CDI units. The New York CDI unit –established in 1998, and one of our first units established – played a critical role in investigating the New York City fraud conspiracy. In 2008, as a result of a number of investigations stemming from referrals by the alert DDS employees, the New York CDI unit identified the potential conspiracy involving third-party facilitators. That CDI unit worked closely with SSA's New York regional office to uncover the vast, longstanding criminal conspiracy.

We have established procedures to handle cases if we have reason to believe that fraud was involved in obtaining benefits. Upon indictment, we immediately suspend benefit payments to indicted beneficiaries (or auxiliaries collecting on the beneficiaries' earnings records). In New York City and Puerto Rico, we suspended benefit payments to over 170 disability beneficiaries and their auxiliaries. In addition, we will redetermine entitlement to disability benefits of individuals implicated in the fraud scheme and disregard the tainted medical evidence. In connection with the Puerto Rico case, we are redetermining approximately 7,400 disability applications. We expect to undertake a similar review of the New York cases as well.

Each of these activities played a critical role in support of the OIG's fight against fraud and helped bring about the indictments of the conspirators. We know that we simply cannot prevent all fraud schemes any more than we can stop all crime in our communities. We can, however, deter and prosecute it. As these cases show, we tirelessly seek to find and bring to justice anyone who attempts to defraud Social Security. I am very proud of our employees for working cooperatively with the OIG to detect and refer the alleged fraud cases in Puerto Rico and New York City. While any level of fraud is unacceptable, the low level of disability fraud in our programs speaks to our efforts; the best available evidence shows that the level of actual disability fraud is below 1 percent. [3]

Our Planned Immediate Enhancements to Our Anti-Fraud Efforts

Fighting fraud is an ongoing and evolving process. We use fraud cases to identify ways to combat fraud more successfully, and continually strive to build upon our successful anti-fraud efforts. I want to share with you several activities that we will implement immediately or in the very near future.

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

Working with the OIG, we will expand the number of CDI units and expand the capacity of existing units. According to the OIG, CDI units have produced savings of more than $860 million over the last 3 years. We provide most of the funding for these units, and in collaboration with the OIG, we plan to expand the CDI program by seven additional units beginning in 2014. We anticipate these seven units will be fully operational in 2015, increasing the total number of units to 32 nationwide. We will also expand the capacity of existing CDI units by increasing the number of law enforcement investigators in a number of current units.

As I mentioned earlier, all SSA field office and DDS employees receive fraud detection training. They remain our first and best line of defense against those seeking to cheat the system. We will expand training to *all* SSA employees during FY 2014 with specific focus on lessons learned from Puerto Rico and New York City.

We are establishing a central, specialized fraud unit comprised of disability examiners dedicated to reviewing and acting on potential fraud cases. This unit will be located in the New York Program Service Center, where disability examiners have developed considerable expertise due to the New York City and Puerto Rico cases. These examiners will be our national experts in working disability fraud cases, and we plan to compile data from the cases that will help us to develop further analytical tools to identify potential fraud.

We are also establishing a National Anti-Fraud Committee, which will be co-chaired by the Inspector General and our Deputy Commissioner for Budget, Finance, Quality, and Management. Building off the model of our successful Regional Anti-Fraud Committees, the National Anti-Fraud Committee will lead and support enterprise-wide strategies to combat fraud, waste, and abuse. It will also collaborate with private insurers and other Federal agencies to learn new ways to combat complex and sophisticated fraud schemes.

In addition, we will expand our Fraud Prosecution project. For more than a decade, in partnership with the DOJ, we have placed a number of attorneys from our Office of General Counsel in several Federal districts to serve as fraud prosecutors. These Special Assistant United States Attorneys are dedicated to Social Security fraud cases and have increased the number of prosecutions. Since FY 2003, our fraud prosecutors have secured over $60 million in restitution and more than 1,000 convictions. We plan to hire or designate 12 additional attorneys to serve as Special Assistant U.S. Attorneys. We already have an attorney on the ground in Puerto Rico working with the U.S. Attorney.

There has been concern expressed that claimants withhold medical evidence that could be unfavorable to their claims. This withholding of evidence could result in improper findings of disability. We engaged with the Administrative Conference of the United States (ACUS) to review and analyze the Social Security Act and our regulations regarding the duty of candor and the submission of all evidence in disability claims. ACUS surveyed the requirements of other administrative tribunals, as well as the Federal Rules of Evidence, Federal Rules of Civil Procedure, and other applicable authority, regarding the duty of candor and submission of all evidence and then issued a report recommending certain improvements. After carefully studying the report and conducting internal analyses, on February 20, 2014, we published a Notice of

Proposed Rulemaking that proposed to revise our regulations to require claimants to inform us about or to submit *all* medical evidence known to them that relates to their disability claim--both favorable and unfavorable. This requirement would be subject to two exceptions, which are for attorney-client privilege and attorney work product. We would also extend the protections afforded by these privileges to non-attorney representatives.

We are undertaking similar efforts with outside experts to update some of our policies in the disability determination process. While these efforts are primarily designed to improve the consistency of our disability determinations, they also may help deter fraud. For example, we have contracted with the Institute of Medicine (IOM) to conduct a comprehensive review of psychological testing including symptom validity testing; and determine the relevance of such testing to disability determinations in claims involving physical or mental impairments. In another ongoing project, ACUS is reviewing our rules and policy regarding how SSA adjudicators at all levels evaluate claimants' symptoms in disability claims, and we anticipate recommendations from them on how we can improve consistency in disability determinations.

Lastly, with the FY 2014 appropriations, Congress provided us with funding to significantly increase the number of medical continuing disability reviews (CDR) that we are able to conduct. We estimate that the money spent on CDRs saves, on average, $9 per every dollar invested, including savings accruing to Medicare and Medicaid, yet we have a backlog of 1.3 million CDRs due to budgetary shortfalls. While the primary purpose of CDRs is to determine whether a beneficiary is no longer entitled to benefits because his or her condition has medically improved, our ability to significantly increase CDRs may allow us to detect increased numbers of potentially fraudulent or suspicious activities.

While we recognize the importance of combatting fraud wherever we can, we are only too aware that all of these enhancements require substantial resources. Without adequate, sustained funding, we will not be able to achieve all that we can in our anti-fraud activities. Due to budgetary constraints, we have been unable to replace nearly 11,000 employees who retired or left our agency for other reasons from FY 2011 through FY 2013. The New York DDS, which identified the New York City fraud conspiracy in 2008, now has approximately 22 percent less staff than it did then. We have fewer frontline employees standing as the first line of defense against fraud. While the FY 2014 appropriations may allow us to replace some of our staffing losses, we need your support in FY 2015 and beyond to ensure that we have adequate staffing and resources to continue and enhance our robust anti-fraud efforts. Please also understand that much of our work is complex and it takes time for us to train employees fully and for them to gain experience.

Data Analytics

We fully appreciate that criminals continually look for an edge against potential victims. They are likely to devise more complex and sophisticated methods in their efforts to defraud Social Security. Consequently, in addition to what I have described above, we have begun a substantial effort to develop and use new logical analysis tools to support the OIG's efforts to combat fraud. SSA has a long, successful history of developing online applications, electronic tools, and predictive models to efficiently process benefits claims, enhance decisional quality, and target

limited resources toward those program integrity reviews most likely to return savings to the taxpayer.

In the anti-fraud arena, we are undertaking a special initiative to expand our use of data analytics to enhance our ability to detect possible fraud. We will apply logical analysis to determine common characteristics and patterns of fraud based on data from past allegations and known cases of fraud. We will apply these tools to look for potential fraud or other suspicious behavior when we review initial applications or existing data on beneficiaries. With these diagnostic tools, we anticipate increasing our ability to identify questionable patterns of activity in disability claims and prevent fraudulent applications from being processed. During the remainder of FY 2014, we will develop and begin testing some of these tools.

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

Other Anti-Fraud Initiatives

Our anti-fraud efforts have not been limited to Social Security matters. In the past several years, we have worked with other Federal agencies and the Administration in developing legislative proposals designed to combat fraud in other programs. For example, we helped develop a legislative proposal for the President's FY 2014 Budget that would eliminate the public's ability to use the Freedom of Information Act (FOIA) to access our recent death records. The proposal would restrict immediate access to a deceased individual's information on the Death Master File (DMF) to those users who legitimately need the information for fraud prevention purposes and delay the release of the DMF to all other users for three years after the individual's death. This provision was designed to reduce opportunities for identity theft and to eliminate the ability of criminals to use our publicly available death records to file fraudulent tax returns. The Congress enacted a legislative provision similar to the one proposed in the President's Budget in the Bipartisan Budget Act of 2013.

We are also working with other Federal agencies. The Bipartisan Budget Act of 2013 includes another Administration proposal to expand both the data we collect from correctional facilities about incarcerated individuals, and the entities with which we can share that information. We are working with the Department of the Treasury (Treasury) to develop the necessary agreement to send them our prisoner information, so they can incorporate it into their Do Not Pay initiative, thereby allowing other agencies to use it to help prevent and detect improper payments. We are also working to find the best ways to collect additional information, such as the actual or anticipated release date, and to get that information to the Do Not Pay portal. In addition, the Bipartisan Budget Act of 2013 also provided Prisoner Update Processing System (PUPS) access for the Internal Revenue Service.

Huntington, West Virginia Hearing Office

There has also been some Member interest relating to a former situation in our Huntington, West Virginia hearing office. Given the nature of certain ongoing investigations, we are limited in

sharing information about the investigation in this report.[4] As we are permitted, we are willing to privately brief the Committee in more detail, if requested.

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

Conclusion

In short, we have long been committed to combating fraud in our programs. Although there is a low level of fraud in our disability programs, no amount of fraud is tolerable. Fighting fraud is an ongoing and evolving process. Therefore, in collaboration with the OIG, we are continuing to enhance our anti-fraud efforts.

Alleged criminal conspiracies like those in Puerto Rico and New York City may mislead the public into overestimating the level of fraud in our disability programs. Hearings like these are a chance for us to correct these distortions and remind the public that we are keeping vigilant watch over these programs.

We appreciate this Committee's assistance in these efforts and stand ready to work with Congress to maintain the public's trust and confidence in our very important social insurance programs.

Rooting out a fraud is a team effort. We need people who suspect something to say something. If you suspect that someone is trying to cheat us, please contact OIG at 1-800-269-0271.

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

Chairman JOHNSON. Ms. Colvin, Social Security's budget increased by 27 percent from 2006 to 2014 at the same time that major fraud scandals were going on. That is nearly double the growth rate of the entire Labor-HHS appropriations bill, which funds Social Security.

As you know, the stimulus provided Social Security $1 billion that was used, in part, to reduce disability backlogs and hire 2,115

workers. Clearly, more money and manpower did not help prevent fraud from happening in Puerto Rico, New York, and West Virginia.

During the period Social Security received special funding to handle the surge in disability applications, how was this funding used to prevent fraud rings from getting claimants on the rolls? And the continuing disability reviews don't count. That happens after they are getting paid.

Ms. COLVIN. Mr. Chairman, we take fraud very seriously in the agency. We have a culture where we are training people, if they see something, say something; if they hear something, do something about it. So every step of our process, there are antifraud activities.

There are many, many cases that you will never see, that will never come to the media, where we prevent fraud every day. We mentioned that last year we referred 22,500 cases of suspected fraud. So this is something where we are vigilant, where we are always looking.

There are going to be cases that we are not going to detect before it happens, but I need to reemphasize that there are thousands and thousands of cases that we do not pay because we have, in fact, detected fraud. And I think that is why the Office of the Inspector General has indicated that our fraud rate is so low.

But when we detect fraud, we very aggressively pursue it. We refer it to the Inspector General, who makes that determination. We prosecute to the full extent of the law. And we actively seek reimbursement or restitution.

One of the things that we would like to do is be able to expand some of those efforts nationwide. I have directed considerable resources away from our direct services in order to address this issue. And that is one of the reasons we had to take some of the drastic actions, like reducing the number of hours that our offices were open to the public, because we wanted our staff to have time to do those things.

Remember, we lost over 11,000 employees in the last 3 years. So that means we have 11,000 less employees who are being vigilant and looking for fraud.

Chairman JOHNSON. Yeah, you have said that several times.

How much did you spend from your operating budget last year to prevent fraud?

Ms. COLVIN. I don't know that I can pull that out specifically because each stage of the process there are antifraud activities involved. For instance, at the front level, when the first application is taken, the individual is looking for whether or not there are any credibility issues based on the actual interview with the individual. And then we have a quality assurance review to make sure that that process has been handled right.

When it moves from the front line of the field office and goes into the DDS, we have an in-line quality review that is even more important and more difficult than at the first level. And then when it moves from there, it goes to the hearing level.

So a part of all of the work that our staff is involved in is also antifraud activity. I can give you the cost of our CDI units, which are specifically our fraud units, the cost of our prosecutors. But

when we look at our staff, because fraud is one piece of what they do, it is somewhat difficult to tease that out.

Chairman JOHNSON. Well, how many dollars are you spending on fraud?

Ms. COLVIN. Again, I have to give you that for the record, because what I will have to do is give you the costs for the CDI units and the prosecution units, which are for specifically fraud.

But, for instance, the dollars that we are spending now just to deal with the cases that have been identified in Puerto Rico and New York are dollars that are being redirected, and we would have to tally what those costs are. And then, of course, the training that we provide that is focused on antifraud, that is another cost.

So I would like to try to pull that together and provide it to you for the record.

[The information follows:]

Insert for Page 21

Last fiscal year, the cost of our CDI units totaled about $21 million and the cost (salaries and benefits) for our special fraud prosecutors was about $2 million.

As I testified, we do not track anti-fraud activities spending as a broad category. To the extent we can, our anti-fraud activities are fully integrated into our normal business process.

Chairman JOHNSON. Okay. I appreciate you getting your plan to us. Unfortunately, there aren't a lot of details. Will you provide the subcommittee a detailed timeline for the implementation of each initiative in your plan?

Ms. COLVIN. I would be happy to do that.

[The information follows:]

SOCIAL SECURITY
The Commissioner

March 27, 2014

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

Dear Mr. Chairman:

Thank you for the opportunity to elaborate further on our fraud-fighting efforts and for bringing attention to our work to root out fraud. Please find enclosed the timeline for implementing our anti-fraud initiatives that you requested during the hearing on February 26, 2014.

I hope you find the timeline helpful, and we look forward to working with Congress on this critical issue. We also are sending this information to Ranking Member Xavier Becerra.

If I may be of further assistance, please contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030. Mr. Frey is available to meet with your staff if requested.

Sincerely,

Carolyn W. Colvin

Carolyn W. Colvin
Acting Commissioner

Enclosure

Timeline for Implementation of Anti-fraud Initiatives in the Social Security Administration's 30-Day Report

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
pp. 6,11,15	**Increase CDRs:** With the recent appropriations act, Congress provided us with funding to significantly increase the number of continuing disability reviews (CDR) that we are able to conduct. We estimate that the money spent on CDRs saves on average $9 per every dollar invested, including savings accrued to Medicare and Medicaid. *Objective:* Increase the amount of program savings. While the CDR process is not specifically designed to detect fraud, increasing CDRs could possibly allow us to detect more potentially fraudulent or suspicious activities.	*Schedule:* By the end of fiscal year (FY) 2014, we will complete over one-half million full medical CDRs, a more than 20-percent increase over FY 2013. With full funding of the President's FY 2015 budget, we will be able to complete 888,000 full medical CDRs in FY 2015, more than double the amount completed in FY 2013. *Responsible Component:* Office of Operations (Operations)
pp. 5,6,11	**Expand CDI Units:** Working with our Office of the Inspector General (OIG), we plan to expand the number of Cooperative Disability Investigations (CDI) units. According to the OIG, CDI units have contributed to Social Security Administration (SSA) savings of more than $960 million over the last 3 fiscal years. As the report shows, we provide most of the funding for these units and, in collaboration with the OIG, we plan to expand the CDI program by seven additional units beginning in FY 2014. We anticipate these seven units will be fully operational in FY 2015, increasing the total number of units from 25 to 32 nationwide. *Objective:* Enhance our ability to prevent and detect disability fraud.	*Schedule:* We expect that the first new unit to open will be the Baltimore CDI unit by the end of FY 2014, with the Detroit CDI unit to open in the first quarter of FY 2015. The remaining units are expected to open in the third and fourth quarters of FY 2015. They will be located in Birmingham, AL; Charleston, WV; Providence, RI; St. Paul, MN; and Washington, DC. This is an aggressive timeline as, based on experience, it typically takes 12 to 18 months from approval to having fully operational units. *Responsible Components:* Operations and OIG

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
p. 5	**Anti-Fraud Training:** We will expand anti-fraud training to all SSA employees during FY 2014, with specific focus on lessons learned from Puerto Rico and New York City. SSA and disability determination services (DDS) front-line employees remain our best line of defense against those seeking to exploit the system. *Objective:* Enhance our ability to prevent and detect disability fraud.	*Schedule:* By the end of FY 2014, all SSA and DDS employees will complete anti-fraud training. *Responsible Component:* Office of Human Resources
p. 12	**Data Analytics:** We will develop analytical tools based on known cases of fraud and past allegations to determine common characteristics and patterns. We will apply these tools to help us uncover potential fraud or other suspicious behavior when we review initial applications or existing data on beneficiaries. We invited the OIG to participate in this initiative. *Objective:* Increase our ability to identify questionable patterns of activity in disability claims and prevent fraudulent applications from being processed.	*Schedule:* In February 2014, we established the inter-component Disability Fraud Predictive Analytics Project Team. The project team will conduct a pilot to utilize data analytics to enhance the agency's ability to detect and prevent disability fraud. We will conduct the pilot in two phases in FY 2014. The first phase will apply predictive analysis to our disability claims data to verify the ability of analytics and our big data platform to identify disability case fraud. The second phase will utilize analytic tools to identify suspicious patterns of activity in disability claims. We will closely examine any identified potential fraudulent cases and if appropriate, we will refer them to the OIG for investigation. *Responsible Components:* Office of Systems and Operations

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
p. 12	**Specialized Fraud Units:** We are establishing a specialized fraud unit comprised of disability examiners dedicated to reviewing and acting on potential fraud cases. *Objectives:* Develop experts in working disability fraud cases. Compile data from the cases that will help us to develop further analytical tools to identify potential fraud	*Schedule:* There will be three disability anti-fraud units established in FY 2014. The New York Anti-Fraud Review Unit became operational in March 2014. The remaining two units, located in Kansas City, MO and San Francisco, CA will be in place before the end of FY 2014. *Responsible Component:* Operations
p. 13	**National Anti-Fraud Committee:** We are reinstituting the National Anti-Fraud Committee (NAFC), which will be co-chaired by the Inspector General and our Deputy Commissioner for the Office of Budget, Finance, Quality, and Management (OBFQM). *Objective:* Lead and support national and regional strategies to combat fraud, waste, and abuse. Support includes providing an open forum for senior executives to collaborate on fraud challenges and opportunities at a strategic level.	*Schedule:* The NAFC co-chairs held a planning meeting with support staff on March 6, 2014, to discuss the new committee charter, membership, baseline initiatives, and means for communicating the agency's anti-fraud effort. NAFC intends to meet on at least a quarterly basis and held its first full meeting on March 24, 2014. On March 7, 2014, the Acting Commissioner announced the availability of a dedicated mailbox for employees to make anti-fraud suggestions, which the NAFC will use to identify and sponsor new initiatives to help prevent and detect fraud. *Responsible Components:* OBFQM and OIG

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
p. 13	**Submission of Evidence Regulation**: We propose to revise our regulations to require claimants to inform us about or submit all evidence known to them that relates to their disability claim—both favorable and unfavorable. We also propose to require a representative to help the claimant obtain the information or evidence that the claimant must submit, and we would extend the protections afforded by attorney-client privilege and attorney work product to non-attorney representatives as well. *Objective:* Address concerns that some claimants may withhold medical evidence that could be unfavorable to their claims.	*Schedule:* Proposed rule published in the *Federal Register* on February 20, 2014. The public comment period closes April 21, 2014. *Responsible Components:* Office of Retirement and Disability Policy (ORDP) and the Office of Legislation and Congressional Affairs
pp. 6,7	**Fraud Prosecution Project:** The Department of Justice (DOJ) is the Federal agency responsible for prosecuting defendants who have violated Federal law. However, due in part to a lack of prosecutorial resources, DOJ declines many cases for prosecution. For more than a decade, our Office of the General Counsel (OGC) has worked with OIG to develop the SSA Fraud Prosecution Project. To support this project, OGC has provided attorneys who serve as Special Assistant United States Attorneys (fraud prosecutors) in many of the Federal districts where we have regional offices and at Headquarters. There are currently 12 attorneys assigned to this project. *Objective:* Increase the number of prosecutions for crimes involving Social Security matters.	*Schedule:* By the end of FY 2014, we will have 12 additional agency attorneys assigned to this project, doubling the current number. *Responsible Component:* OGC

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
p. 14	**Representative Payee Criminal Bar:** We seek only qualified individuals and organizations to serve as representative payees, and we take steps to ensure continued qualification and proper use of the benefits. We have completed a pilot of a policy change that we believe will help us identify payee applicants who have committed certain serious crimes and bar them from serving as payees. Felony convictions for any of 12 crimes will bar the individuals from serving as a representative payee. *Objective:* Help identify representative payee applicants who have committed certain serious crimes and bar them from serving as representative payees.	*Schedule:* Based on the pilot's results, we implemented the criminal bar policy nationally on February 28, 2014. *Responsible Component:* ORDP
p. 14	**Symptom Evaluation** (Research Effort): We have asked the Administrative Conference of the United States (ACUS) to review the Social Security Act, current regulations, and our sub-regulatory policy regarding how decision-makers at all levels evaluate claimants' symptoms in disability claims. ACUS will also review a sample of related Federal case law, conduct additional research concerning symptom evaluation in other formats, review international perspectives, and gather stakeholder perspectives on our current standards for evaluating disability claimants' symptoms. *Objective:* This initiative's primary objective is to increase the objectivity of our individualized evaluation process. However, we believe this study may help us prevent fraud.	*Schedule:* We anticipate having a report from ACUS in August 2014. The ACUS report will determine our next steps in this area and the timeline for implementation. *Responsible Components:* ORDP and the Office of Disability Adjudication and Review

Enclosure – Page 6 – The Honorable Sam Johnson

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
p. 14	**Psychological Testing** (Research Effort): We have asked the Institute of Medicine (IOM) to perform a comprehensive review of psychological testing, including symptom validity testing. IOM will examine the relevance of psychological testing to disability determinations in claims involving physical or mental disorders. IOM will also provide us guidance that we can use to help adjudicators interpret the results of psychological testing.	*Schedule:* We anticipate having a report from IOM in June 2015. The IOM report will determine our next steps in this area and the timeline for implementation.
	Objective: This initiative's primary objective is to increase the objectivity of our individualized evaluation process. However, we believe this study may help us prevent fraud.	*Responsible Component:* ORDP

Ms. COLVIN. Most of the things that we identified in the plan are ongoing. Some of them are going to be expanded in 2015. We are very fortunate that, with the fiscal year 2014 appropriations, we are able to expand our CDI units. We were able to establish a special fraud unit in Ms. Disman's area in New York, where those individuals will have specialized experience in dealing with these types of cases. We want to expand that and bring in some additional skills. We are doing a number of things as a result of the 2014 budget, and then, depending upon a sustained budget for 2015, we would expand that further.

But I can certainly give you a breakdown. But right now the things that we are doing in 2014 include more hiring on the front line, so we are bringing in more staff as a result of our 2014 budget to replace some of the losses. It won't make us whole.

We are increasing the number of CDRs. Now, even though CDRs are not designed specifically to deal with fraud, when we do those medical reviews, we may find situations where there is conflicting information or whatever, and then we can refer those cases. So the fact that we have 1.3 million CDRs in our backlog does not help our program integrity efforts.

We are in the process of developing and testing our predictive analytic tools. You have seen the things that we are doing with Judge Ray in ODAR. We would like to be able to expand that. So we are looking at our ability to do some expansion in 2014, and, again, with additional funding, we would like to do that more. But remember, even though data analytics has some real potential for us, it still requires human intervention. We have to have staff to analyze the data and to identify the patterns that exist and to develop the cases.

The specialized fraud unit is already in existence in New York. We are looking at all of those cases, the lessons learned. Bea Disman has experience with this as a result of what has happened in Puerto Rico and New York. She will be taking cases from all over the country so that we will have a specialized unit. We would like to be able to fully staff that unit, and as it perfects its work there, we would like to expand that.

We want to double the number of fraud prosecutors. We want to reestablish the antifraud committee. Bea Disman established an antifraud committee back in the 1990s when I was here; it was highly successful. But for the last 10 years, it has been dormant. We are reestablishing that. That has already been reestablished.

And with that committee, I think—I mean, with that antifraud committee, we will use that to benchmark what is happening in the industry, because fraud is not just an SSA problem. We will look at what is happening in other Federal agencies, and what is happening in the private sector. We have already had a meeting with eight Federal agencies to look at what they are doing with data exchange and data analysis so that we can develop a community of practice that will allow us to try to tackle this problem.

Fraud is a social problem. It exists everywhere. The fraudsters are becoming more sophisticated, and we want to be able to get out in front of them. And so that is why data analytics is important.

Chairman JOHNSON. So you have brought back the national antifraud committee?

Ms. COLVIN. Yes, we did.

Chairman JOHNSON. Why was that dismantled in the first place?

Ms. COLVIN. I have only been in this position for 1 year this month——

Chairman JOHNSON. Yeah, but they probably told you about it.

Ms. COLVIN. It was obviously determined not to be as high a priority as some of the other work.

One of the things I did when I first assumed this role a year ago was say we had to balance our direct services with our antifraud

services and other program integrity activities. So that meant redirecting the resources, but we had to make tough decisions there. As a result, I closed offices and consolidated. I mentioned that we had to stop—a lot of the training previously had been stopped because of the budget. I reinstituted training.

So what we are trying to do is just balance the need to provide services to people who have earned these benefits. We have very long waiting times, very long processing times. We were making progress, and now, with the funding, because we have had $1 billion less per year than the President's budget, we have had to cut those things, Mr. Chairman.

I know you don't want me to talk about resources, but SSA is one of the most efficient organizations I have ever worked with. Our overhead is 1.4 percent of our outlays—1.4 percent. I am not sure that even Unum, the insurance company here, has that number. I certainly have checked with other private agencies.

So SSA is an efficient organization, but we can't do everything that we were able to do when we had 11,000 more employees at the same time that our workload is increasing.

Chairman JOHNSON. Mr. Becerra, you are recognized.

Mr. BECERRA. Thank you, Mr. Chairman.

Commissioner, thank you again for being here.

Let me begin by asking a question that I posed in my opening statement. New York, you had a Cooperative Disability Investigations Unit. You found this fraud committed by people that we typically trust——

Ms. COLVIN. Absolutely.

Mr. BECERRA [continuing]. Former police officers, firefighters, people that we hold in high regard. But in 29 States you don't have a CDI unit.

Ms. COLVIN. Absolutely.

Mr. BECERRA. If this same fraud had occurred in 1 of those 29 States, would we have detected it?

Ms. COLVIN. Maybe. We refer cases to the Office of the Inspector General. But unlikely, because we would not have had the strong coordination.

The CDI unit, for those who may not know, is comprised of SSA staff, DDS staff, OIG staff, and local law enforcement, so it is a coordinated effort. And they are able then to look very carefully at the cases that come in and use the data. We spend a lot of time developing those cases for OIG. So when you don't have that, you don't have the same level of coordination.

I am very proud that the first CDI unit was developed when I was here in 1998 as the Deputy Commissioner. And, again, that was because we had a culture where we wanted to make sure the right check got to the right person at the right time. We are not an organization that pays first and chases later. I want to stress that.

And so all the kinds of things that we are doing that have been effective could be much more effective if we had the resources.

And I want to reemphasize again that you don't hear of the cases that we don't pay. There are hundreds, thousands of cases that we don't pay because we do see that there is something fraudulent, and they are not paid.

Mr. BECERRA. Could you use this coordination of the different agencies and offices so you would have more fraud busters in these 29 States?

Ms. COLVIN. Yes, Mr. Becerra, we certainly could. We would double what we are doing in the other areas with new money.

Mr. BECERRA. And would you expect to have the same type of return on investment——

Ms. COLVIN. Absolutely.

Mr. BECERRA [continuing]. Where you would return far more money in savings of not having fraud committed than the money you use to pay these fraudbusters?

Ms. COLVIN. Absolutely, sir. We would still be looking at $17 for every dollar we spend in our CDI unit, $9 for every $1 we spend in our CDRs.

We have demonstrated that if you give us the resources, we produce what we say we are going to produce. We are a production agency, a service agency, and it is very easy to show you how we spend that money. And I think you will find that we have always had good financial audits that show that we spend that money wisely. We are good stewards of the American taxpayers' dollars.

Mr. BECERRA. Yeah. Any investor on Wall Street would love those types of returns, $17 for every dollar invested, $9 for every dollar invested.

Let me ask you this. Would it help the Social Security Administration if Congress increased the financial penalties that we assess for Social Security fraud committed by people who should know better?

Ms. COLVIN. Absolutely. When there is a conviction, it acts as a deterrent. If others see that they can commit fraud and they are going to get a slap on the hand, why wouldn't others be encouraged to do it? So, yes, a deterrent would help us.

Mr. BECERRA. Would it help the Social Security Administration if we gave you the ability to ban doctors who have committed fraud from participating in the determination of eligibility for benefits?

Ms. COLVIN. Yes. We do have that, to some degree. We do not use physicians who are on the do-not-pay list as maintained by Medicare. But certainly there would be others that perhaps we could find, and we would benefit from that.

Mr. BECERRA. Those are some of the provisions that we have in our legislation that we are introducing today to give you more tools to try to fight this fraud.

Let me go back to something with regard to your budget. Again, recognizing that you serve 56 million Americans who are receiving benefits from you, not here and there—56 million Americans. One in every six Americans receives Social Security benefits, having paid for them, having earned them. Now it is up to you to make sure one in six Americans gets what he or she earned on time and in full.

Yet, with that number—and I think any business in America would love to say that their error rate is less than one-half of 1 percent. Having said that, it is a growing population that you serve, because all those baby boomers are beginning to retire.

Now, on the budget, your budget today is about $800 million lower than it was 4 years ago.

Ms. COLVIN. Yes, that is correct.

Mr. BECERRA. So, even though more and more baby boomers are retiring and going on to Social Security to collect their benefits that they earned, you are receiving less money today than you received 4 years ago. In 2011, this Congress, under Republican leadership, cut your budget and rescinded most of your reserve funds that you had. In 2012, they left the budget as it was, at that low 2011 number, despite your growing number of beneficiaries. And in 2013, your budget was cut again by the autopilot, across-the-board, insane sequester cuts.

So this year's budget only restored part of those 2013 losses that you suffered, and none of the other cuts were restored, except for providing program integrity money after a 2-year delay. And that program integrity money is what helps us go after the fraud; it is those fraudbusters.

And so I think we have to recognize that you have work to do, but we have work to do here in Congress, as well. And the worst thing that we can do is shackle your ability to do your job with a growing number of beneficiaries so that you can go after the fraud to protect the money that people have earned and put into Social Security.

And so it is a tango; you have to dance, we have to dance. I hope you will continue to be honest with us, about what we have to do. Because we have to help you make sure that the money that people send to Social Security is there for them when they need it and they have retired and have to pay their bills.

With that, Mr. Chairman, I yield back my time.

Chairman JOHNSON. The gentleman's time has expired.

Mr. Renacci, you are recognized.

Mr. RENACCI. Thank you, Mr. Chairman.

And thank you, Acting Commissioner Colvin, for being here.

You know, it is interesting because, coming from the private sector, we always had to learn to live with less. And, you know, I hear the Ranking Member talk about your budget being cut, and I don't know whether your budget 4 years ago was already too high, so we don't know that. But what I really know is that the best way to fix things is fixing them early on and having you have the ability to prevent this early on.

And I think, again, a couple of the ideas the Ranking Member brought up I think are good ideas, and I would like to hear some of those from you, as I think we in Congress should be hearing what you believe are some of the ways we can help you.

But I would really like to find out, what are we doing with all this information to train those employees? I mean, I know you have a lot of good employees, but are they being trained properly? I will give you an example. How much time do your regional managers and executives really spend with the frontline staff? And then all these areas that we are finding problems, are we fixing them at the frontline staff?

Can you kind of go into that a little bit? Because I think that is so important.

Ms. COLVIN. Thank you, sir.

We have always said that the strength of our organization is our employees. So we spend tremendous time and resources in training

them. It has often been said that it takes longer to train one of our staff than it does to train an astronaut.

And we have very comprehensive training, both how to do the work as well as how to identify fraud. This is done when they first come in. It is done on an ongoing basis, on a yearly basis. If we identify that there are specific problems, then there is special training so that they are prepared to address that.

The managers assign mentors to the employees to work with them. There are quality reviews to see if the training that we have given them has benefited them and that they are learning it and doing the work right.

So I believe that the training is key to the success of what we do. We have a highly competent group of staff. They have mentors. And our managers are very committed to ensuring that they get the job done. There is a lot of pride in the organization in providing good customer service but more pride in being good stewards of the tax dollars. So I think we do that.

And I would reemphasize that, unfortunately for us, you don't see all the good things we do, so you don't see all the fraud that is prevented.

Mr. RENACCI. All right. Well, and I do believe that there are cases that aren't being paid. I heard you say that. The question is, for the people back in my district, they are concerned about the dollars that do get paid out and trying to avoid those. And I realize you have a low percentage, but any percentage——

Ms. COLVIN. Any percentage is too much.

Mr. RENACCI [continuing]. Any percentage is too much.

Ms. COLVIN. Absolutely.

Mr. RENACCI. So when you find problems like we find in Puerto Rico or West Virginia or New York, when you found issues that was fraud-related, what is process of taking some of those issues and bringing them back to the frontline staff to stop it?

Ms. COLVIN. Absolutely. That is what Ms. Disman is doing. I mentioned that we have established a special fraud unit, so we have individuals who have a great deal of experience in dealing with these types of cases. So we identify lessons learned, and then we come back and we incorporate that in the new training for the staff on the front line.

We are really problem solvers in SSA. I will give you a good example. When Treasury decided that all benefits had to be through direct deposit, we had a significant number of fraudsters who were attempting to redirect those direct deposits. At one time, we were looking at as many as 3,000 attempted fraud activities in a week. We are now down to fewer than, around 400. And that is because we identified what was happening, and we put things in place to ensure that it would not continue to happen.

But, even more importantly, I would say 75 percent of the attempts we were able to prevent from even happening before a benefit is redirected. And the 25 percent of the cases where there may be a benefit directed, we are talking about 1 month, and then we aggressively go back to pursue that.

So whenever we see a situation occur, we do a careful analysis of what happened and what we need to do to prevent it from happening again. Fraudsters have become very sophisticated, and that

is why we are turning to data analytics and looking at what tools can be addressed. Because when you have a third-party person facilitating the fraud, like a physician or a firefighter or someone who are persons of trust, it becomes more difficult.

Mr. RENACCI. Real quickly, I know my time has run out, but how quickly does that process get put back into the front line?

Ms. COLVIN. Immediately. Immediately.

Mr. RENACCI. All right.

Ms. COLVIN. We have ongoing training. It is not one-time. It is ongoing.

Mr. RENACCI. All right. Thank you. I thank you for your testimony.

I yield back.

Chairman JOHNSON. Thank you.

Mr. Kelly, you are recognized.

Mr. KELLY. Thank you, Mr. Chairman.

Ms. Colvin——

Chairman JOHNSON. Oh, excuse me. I skipped over my Democrat friend, Doggett. And he is from Texas. How could I miss him?

Mr. DOGGETT. Well, Mr. Chairman, I want to join with you particularly in your concluding remarks, that crimes against Social Security cheat hardworking Americans and honest beneficiaries. And I think that there is strong bipartisan support, as we have looked at these various instances of fraud, about our need to ferret them out.

And I think, just as your statement and all of our comments is not directed at attacking all police and firefighters around the country because of the wrongdoing of a handful, but a significant handful, of firefighters and police officers, retired officers in New York City, that it is important as we look at this overall system that we not attack all advocates on behalf of the disabled because there may be some wrongdoing or misconduct by a handful of them. It is important when these individuals with disabilities go before the Social Security Administration that they have the opportunity to be represented by honest advocates, as many of them are.

Similarly, it is important to recognize that, while not every employee in the Social Security Administration or every administrative judge working on Social Security cases is doing a good job, that the vast majority of them are. And as we find examples of individuals that are not up to the task, that needs to be dealt with. But we need to recognize that we basically have a system that works. And what we are trying to do is ferret out the crimes, just as though law enforcement officers around the country dealing with other kind of crimes and fraud are trying to ferret that out. Even though we never get to 100 percent in preventing burglaries, robberies, other kinds of fraudulent conduct, we won't get to 100 percent of fraud of Social Security, but that ought to be our goal.

Now, how do we accomplish that goal? Well, I think we have to have adequate resources, as the Acting Commissioner has indicated, and adequate tools to address fraud.

And without doing a lot of finger-pointing about the cuts and the inadequacies of the Social Security budget, Mr. Chairman, I think it would be constructive—I know that in our full committee we have Secretary Sebelius and Secretary Lew coming to testify about

aspects of the President's budget; I don't know what will be in the budget concerning fraud reduction and the Social Security Administration generally—but to have a hearing in this subcommittee on the budget for Social Security and its adequacy.

When you hear that a dollar spent on OIG generates such significant returns, I think we need to scrutinize carefully the entire budget for Social Security and ensure that it is up to the task of fulfilling our bipartisan commitment to reducing crime.

And then, in addition to just the dollars that are available, we need to be sure that we have the tools available. I joined with Mr. Becerra in his legislation. I realize that this is recently filed legislation, but I think it is the first specific legislative steps that have been presented to this subcommittee for how to deal with this problem.

And I would hope that we could have a hearing on the proposal that you have advanced. I am sure that there are many other ideas that can be advanced about the best way to deal with fraud. But instead of our just talking and having an expose about fraud that some may feel is designed to kind of tarnish the whole Social Security disability system, let's focus on what we can do about it in the dollars and the specific tools.

I think you have some good ideas. I am sure you are open to getting other specific legislative proposals. But we are not short of time in this Congress. We have the opportunity for constructive action and a prompt hearing on the Social Security budget and on the Becerra proposal and any other ideas that Members have for addressing fraud. Seems to me to be the most specific and constructive way forward to put a stop as much as we possibly can to the abuse we have seen in New York and Puerto Rico and some other parts of the country.

I thank you, and I yield back.

Chairman JOHNSON. Thank you, Mr. Doggett.

Mr. Kelly, you want to speak?

Mr. KELLY. Thank you, Mr. Chairman.

Ms. Colvin, thanks for coming in to see us again.

What I always wonder about in these things, how big is your agency right now, when you take total people on staff?

Ms. COLVIN. We have about 62,000 employees throughout the country.

Mr. KELLY. And your budget?

Ms. COLVIN. $11.7 billion? Yes, $11.7 billion.

Mr. KELLY. Okay, so it is 66,000, did you say?

Ms. COLVIN. No, 62,000.

Mr. KELLY. Sixty-two thousand staff.

Ms. COLVIN. We have lost 12,000.

Mr. KELLY. Okay. And, again, the budget is what?

Ms. COLVIN. $11.7 billion is about right.

Mr. KELLY. $11.7 billion. Okay.

And the reason I bring it up, because I think there is always confusion that says, well, if the government would just give us more money—listen, this is not an indictment on Social Security people.

Ms. COLVIN. I understand.

Mr. KELLY. But in my life and in what I have done for a living up until the last 3 years, it is employers and employees paying in

together into this fund. And if I am reading the notes right, we say that by 2016 the revenues will be sufficient to pay only 80 percent of SSDI benefits beginning in 2016.

So we are on a trajectory that doesn't look good. And what you are doing, you are trying to get this fraud eliminated. Early detection is always the best type of correction, right? You are going to minimize your loss if you get it early enough.

And I am interested to hear Mr. Royal from Unum, because I know from the private sector it is not a matter of whether you want to do it or not. It is you either do it or you don't survive. You have to get it in line.

What else can you do? Because it seems to me, in a country that leads the world in technology and being able to derive tendencies—and in my business, I am an automobile dealer, we have something called warranty reimbursement. That is where something goes wrong with your car and they say, well, it is the result of either poor workmanship or something didn't work right. But I have to tell you, the factories are all over me all the time when they look at the number of dollars we are claiming for doing warranty work. And we are doing the same thing with the Social Security Disability system. You are saying, okay, this is fraudulent, we want to go back and collect it.

Mr. Becerra made some points. What are the penalties for people who do these fraudulent things?

Ms. COLVIN. Unfortunately, we don't control the penalties. That is in the law, in the judicial system. I have always been concerned that they get off rather lightly, but, you know, that is white-collar crime. And it always has been a light sentence. We would like to see the maximum sentence under the law, but we don't control that. Once it goes to the Office of the Inspector General and then gets——

Mr. KELLY. But that is something we could help you with, right? I am assuming Mr. Becerra is making some suggestions about how to change.

Ms. COLVIN. I would certainly hope that you can.

Mr. KELLY. Because if the time doesn't fit the crime, I mean, what is the reason for not doing it? Too many of these people are making a great living off it.

Ms. COLVIN. Well, you are aware that in many States the U.S. Attorneys will not even accept our cases because they don't come up to the dollar value that they are interested in pursuing. That is one of the reasons we began to use Social Security dollars to use our own attorneys in the 12 States where we are, where the U.S. attorneys were willing to work with us. But many States will not accept these cases for prosecution because they don't rise to the dollar level, so that is a big issue for us.

Mr. KELLY. Yeah, I am sure it is. That is difficult. If you really aren't going to hit them in the wallet, they are going to say, well, no big deal, I will just keep doing what I am doing, it is not that big of a deal.

Ms. COLVIN. Well, we are still aggressive in identifying them. Unfortunately, we don't control the outcome, but we are very aggressive. As I mentioned, last year we referred 22,500 cases.

Mr. KELLY. And so, of those 22,500, how many were actually looked at?

Ms. COLVIN. I think about 100 were accepted for prosecution.

Mr. KELLY. One hundred?

Ms. COLVIN. One hundred.

Mr. KELLY. Out of how many?

Ms. COLVIN. Twenty-two thousand, five hundred.

Mr. KELLY. That is incredible.

Ms. COLVIN. I don't control that, sir.

Mr. KELLY. I know. I am not saying you do. Whenever employers and employees put this money into this fund—this isn't government-funded, this is wage-tax funded, and I think sometimes we forget about this. And so when people start saying, if we just put more money into it—if you are going back to these people to pay this and saying, if you just put more money in, maybe it will stay—but it has always bothered me that sometimes there is a disconnect about who actually funds all this stuff.

If you are telling me that you come up with 22,000-some cases and they accepted 100, that has to be very frustrating for the people that are out there doing that work.

Ms. COLVIN. It absolutely is, but fortunately we have a dedicated team who still refer the cases.

Now, we have been able to do some things. For instance, the Office of Inspector General has increased the number of civil penalties that they are able to impose. I don't think I have the dollar here, but they are doing more. We strengthened our administrative sanctions process.

But, basically, the prosecution is the thing that would deter folk, and the prosecutions are not that successful.

Mr. KELLY. All right. Well, then I would think, though, for us, for both sides, if we would help you, if we would put more teeth into these things, it would help you to win. So it does come back to the, you know, help us to help you.

I am glad you are here. I am glad you are telling us all about that. I am concerned about it, because I do know where the funding comes from. I know it is not from the government; I know it is from people who paid wage taxes. I would like to see more people get back to work, quite frankly.

Ms. COLVIN. Right.

Mr. KELLY. That would help, too. But we don't see that happening as quickly as we would like to see it happen.

But, again, stay in touch with us on this, and let us know how we can help you.

Ms. COLVIN. Absolutely.

Mr. KELLY. Mr. Becerra, I would like to take a look at your piece. I think that we are on the right track, but we got to make sure—throwing money at a problem isn't the answer. We have to get more bang for the bucks. And I know we talk about the percentage, but a small percent of a big number is a big number. And it is all taxpayer-funded.

Mr. BECERRA. Will the gentleman yield?

Mr. KELLY. Yes, certainly.

Mr. BECERRA. The chairman and I were just chatting about how what we could try to do is move forward from these hearings

and see if we could come up with a bipartisan approach to see if we could move something forward.

Mr. KELLY. Absolutely.

Well, you know what I want to have. I don't want Ms. Colvin or anybody that works for you to walk out of here thinking, you know, these people just want to beat the living daylights out of us every time they get a chance. That is not the case. We both work for the same person: That is the American taxpayer. So if we can help you, I would love to do it.

And, Mr. Chairman and Ranking Member, let's work together and get this fixed for the American people.

Chairman JOHNSON. Oh, who have we got left? Mr. Crowley. Wait. Mr. Thompson I think is ahead of you.

Go ahead.

Mr. THOMPSON. Thank you, Mr. Chairman.

And I want to just chime in with the folks who have expressed an interest in working together on fixing these issues. I think it is extremely important.

And I want to say that, you know, I have represented just about every county in northern California at one time or another. And there are Social Security employees and offices all over northern California, and your employees are an absolute joy to work with. I have found that every one of them is there to do the right thing.

Ms. COLVIN. Thank you so much, Mr. Thompson.

Mr. THOMPSON. They work hard. They work well with my different offices. And I am sure it is terribly frustrating for them when these issues are pointed out.

And so I would like to—I am proud to be a co-author of Mr. Becerra's bill, but I am proud to hear that folks on both sides of the aisle want to work it out.

And I would suggest, Mr. Chairman and Mr. Ranking Member, if we could do it with the cooperation of the folks at Social Security. It is terribly frustrating, my time here in Congress—and I just had another go-around at this last year with USDA on a huge problem, and I wanted to sit down and work out a solution, and there was just no interest in that agency working with Congress. They thought that they had it dialed in and that all we were going to be is a problem for them. And I hope that is not the same with Social Security.

Ms. COLVIN. You will find that it is not. I think the chairman will tell you that we have been very interested in working with this committee. The chairman and Mr. Becerra have been very supportive. We understand your concerns about the problem. We are as concerned.

And we welcome the fact that you are proposing legislation. Thank you, Mr. Becerra. We will provide technical assistance and do anything else that you request that we can do.

Mr. THOMPSON. Well, my sense is that you know better the issues and the obstacles than any of us do. So if we could do that, if we could work collaboratively and collectively, I think we could——

Ms. COLVIN. We welcome that.

Mr. THOMPSON. I am interested in one issue. You have mentioned all of the fraud that you stop from happening. And I know

that errors are also a problem. How do you differentiate between fraud and error? Because some people aren't frauds; they just make mistakes.

Ms. COLVIN. Absolutely.

Mr. THOMPSON. Are you able to break that out, as well?

Ms. COLVIN. We are. One piece of overpayments is fraud, and that is a very, very small percent, as identified by the Inspector General. But it means that the person has taken action or given misleading information designed to get a benefit to which they are not entitled, and that is fraud.

But we have a large amount of overpayments due to the complexity of the program, individuals not reporting their wages timely. Or, in some instances, we cannot get it processed fast enough, so that the benefit goes out and then we have to try to get it back.

But even with the shortage of staff—and I need to emphasize this—our accuracy rate increased this year. So we didn't just say, oh, my goodness, we don't have resources and we let it go. SSI is one of our most complex programs, and we still had an increase of 1 percent accuracy right in that program.

So we live this every day, and we are always looking for ways to improve it. And we aggressively pursue going after the money, whether it has been paid out by error or if it were deliberate.

Mr. THOMPSON. And your recovery rate is what?

Ms. COLVIN. Less than I would like, 58 percent. But we have a very aggressive——

Mr. THOMPSON. What percent?

Ms. COLVIN. Fifty-eight percent.

We have a very aggressive debt-collection process. Of course, we can do the offset if the person is receiving a benefit. We know we can do the Treasury offset if they are getting a Federal check for any reason, taxes or anything else. But if we have to do our external collections, then that is the regular process of collecting a debt. That is more problematic, but we also do that.

And one of the things we have done recently is taken the time limit off when a debt can no longer be collected, so that if someone is not in pay status but they come in pay status later, we can go back and get that money.

Mr. THOMPSON. And I would like to see if you could submit it to the committee or maybe part of the working group, however it is going to be set up, a list of things that you think that we could do that would help you both defray the errors, error rate, as well as prevent fraud, but also go after these guys or make it so the IG can better go after them. Anything at all that you could give us that would help us do that I think would be important.

Ms. COLVIN. In the next panel, you are going to hear from Bill Zielinski, who is our CIO and our deputy for systems. We have done, I think, some incredibly good work in that area, and he will talk about that more.

The chairman has been very supportive of IT. And, of course, we have been able to continue to do the kind of production that we have because of our investment in IT. And we need to be able to continue to do that.

Chairman JOHNSON. Thank you.

Mr. Crowley.

Mr. CROWLEY. Thank you, Mr. Chairman.

Thank you again for holding this hearing, and Commissioner, thank you.

The alleged wrongdoing we have all seen in the media, including people claiming fake ailments due to September 11th to Social Security disability payments, it sickens me to say the least. I want to thank the district attorney of New York county, Mr. Vance, for his work in terms of prosecuting those cases.

I myself am from New York City, I am the son and grandson of New York City police officers. My father was a detective. I have cousins both in the fire department and the police department. I had a first cousin who was killed on 9/11.

Ms. COLVIN. I'm sorry.

Mr. CROWLEY. His brother Michael continues to work as a fireman, lost 12 men in his house that day.

Ms. COLVIN. I'm sorry.

Mr. CROWLEY. He happened to be off duty that day, otherwise he would have perished as well. So I need to begin by highlighting that there are far too many brave men and women who put their lives on the line every day, and they do that ofttimes injured and they do it ofttimes not feeling well.

Ms. COLVIN. Absolutely.

Mr. CROWLEY. We were all damaged by 9/11. Anyone who lived in New York and beyond, our country was damaged psychologically. We have all, I am sure have some effect from that.

Ms. COLVIN. Absolutely.

Mr. CROWLEY. But what these individuals have done—and three-fourths of the people who are being prosecuted so far are former police officers and firefighters. They are traitors to their brothers and sisters in those departments. I would even suggest that they are borderline traitors to our country because they erode the confidence that people have in their government, when they believe they can get away with this, and it is not only perceived but they actually in many cases are getting away with this.

And so what they do is also they not only dishonor their uniform or their former uniform, they are really, really eating away at the fabric of responsibility of our government to provide for those who need help.

These men and women are legitimate recipients, many of them are——

Ms. COLVIN. Absolutely.

Mr. CROWLEY [continuing]. Who have suffered of the Federal Social Security Disability Insurance program, and we should not and cannot let the few ruin a necessary program for the many, or a few ruin the good name of thousands of heroes who work for the NYPD and the FDNY.

Commissioner Colvin, I would like to ask you a few questions, and just yes or no answers if I could from you please.

Wasn't it a Social Security administrative frontline caseworker who detected the fraud there? Fraud that was not detected by the City of New York when it awarded disability pay and benefits to officers who were alleged to have committed this fraud against the Social Security system?

Ms. COLVIN. Yes, it was.

Mr. CROWLEY. When the Social Security Administration invested in your special fraud busting teams known as CDIs, does that save taxpayers' money and reduce fraud in the Social Security program?

Ms. COLVIN. Yes, it does.

Mr. CROWLEY. Thank you, Commissioner Colvin.

Social Security is a bedrock principle of America and we must do everything we can to protect and strengthen the program for future generations. This includes cracking down on criminals and fraudsters. It was the Social Security Administration staff that detected the fraud in the disability program. The frontline workers there are our best defense against criminals.

But I am concerned about some of the jargon that would malign their work in the name of maligning government services. I think there are far too many antigovernment groups out there that would use this to further malign the Social Security Administration.

Congress must stop the attacks on Social Security, including the over $1.2 billion in cuts that many of my Republican colleagues put forward and have taken away from Social Security programs, with more planned if that is not stopped.

Democrats have a plan to protect the integrity of the Social Security system. Protect taxpayers' money, and send these ripping off Social Security individuals to prison, and that is why I am pleased to join my colleague, Mr. Becerra, and I am very happy Mr. Kelly has indicated his desire to work in conjunction in a bipartisan way with the Chairman as well. I would like to see that bill come to the floor. A bill that will go after those individuals and put them behind bars for a very, very, very long time and make this a nonprofitable scheme.

I am concerned that many on the far, far right in terms of the Tea Party aspect are again using this as an opportunity to attack our Government itself. But I do think that support of a bipartisan bill to put these people behind bars will go a long way to curtailing that.

Finally, recognizing that we can't stop every criminal act at the front end, this bill will send those caught ripping off the Social Security system to prison. The bill makes clear that conspiracy to defraud Social Security is a felony and authorizes a higher penalty of up to 10 years in prison for conspiracy for ring leaders and corrupted sources who recruit others to commit fraud, coach witnesses, and multiply the losses of Social Security and its trust fund.

I am hopeful, Mr. Chairman, that the Social Security Fraud and Error Prevention Act of 2014, as you can work out the details of that bill, can be one of those bills that can come to the floor in a bipartisan way in a bipartisan spirit to bolster the people at Social Security, a valued program, to help those who are suffering continue to get the services they need, and to capture those who would defraud the system for their own personal gain—it doesn't get much worse than that in my opinion—and put them to jail for many, many years to come.

With that, I yield back the balance of my time.

Chairman JOHNSON. Thank you for your comments.

Commissioner, our witnesses on the next panel have some ideas on how to prevent fraud. If you are able to stay, we invite you to stay and listen.

Ms. COLVIN. I will stay. Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you for being here.

We now proceed to the second panel. Please move forward.

Thank you all for sticking around, I appreciate it. Maybe you learned something. We did.

Seated at the table we have J. Matthew Royal, Vice President and Chief Auditor, Unum Group, Chattanooga, Tennessee; William Zielinski, Deputy Commissioner of Systems and Chief Information Officer, Social Security Administration; and Allen Shark, Fellow, National Academy of Public Administration. I welcome you all to the hearing this morning. Thank you so much for being here.

Mr. Royal, welcome. Please go ahead.

STATEMENT OF J. MATTHEW ROYAL, VICE PRESIDENT AND CHIEF AUDITOR, UNUM GROUP, CHATTANOOGA, TENNESSEE

Mr. ROYAL. Thank you, Mr. Chairman, and Members of the Subcommittee.

We are pleased to be here today and we appreciate the opportunity to share some of our aspects of our fraud risk management program at Unum.

Unum is a market leader in disability, life, critical illness, and accident insurance with more than 160 years of experience. We work with more than 175,000 businesses worldwide, from Fortune 500 to small businesses covering more than 22 million people. In 2013, we paid more than 6 billion in benefits. We are a U.S.-based company with approximately 10,000 employees with major operations in California, Maine, Massachusetts, South Carolina, Tennessee, and in the UK.

Insurance fraud is the second most costly white collar crime in America, exceeded only by tax evasion. Nearly 80 billion in fraudulent claims are processed each year in the United States. This may be a conservative figure based on known acts of insurance fraud and not the unknown, undetected, or unreported acts.

To effectively combat insurance fraud insurers must be capable of quickly identifying potential fraud, have the proper infrastructure in place to adequately manage and respond to fraud risk, and frequently monitor and test antifraud control effectiveness.

At Unum, the significant investment we have made in our antifraud program has helped position our company as an industry leader in detecting and preventing fraudulent disability claims.

While the total amount of fraud is undeterminable, we estimate less than 1 percent of the approximately 400,000 disability claims received by Unum each year are fraudulent.

From Unum's perspective, strong fraud risk management is critical to successfully managing our business and offering affordable financial protection to our customers. Unum's fraud risk management program is managed by the SIU, the Special Investigative Unit, led by Jeff Connor, Vice President, who joins me here today.

The SIU conducts investigations into potentially fraudulent claims and promotes corporate antifraud strategies and initiatives.

The following summarizes key aspects of Unum's fraud detection and prevention program.

The foundation consists of our policies and procedures. Unum maintains policies which help ensure compliance with applicable insurance fraud laws and regulations. The SIU makes a fraud detection and response guide available to all employees to help them recognize and report suspicious claims. The company also maintains a toll-free fraud reporting hotline and encourages anyone with information about insurance fraud to report the information, allowing them to do so anonymously and confidentially.

Strong training and education reinforces our policies and procedures. Unum's comprehensive antifraud training program ensures employees possess the requisite skills to identify and report insurance fraud. Unum also designates certain employees based on job function as integral antifraud personnel. These employees, including claims processors, underwriters, and certain corporate personnel, receive mandatory antifraud awareness training at regular intervals.

Now, complementing our front line is the use of advanced technology. Unum uses predictive analytics to continuously monitor disability claims for potential fraud. We developed our model using data from our own historical fraudulent claims. The model analyzes our claims inventory daily, scoring each claim based on how closely it resembles customized fraud attributes. Higher scores indicate greater fraud potential and claims exceeding a baseline score are reviewed by a trained analysts. About 1 out of five high scoring claims that are reviewed result in additional investigation and that accounted for 30 percent of the total amount of potential fraudulent loss activity detected and reported in 2013.

Unum works closely with law enforcement to ensure that those who commit insurance fraud are held accountable. The SIU reports all suspected fraud to law enforcement and/or the appropriately designated regulatory agency responsible for the investigation and prosecution of insurance fraud. We frequently provide disability fraud training to key law enforcement agencies and actively assist in investigations and prosecutions.

Our antifraud initiatives are focused on maintaining a strong public-private partnership to combat fraud and share information about emerging fraud trends and risks.

In conclusion, while the overwhelming majority of claims Unum receives are legitimate, there are bad actors that seek to game the system and file over facilitate fraudulent claims. Unum has a comprehensive approach to fraud prevention which includes establishing effective policies, continuous employee training, and the use of advanced technology and modern information sources. There is a strong business case for our approach to fraud prevention and it plays a role in keeping group disability insurance policies affordable.

Unum stands ready to work with this committee and the Social Security Administration to share our best practices and our experience. Thank you.

[The prepared statement of Mr. Royal follows:]

WRITTEN STATEMENT OF J. MATTHEW ROYAL
VICE PRESIDENT AND CHIEF AUDITOR
UNUM GROUP, CHATTANOOGA, TN
BEFORE THE U.S. HOUSE OF REPRESENATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY

FEBRUARY 26, 2014

Mr. Chairman and Members of the Subcommittee:

Unum is a market leader in disability, life, critical illness and accident insurance with more than 160 years of experience. We work with more than 175,000 businesses worldwide – from Fortune 500 to small businesses – covering more than 22 million people. In 2013, we paid more than $6 billion in benefits.

We are a US based company with approximately 10,000 employees and major operations in Tennessee, Maine, Massachusetts, South Carolina and the UK.

Insurance Fraud

Insurance fraud is the second most costly white collar crime in America exceeded only by tax evasion. Nearly $80 billion in fraudulent insurance claims are processed each year in the United States.[1] This may be a conservative figure based on known acts of insurance fraud. The magnitude of the problem is likely greater because fraud can go undetected and unreported.

To effectively combat insurance fraud, insurers must be capable of quickly identifying potential fraud, have the proper infrastructure in place to adequately manage and respond to fraud risks, and frequently monitor and test anti-fraud control effectiveness. Though disability insurance fraud is less prevalent than in other lines of insurance, at Unum, the significant investment we have made in our anti-fraud program has helped position our company as an industry leader in effectively detecting and preventing fraudulent disability claims. While the amount of total fraud is undeterminable, we estimate less than one percent of the approximately 400,000 disability claims received by Unum each year are fraudulent.

While the vast majority of claims Unum processes are legitimate, even a small percentage of fraudulent claims can increase the cost of doing business and translate into higher premiums or reduced product offerings. From Unum's perspective, strong fraud risk management is critical to successfully managing our business and offering affordable financial protection to our customers. For example, individuals seeking income protection insurance from Unum can typically cover 60 percent of his or her salary for as little as $25-$30 per month.

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[1] Based on a 2006 study by the Coalition Against Insurance Fraud, a national alliance of insurance companies, consumer groups, public interest organizations, and government agencies.

Unum's Approach to Fraud Detection and Prevention
Unum's fraud risk management program is managed by the Special Investigative Unit (SIU) reporting to the Chief Auditor. The SIU conducts internal investigations into potentially fraudulent claims for benefits and promotes corporate anti-fraud strategies and initiatives designed to assist employees in detecting and preventing insurance fraud. The following summarizes key aspects of Unum's fraud detection and prevention program.

Policies and Procedures
Unum maintains anti-fraud policies which include corporate-wide fraud prevention strategies and help ensure compliance with applicable insurance fraud laws and regulations. The SIU makes a fraud detection and response guide available to all employees to help them recognize and report suspicious and fraudulent claims.

The company also maintains a toll-free fraud reporting hotline, and encourages anyone with information about insurance fraud to report the information anonymously and confidentially. Fraud reporting hotlines are one of the most effective tools organizations can implement to detect and prevent fraud. From 2011-2013, Unum received over 350 fraud hotline reports, many of which generated credible leads in investigations into potentially fraudulent disability claims.

Training and Education
Unum's comprehensive anti-fraud training program is designed to reinforce our company's fraud prevention strategies and ensure that employees possess the requisite skills to identify and report insurance fraud. Anti-fraud training programs are updated regularly to include new regulations, corporate anti-fraud policies, procedures, and controls, fraud schemes and methods, emerging fraud trends and indicators, fraud detection methods, and fraud reporting procedures.

Unum also designates certain employees, based on their job function within the company, as integral anti-fraud personnel. These employees, who include, among others, claims processors, underwriters, and certain corporate personnel, receive mandatory anti-fraud awareness training at regular intervals.

Predictive Analytics
Unum uses predictive analytics to continuously monitor disability claims for potential fraud. We developed our own model using data from our own historical fraudulent claims. The model analyzes our claims inventory contemporaneously scoring each claim based on how closely it resembles customized fraud attributes. Higher scores indicate greater fraud potential. Claims reaching or exceeding a baseline score are reviewed by trained fraud analysts in the SIU. Model updates incorporate data from newly reported or updated claims into the models' algorithms to improve scoring accuracy.

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. Approximately one out of five claims reviewed by our

fraud analysts result in additional investigation for validity or fraudulent activity and accounted for 30% of the total amount of potential fraudulent loss activity detected and reported by Unum in 2013.

Investigations and Cooperation with Government Agencies

Most states require licensed insurance companies to report suspected fraudulent claims. In addition, an increasing number of states require insurance companies to maintain an SIU to investigate and report suspected fraud to designated state fraud bureaus and law enforcement agencies.

Unum's SIU investigates all types of suspected fraud, including suspicious and fraudulent disability claims, suspected fraud involving employees, insurance agents and brokers, suspected fraud resulting from misrepresentations in the application, renewal or rating of insurance policies. Instances of possible fraud are referred to the SIU from the predictive analytics unit, employees across the organization, other SIU departments, and government agencies.

Unum works closely with law enforcement to ensure those who commit insurance fraud are held accountable. The SIU reports all suspected fraud to law enforcement and/or the appropriately designated regulatory agency responsible for the investigation and prosecution of insurance fraud. We frequently provide disability fraud training to key law enforcement agencies and actively assist in investigations and prosecutions of insurance fraud. Our anti-fraud initiatives are strongly focused on maintaining a strong private-public partnership to combat fraud and share information about emerging fraud trends and risks.

In conclusion, while the overwhelming majority of the claims Unum receives are legitimate, there are bad actors who seek to game the system and file or facilitate fraudulent claims. Unum has a comprehensive approach to fraud prevention which includes establishing effective policies, continuous employee training, and the use of advanced technology and modern information sources. There is a strong business case for our approach to fraud prevention, and it plays a role in keeping group disability insurance policies very affordable. Unum stands ready to work with this Committee and the Social Security Administration to share our best practices and experience.

Chairman JOHNSON. Thank you, sir, appreciate that.

Mr. Zielinski, welcome. Please go ahead.

STATEMENT OF WILLIAM B. ZIELINSKI, DEPUTY COMMISSIONER FOR SYSTEMS AND CHIEF INFORMATION OFFICER, SOCIAL SECURITY ADMINISTRATION

Mr. ZIELINSKI. Chairman Johnson, Ranking Member Becerra, Members of the Subcommittee, I want to thank you for this opportunity to discuss Social Security's use of information technology to administer our programs and to detect and prevent improper payments and support antifraud initiatives. My name is Bill Zielinski and I am Social Security's Chief Information Officer and Deputy Commissioner for Systems.

I am responsible for all aspects of our information technology program from planning new IT projects to overseeing their implementation and managing their day-to-day operation and upkeep.

Every year, we pay $850 billion in benefits to 63 million people. The vast majority of these payments are accurate and timely. We owe this record of success to a highly skilled and dedicated workforce that is supported by IT. IT is behind everything that we do. Our employees work with electronic claims files using applications

that enhance the productivity, automate many routine tasks, and enforce the program laws and policies. Without the productivity increases gained from our strategic IT investments, we would not have been able to keep pace considering our growing workloads and limited resources.

In addition to supporting our programs through IT, we have built on-line services for the public that are easy to use, secure, and highly rated. For example, our customers can use on-line services to apply for benefits, change their address, request a benefits statements. These services allow our customers to choose their preferred method of doing business with us and allows us to keep up pace with our ever growing workloads.

I do want to stress that productivity increases do not come at the expense of quality. In fact, our applications are designed to ensure quality work products and payment accuracy. For example, in my written testimony I highlight the eCAT program which helps State disability examiners apply policies correctly throughout the entire decision-making process.

Our applications also enable our employees to gather third party data that may reveal when a beneficiary has been overpaid. Without IT supporting it, this type of investigation is labor intensive and impractical. For example, regarding the means test SSI program in fiscal year 2012 we fully implemented the Access to Financial Institutions program which allows our employees to obtain electronic bank information directly from the banks and we are currently testing a similar process for obtaining information on ownership of non-home real property.

We do not rely solely on our employees to discover on or beneficiaries to report all the changes that may affect their benefits. We have the largest data exchange program in the Federal Government. Our exchanges provide us with a wealth of information that we use to pay benefits accurately and efficiently administer our programs. We get information that varies across the board from income and asset data to incarceration data and medical information. We take seriously our responsibility to be effective stewards of our programs.

Each year we complete periodic medical reevaluations to determine whether beneficiaries are still disabled and SSI redeterminations to review the nonmedical factors of eligibility. These reviews save billions of program dollars with only a small investment of administrative funds, yet we do not receive the resources to complete all of them. Instead, we have long used predictive models to prioritize the cases with the best chance of finding improper payments. These models have allowed us to achieve an impressive return on the taxpayers' investment. For example, we estimate that our SSI redetermination model helped us recover or prevent $3.4 billion in SSI overpayments in fiscal year 2013 alone.

As we move forward we are developing additional models such as the representative payee misuse model that will allow us to target fraud specifically. The next area we are looking at is data analytics. We expect these diagnostic tools to increase our ability to find questionable patterns of activity in disability claims and prevent fraudulent claims from being processed. We will spend the rest of this fiscal year developing and testing some of these tools.

We have a long history of delivering results and administering our vital programs in an efficient and cost effective manner. We have been successful in large part due to our highly trained and dedicated employees and because we have made significant and strategic investments in IT that have allowed us to keep up with the ever-increasing workloads. However, these investments in IT and staffing come with a cost. Reduced budgets in recent years have meant less and less available for IT development and training.

And while we appreciate the resources that have been provided for the current fiscal year, we hope you will continue to make that investment in our programs. And as Commissioner Colvin expressed this morning, only with that sustained funding can we build upon our efforts to stop those who would steal from the American people.

Thank you for the opportunity to update you on our programs, and I will be willing and happy to answer any questions you may have.

[The prepared statement of Mr. Zielinski follows:]

COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

UNITED STATES HOUSE OF REPRESENTATIVES

FEBRUARY 26, 2014

STATEMENT FOR THE RECORD

BILL ZIELINSKI
DEPUTY COMMISSIONER FOR SYSTEMS
AND
CHIEF INFORMATION OFFICER
SOCIAL SECURITY ADMINISTRATION

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

Thank you for the opportunity to discuss the ways in which the Social Security Administration (SSA) uses information technology to administer its programs, detect and prevent improper payments, and support anti-fraud initiatives. I am Bill Zielinski, and I am the Chief Information Officer and Deputy Commissioner for Systems at SSA. I am responsible for delivering cost-effective information technology (IT) services, and for protecting the information assets of Social Security.

Overview of Our IT operations and Online Services

SSA has many IT strengths. For example, we have a superb technical workforce and are experts at technical project management. We have designed and maintained a highly automated process for handling benefits claims and other work, including program integrity reviews. We have consolidated most of our agency's IT so that we benefit from economies of scale. We excel at designing applications that focus on users. We also have developed a rigorous, annual process to assess and prioritize future IT investments, as we always have more IT needs than available or expected resources. All agency components actively engage in this process. As the CIO for the agency, I am committed to ensuring that our IT infrastructure and services are secure, scalable, and available.

We have a proud history of using IT to support our administration of the Social Security and Supplemental Security Income (SSI) programs, and to provide substantial support to the related Medicare, Medicaid, and other government programs. These programs are immense in scope: in FY 2013, we paid over $855 billion to more than 63 million Social Security beneficiaries and SSI recipients. To support our programs, our mainframe contains approximately 14 petabytes of data, and our open, client-server IT infrastructure maintains 13 petabytes. In FY 2013, this IT infrastructure supported the processing of an average *daily* volume of nearly 150 million individual transactions. For the year, our IT operations supported approximately: 1.6 billion automated Social Security number verifications; 251 million earnings items; 5 million retirement, survivor, and Medicare applications; 3 million initial disability claims; 2.6 million nonmedical redeterminations; 1.5 million continuing disability reviews, including approximately 429,000 full medical continuing disability reviews; and 17 million new and replacement Social Security card applications.

Customer Satisfaction

In addition to maintaining robust IT operations capable of supporting the large demands of our programs, we are committed to building online services for the public that are simple and easy to use. We have been successful in this regard. According to the most recently released American Customer Satisfaction Index (ASCI) E-Government Satisfaction Index, we have the three highest rated—and four of the top five—e-government websites in the Federal government. Moreover, these four online services (Extra Help with Medicare Prescription Drug Plan Costs, iClaim, Retirement Estimator, and our *my Social Security* portal) outperformed or tied Amazon, the highest scoring e-retail website.

Supporting Increased Productivity

Our strategic investments in online services and our core IT operations have increased our productivity and efficiency—allowing us to keep up with ever-increasing workloads. For example, we currently have about the same number of employees that we had in 2007, even though our workloads have increased dramatically. In FY 2014, we estimate that the number of retirement and survivor applications will be about 30 percent higher than in FY 2007. Over the same period, the volume of initial disability claims we received increased by nearly 20 percent.

Our easy-to-use online application for applying for disability, retirement, and Medicare—iClaim—is a huge success. Applicants file for benefits online at their own pace and on their own schedule. In FY 2013, over 1.27 million Disability Insurance (DI) claimants, or about 46 percent of DI claimants, filed online and over 1.25 million retirement claimants, or about 49 percent of retirement claimants, filed online. To compare, in FY 2008 (when we first introduced iClaim), only about 11 percent of DI claimants, and just over 15 percent of retirement claimants, applied online.

Similarly, *my Social Security*, is a personalized online portal that individuals can use beginning at age 18 and continuing throughout the time they receive Social Security benefits. Through this portal, individuals who register can view their Social Security Statement, view detailed information on benefits received (for up to 24 months), get a benefit verification letter, start or change direct deposit information, and change their address – all online. We will continue to expand the services provided in the *my Social Security* portal to enhance customer service. Currently, over 10 million people have established *my Social Security* accounts and used their accounts to access:

- Online Social Security Statement – 29.2 million times;
- MyDirect Deposit - 0.6 million times;
- MyChange of Address – 1 million times;
- Internet Benefit Verification Letter – 4.5 million times; and
- MyCheck Your Benefits – 20.6 million times.

Due in large part to these successful online services and our other IT initiatives, we are able to keep our administrative costs low – about 1.4 percent of the benefit payments we pay each year.

Quality Has Improved

Our efforts to improve processing times and increase productivity have not come at the expense of our quality. Quality is integral to all of our processes, including our disability claims process. For instance, we have developed and implemented the electronic Claims Analysis Tool (eCAT), a web-based application, to help State disability determination services (DDS) examiners apply policies correctly throughout the disability decision-making process. eCAT uses "intelligent pathing," which prompts users to consider the appropriate questions based on the unique characteristics of each case. This documentation is particularly useful for future case review because it enables an independent reviewer to understand the examiner's actions and conclusions

throughout the development and adjudication of the claim. We fully implemented eCAT last year and made it mandatory for use in every DDS.

We are also piloting our Electronic Bench Book (eBB) application. eBB aids in documenting, analyzing, and adjudicating disability cases at the hearings level in accordance with the Social Security Act and our regulations. We expect that eBB will improve the accuracy and consistency of our disability decision process.

Another example of where we use IT to support our programs is our development of the Disability Case Processing System (DCPS). DCPS will replace the 54 different systems that support the DDSs with one national system based on state-of-the-art technology. This system will incorporate eCAT and other tools designed to improve quality and productivity. Additionally, DCPS will allow us to systematically implement policy changes in a faster way, and it will promote more consistency among the DDSs.

Applications that Support Payment Accuracy

We also develop applications that allow our employees to more efficiently gather information and identify improper payments. For example, in FY 2012, we implemented the Access to Financial Institutions (AFI) program nationally. This program allows our employees to automatically and electronically gather financial account information directly from financial institutions. Historically, having financial accounts in excess of the allowable resource limits is the leading cause of improper payments in the SSI program. Because AFI is more efficient than a paper-based process, we are able to verify financial account information—and thereby reduce improper payments—on more SSI claims and post-entitlement actions.

We also develop applications that allow beneficiaries to directly update their claim information—which results in more accurate benefit payments—without the need to contact a field office. For example, in FY 2008, we implemented the SSI Telephone Wage Reporting System (SSITWR), an automated toll-free number that makes it easy for SSI recipients to update the wage information on their records. Our studies indicate that wages submitted through SSITWR are highly accurate and we confirm their accuracy using our data exchanges. Based on the success of SSITWR we recently created a mobile wage reporting application.

Data Exchange and Electronic Verification Services

We have thousands of data exchange agreements with Federal, State, Local, and Foreign governmental entities. Data received from external exchange partners allows SSA to pay benefits accurately, efficiently and timely. Examples of data received are income, assets, incarceration status, medical evidence, and benefit payments received from other government programs.

By efficiently sharing data with other agencies and private organizations through our electronic verification services (where allowed by law), we help them to efficiently administer their programs and reduce the number of field office visits and 800 number calls to verify benefit

information. This improves customer service and allows us to redirect our resources to our other critical program work.

SSA's Use of Predictive Models to Support Program Integrity

We take seriously our responsibility to maintain the public's trust through effective stewardship of program dollars and administrative resources. We use our IT operations and technical expertise in support of this critical strategic objective. Specifically, we use statistically valid predictive models that enhance key agency program integrity functions while ensuring that agency resources are used in the most cost effective and efficient manner possible. I will briefly summarize the predictive models we have used successfully to curb improper payments.

CDR Predictive Model

Beginning in FY 1993, SSA began developing a series of predictive models to ascertain the likelihood that a full medical continuing disability review (CDR) would result in a finding that a disability beneficiary has medically improved and is no longer eligible for benefits. Our predictive models for CDRs use a multitude of variables to provide an aggregate score that predicts the likelihood of medical improvement and cessation. Our use of the predictive models has allowed us to be extremely cost effective in prioritizing full medical CDRs with our limited resources. In FY 2013, we conducted approximately 429,000 full medical CDRs. We estimate that the money spent on CDRs saves, on average, $9 for every dollar invested, including savings accruing to Medicare and Medicaid.

SSI Redetermination Model

SSI redeterminations are reviews of all of the nonmedical factors of eligibility to determine whether a recipient is still eligible for SSI and still receiving the correct payment amount. All SSI recipients are subject to periodic redeterminations. Every year SSA schedules redeterminations for the cases most likely to have payment error. To do this, we use a statistically valid scoring model—the SSI Redetermination Model. This model, which we first implemented in the late 1970s, predicts the dollar amount of likely overpayments for every SSI recipient and, having such information in hand, ensures that we select SSI cases to be reviewed efficiently and in a highly cost effective way.

Like our other predictive models, we continually review and improve our SSI Redetermination Model; in FY 2011, we expanded the model to include SSI living arrangement information, which enhanced the effectiveness of the model in selecting the most productive SSI redeterminations. In FY 2013, we completed over 2.6 million SSI redeterminations; by targeting the highest priority cases, the SSI Redetermination Model helped us to recover or prevent $3.4 billion in SSI overpayments.

Pre-Effectuation Review (PER) Model

The law requires us to review at least fifty percent of all State Disability Determination Service (DDS) initial and reconsideration disability allowances, and a sufficient number of CDR

continuances to ensure a high level of accuracy. In FY 2011 (the most recent year for which information is available), we reviewed over 500,000 allowances and 8,400 continuances. To ensure we target for review those cases with the highest risk of decisional error, we have developed and continue to improve our PER Model, which predicts the probability of error and dollar amount cost of erroneous DDS allowances. In FY 2011 alone, completed PER reviews resulted in preventing the release of $752 million in improper DI, SSI, Medicare and Medicaid program payments.

Continuing Disability Review Enforcement Operation Predictive Model

The Continuing Disability Review Enforcement Operation (CDREO) identifies DI beneficiaries who appear to have substantial earnings after disability onset, through an automated matching of our current DI beneficiaries with the Internal Revenue Service (IRS) reported earnings posted to our Master Earnings File. We recently developed a predictive model to identify which alerts are most cost effective. We implemented the model nationally in June 2013 after piloting the model in 2011 and 2012 by analyzing our CDREO alerts and prioritizing which alerts should be reviewed first.

Medicare Part D Subsidy Redetermination Model

SSA has primary responsibility for redetermining whether a beneficiary is eligible for a Medicare Part D Subsidy. To help us prioritize which cases to review, we have developed the Medicare Part D Subsidy Redetermination Model, which predicts those Medicare Part D cases most likely to have an incorrect subsidy amount. In FY 2013, the model identified the most productive 25 percent of Medicare Part D subsidy cases for redetermination; we estimate that these cases contain about 60 percent of all incorrect subsidy amounts.

This model helped us prioritize the roughly one million Medicare Part D subsidy cases for redetermination, which resulted in the correction of about $800 million in Medicare subsidy payments in FY 2012 alone.

Supplemental Security Record (SSR)/OCSE Wage Profiling Model

To help us prevent and detect SSI improper payments, we use the SSR/OCSE Wage Profiling model—a predictive model that uses data from a quarterly Office of Child Support Enforcement (OCSE) wage data match to determine which SSI recipients have received wages that are likely to result in significant SSI overpayments. From FY 2000 through FY 2013, the cases selected under this model have resulted in the recovery or prevention of $1 billion in SSI overpayments.

SSR/IRS 1099 Income Profiling Model

Similar to the SSR/OCSE model, the SSR/IRS 1099 Income Profiling Model uses data from SSA's quarterly IRS 1099 data match to determine which SSI recipients have received unearned income that is most likely to result in significant SSI overpayments. From FY 2000-FY 2013, the cases selected under this model have resulted in the recovery or prevention of $740 million in SSI overpayments.

Representative Payee Misuse Models

The Representative Payee Misuse Models allow us to more effectively target reviews of representative payees to detect, deter, and prevent misuse of beneficiary funds by representative payees. Based on recommendations from a National Academy of Sciences study commissioned by Congress, we developed statistical models to identify cases that had the greatest likelihood of detecting beneficiary funds misuse. These models target both individual representative payees and representative payee organizations. The models are able to detect cohorts of cases with a misuse rate at about twenty times the overall rate occurring in the universe of all beneficiaries served by representative payees.

SSA's Increasing Use of Big Data and Data Analytics

In addition to our successful predictive models, we are increasingly using data analytics to make our processes more efficient and more productive. Recently, i360gov.com recognized the efforts of our Office of Disability Adjudication and Review (ODAR) in using data analytics to operate "one of the largest administrative judicial systems in the world."[1] ODAR has developed extensive and rigorous data analytics capabilities that allow it to identify patterns and areas for further examination of policy compliance and consistency. As i360gov.com noted, ODAR uses an "analytic feedback process" to lead to better results in the appeals process:

> ODAR now captures key claims data, visualizes the results, analyzes those results and delivers feedback to managers and appellate judges, so the organization can change the policy, system, or advise personnel to take corrective steps based on what the data uncovers. The ability to analyze large and complex data sets using case analysis tools, data visualization, clustering analysis and multiple variable models allows ODAR to efficiently tackle the complex challenges faced daily in adjudicating disability appeals. Overall, ODAR has gained more consistency and accuracy in the processing of all appeals, along with the ability to process more claims, more quickly as well.

Building upon our successes in using predictive models and data analytics, we are undertaking a special initiative to expand our use of data analytics to enhance our ability to detect and prevent disability fraud. Specifically, we will apply analytical tools that can determine common characteristics and patterns of fraud based on data from past allegations and known cases of fraud. We will apply these tools when reviewing initial applications or existing data on beneficiaries for potential fraud or other suspicious behavior. With these tools, we expect to be able to identify suspicious patterns of activity in disability claims and prevent fraudulent applications from being processed. During this fiscal year, we plan to pilot these analytic tools and demonstrate their value.

We already have been proactive in using data analytics to detect and prevent possible fraud on our *my Social Security* portal. While the detected level of potentially fraudulent activity on *my Social Security* is low, as our Acting Commissioner has stated repeatedly, "we have no tolerance

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[1] *See* Leaning In, http://www.i360gov.com/whitepapers/leaning-in-government-s-push-to-leverage-big-data/. (Last visited February 19, 2014)

for fraud." In FY 2013, we created a new integrity review system and established a Fraud Analysis and Coordination Team (FACT) unit to analyze – using data analytics – suspicious behavior and potential fraud in our online services. The FACT unit takes necessary steps to mitigate any losses to SSA and to our customers.

Similarly, we are working with OIG on our data analytics projects to combat potential disability fraud. OIG's participation is valuable due to their knowledge of actual fraud cases that will inform our development of analytics processes. We continue to assess the potential extent to which data analytics will help in the fight against fraud. We will keep you apprised of our progress as we develop and pilot potential tools and applications.

Need for Adequate, Sustained Funding

We have a long history of delivering results in administering our vital programs in an efficient, cost-effective manner. We have been successful, in large part, due to our highly trained employees who are dedicated to serving our customers and being good stewards of the Social Security and SSI programs, and because we have made significant and strategic investments in IT that have allowed us to keep up with ever-increasing workloads. However, as the agency's CIO and Deputy Commissioner of Systems, I want to underscore the importance of receiving adequate, sustained resources to fund long-term strategic improvements to our IT infrastructure and the applications we use to administer our programs and to conduct program integrity and anti-fraud activities.

Adequate funding enables us to invest in tools and technology, which are vital for delivering quality service. Technology benefits our customers by providing more options to do business with us over the Internet or through self-service options. We must build upon the success of our online tools and *my Social Security*, which provides Internet users a secure way to do business with us. As we perfect these self-service options, we can add more business functions to them, which free our employees to focus on complex work and the customers who most need our help.

However, when our resources are significantly constrained, it may prove difficult for us to do anything more than maintain our current infrastructure or make marginal improvements. While the recent appropriations act helps, investments in IT require timely, adequate, multi-year funding. As I noted earlier, we have been recognized for our use of data analytics to administer one of the largest administrative judicial systems in the world. Our success in that regard was based in no small part on the infusion of resources from FY 2008 through FY 2010 when we received the full President's Budget request for those years and additional resources from the Recovery Act in FY 2009 and FY 2010.

Conclusion

Thank you for this opportunity to update you on how we use our IT operations to help administer our programs and for program integrity. We have a successful history of using IT to leverage our limited resources. Over the past few years, limited resources have challenged us to maintain our high-quality service to all of our customers. We believe we can do more. With adequate and sustained funding, we can hire and retain a highly skilled workforce, invest in the technology that will help us work smarter and faster, and deliver a quality return on investment to the American people.

Chairman JOHNSON. Thank you, sir.
Dr. Shark, you are welcome.

STATEMENT OF ALLEN SHARK, FELLOW, NATIONAL ACADEMY OF PUBLIC ADMINISTRATION

Mr. SHARK. Good morning, Chairman Johnson, Ranking Member Becerra and Members of the Subcommittee. I guess I am the outsider looking in, so I guess I have a different perspective.

I wanted to thank you for the invitation to testify today to discuss high impact, viable and feasible recommendations that can assist the Social Security Administration preventing and detecting conspiracy fraud in the disability insurance program. It is an honor to contribute to this important discussion.

My name is Alan Shark. I am a fellow and chair of the technology leadership standing panel of the National Academy of Public Administration. I also serve as the exec director of the Public Technology Institute and an associate professor of practice at Rutgers University School of Public Affairs and Administration.

I need to say that my comments today represent my own views from the outside looking in and also derive in part from the recommendations issued by an independent panel of our academy to the Recovery Accountability and Transportation Board following the results of a national dialogue on innovative tools to detect and prevent fraud, waste, and abuse.

Unchecked, we know that conspiracy fraud in the disability insurance program illustrates the importance of leveraging technology to strengthen SSA's capacity to intercept suspicious activity at its inception. Absent more sophisticated adaptable measures, the problems recently uncovered will only repeat themselves in some form or fashion and likely worsen. SSA must focus its efforts on implementing the newest analytic tools for fraud detection used by the private sector and develop an agency wide culture of fraud prevention that emphasizes the need for advanced technology, provides the leadership and training to support it. Towards this end I offer six recommendations.

The first in the process, is for SSA to develop an IT system that incorporates textual analysis tools and predictive analytics technology to maximize its ability to detect fraud. They can no longer rely on the integrity of the participants and the complex benefits application process. SSA needs to acquire technology-driven detection methods capable of flagging fraudulent activity more consistently, systematically and accurately. In other words, it needs to be further integrated into the system more so than it is today.

Today's technology allows for unstructured data stored by SSA regarding disability claims to find patterns indicative of fraudulent activity. These tools offer the potential to prevent and detect fraud by automating the scanning of lengthy government documents thus using structured data with unstructured data with the ability to flag suspected fraudulent activities.

Predictive analytics is another tool that including pattern recognition among data sources, and is used for techniques such as heat mapping, which presents a visual influx of commonalities such as sudden increases in claims with common diagnoses or claim representatives.

The second is SS needs to develop and maintain a culture of collaboration and information sharing, which provides another level of protection against fraud. Technology-driven detection methods will

enable SSA to better leverage data sources, including State and local government data, proprietary business data to improve data validation and predicting potential fraud.

Number 3, SSA should also explore potential partnerships with other government agencies that are coordinating efforts to combat fraud, waste, and abuse. They are highlighted in my prepared remarks.

Number 4, SSA must improve its current IT infrastructure to accommodate this new fraud detection technology. SSA Office of Disability Adjudication, ODAR, has already paved the way for these changes through its use of similar technology. As part of this effort, SSA should determine how databases throughout the Administration, regional offices, field offices, and state DDDS offices can be integrated.

Number 5, SSA must develop a culture of prevention and detection that extends to all employees. This effort should include fraud detection training for all SSA employees; educating employees about data analysis tools and other technologies, which is kind of a new part here; rewarding, which is something I haven't heard yet, rewarding vigilance among employees through recognition and performance appraisal system, so that they are not just doing their job, they are getting rewarded for doing these things that go beyond and finding these things; additional ethics training for supervisors and employees.

Consideration should also be given to creating a senior level executive position whose primary responsibility is overseeing and managing SSA's fraud detection and prevention efforts.

And finally number 6, early in the application process SSA should incorporate clear warnings, stronger warnings to claimants and their representatives about the measures being taken to detect fraud and the consequences of defrauding the disability insurance program.

Mr. Chairman, an operation of this magnitude will always be a target of fraud and abuse. We know that. Investing in new analytic tools, integrating and expanding its data sources, fostering a culture of fraud prevention among all employees, and increasing applicant awareness of SSA fraud prevention efforts and the consequences for defrauding the Federal Government will assist SSA in achieving its stated goals and strengthen its antifraud activities and securing the public's trust.

Mr. Chairman, this concludes my oral testimony and I would be pleased to answer any questions you might have.

[The prepared statement of Mr. Shark follows:]

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Written Testimony of Dr. Alan R. Shark

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and

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Before the Committee on Ways and Means

Subcommittee on Social Security

U. S. House of Representatives

February 26, 2014

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

Thank you for the invitation to testify today to discuss high-impact, valuable, and feasible recommendations that can assist the Social Security Administration (SSA) in preventing and detecting conspiracy fraud in the Social Security Disability Insurance program (SSDI). It is an honor to contribute to this important discussion.

I am a Fellow and Chair of the Technology Leadership Standing Panel at the National Academy of Public Administration (the Academy). Established in 1967 and chartered by Congress, the Academy is an independent, non-profit, and non-partisan organization dedicated to helping leaders address today's most critical and complex challenges. The Academy has a strong organizational assessment capacity; a thorough grasp of cutting-edge needs and solutions across the federal government; and unmatched independence, credibility, and expertise. Our organization consists of nearly 800 Fellows—including former cabinet officers, Members of Congress, governors, mayors, and state legislators, as well as distinguished scholars, business executives, and public administrators. The Academy has a proven record of improving the quality, performance, and accountability of government at all levels.

I am also the Executive Director and CEO of the Public Technology Institute and Associate Professor of Practice at Rutgers University School of Public Affairs & Administration.

As an Academy Fellow, I served as Panel Chair for the Academy's work with the Recovery Accountability and Transparency Board (RATB) on the "National Dialogue on Innovative Tools to Prevent and Detect Fraud, Waste and Abuse." Facing similar challenges to SSA, RATB sought to identify new tools and strategies by which it might prevent and detect fraud, waste, and abuse. The Academy is currently working with SSA on a congressional mandate that includes developing a high-level plan to assist the agency in addressing service delivery challenges in the coming ten to fifteen years. In working on the long-term strategic plan for SSA, the Academy has identified several imperatives that describe SSA's approach to rendering its services, including maintaining the public trust and enhancing program integrity. That said, it is

important to note that this current study does not address the issue of deterring disability insurance fraud.

My comments today represent my own views and also derive in part from the recommendations issued by an independent Panel of the Academy to the Recovery Board following the results of the national dialogue.

Summary

The SSA OIG identified an urgent need for SSA to adopt more effective methods to detect fraud earlier in the disability claims process, particularly with regard to "facilitator fraud," like that which occurred in Puerto Rico and New York. These cases highlighted the deleterious effects of unchecked conspiracy fraud and the importance of leveraging technology to strengthen SSA's capacity to intercept suspicious activity at its inception. This task is complicated by the disability program's complex eligibility rules, multiple layers of review, and multiple handoffs from one person to another at the state and federal level. In order to optimize its capacity for preventing payments on fraudulent disability claims, SSA must focus its efforts on implementing the newest analytic tools for fraud detection used by the private sector, while also developing a culture of fraud prevention and openness to new technology across SSA. SSA's Office of Disability Adjudication Review (ODAR) has already paved the way for these changes through its effort to more consistently and accurately process benefits appeals using case analysis tools and analytical methods. Furthermore, SSA should incorporate warnings at the beginning of the application process clearly stating SSA's advanced capacity for detecting fraud and the consequences of defrauding the federal government. By implementing agency-wide changes to its IT infrastructure and work culture, SSA can restore confidence in the disability program and ensure that taxpayer dollars are spent wisely and efficiently.

The recommendations presented today are intended to support the current anti-fraud efforts SSA is in the process of planning and implementing.

SSA must develop an IT system that incorporates textual analysis tools and predictive analytics technology to maximize its ability to detect disability insurance fraud.

SSA's "pay and chase" methods have yielded success in detecting improper disability payments, however, it is critical that SSA increase its capacity to prevent fraud rather than respond to it. To do this, SSA must move beyond its reliance on the integrity of the participants in the complex benefits application process. This includes SSA's own employees, State and Commonwealth Disability Determination Services (DDS) employees, claimants, and third party claimant representatives -- including attorneys, doctors, and interpreters, who are collectively relied upon to serve as primary sources of fraud detection. While State DDS and SSA employees are credited with bringing alleged fraudulent activities in Puerto Rico and New York to the attention of the OIG, SSA must also implement technology driven detection methods capable of flagging fraudulent activity more consistently, systematically and accurately. Early detection of suspicious activity is imperative to prevention.

The unstructured data stored by SSA regarding disability claims processing holds critical information that data analytical tools can utilize to find patterns indicative of fraudulent activity. Automated textual analysis and mining of unstructured data, also known as Natural Language Processing (NLP) or Statistical NLP tools, have the potential to prevent and detect fraud in addition to streamlining bureaucratic processes. Tools are available that automate the scanning of lengthy government documents, which are replete with this unstructured, semi-structured, as well as more standard structured data, into rows and columns. The tools can convert free-form text into relational tables and fuse this data with structured data. In order to maximize the benefit of these types of data mining tools, SSA must take steps to ensure digitization of disability benefit applications and associated records.

Predictive analytics technology is another tool that involves pattern recognition among data sources. For example, when State DDS offices collect medical records and other documentation used to review disability claims, they are developing a database of critical data points that can be mined to create visual data patterns, such as "heat mapping." For example, a particular office

may suddenly experience an increased volume in claimants with similar disabilities, whose medical records are being provided by the same physician, or who are being represented by the same attorney. Similar key identifying factors were present in the recent alleged organized fraud in New York with several beneficiaries claiming injuries related to the 9/11 attacks and using common facilitators throughout the process. Heat mapping would have presented a visual influx of these commonalities which may have led to a more expedient awareness of potential fraudulent activity.

The Department of Health and Human Services (HHS) has successfully implemented predictive analytics technology to deter Medicare and Medicaid fraud by running analytics on claims nationwide. Facing similar challenges in combatting fraud, waste, and abuse in the administration of benefits, HHS and the Centers for Medicare and Medicaid Services (CMS) launched a national effort in 2010 to prevent fraud. Since enactment of the Affordable Care Act, CMS has also implemented new anti-fraud tools provided by Congress in addition to shifting to an innovative approach that identifies fraud before payments are made instead of a "pay and chase" approach. CMS's Center for Program Integrity (CMP) uses state-of-the-art predictive analytics technology, the Fraud Prevention System (FPS), to identify and prevent fraud, waste and abuse in the Medicare fee-for-service (FFS) program. The FPS is able to run sophisticated analytics nationwide against all Medicare FFS claims prior to payment to identify aberrant and suspicious billing patterns, enabling CMS to work toward stopping payments as soon as problems are detected. The FPS reported that CMS stopped, prevented, or identified an estimated $115.4 million in payments in its first year.

Since June 30, 2011, CMS has been screening all Medicare FFS claims nationwide and prepayment with the predictive analytics technology of the new FPS. Through procedures under the Federal Acquisition Regulation, CMS partnered with industry-leading private-sector contractor teams to adapt existing telecommunications and banking industry anti-fraud technology to the unique requirements of combatting Medicare fraud. It is also worth noting that CMS implemented a governance process to provide oversight, management, and control in the selection of new models, model enhancements, and system changes to improve the FPS. This

process enables CMS to respond to vulnerabilities identified by the OIG, GAO and other stakeholders with adaptive fraud-detection models.

By combining data analysis tools and predictive analytics technology with its current fraud detection training of field officers and DDS employees, SSA could significantly increase its success in the early detection of potential and actual fraud.

SSA could better leverage data sources, including state and local governmental data and proprietary business data to improve data validation in predicting potential fraud and abuse.

Fostering a culture of collaboration and information sharing provides another level of protection against fraud. OIG and SSA jointly established the Cooperative Disability Investigation (CDI) Program to pool resources, including databases, from State DDS offices and State and local law enforcement agencies. Web-scraping tools are available to pull quality state and local data, enabling SSA and CDI to better leverage these resources. The New York conspiracy fraud case is a perfect illustration of the importance of leveraging state and local data. The NYPD licensing division maintains records on individuals holding gun permits and applicants must certify that they have no mental impairments. Many of the beneficiaries suspected of defrauding the disability insurance program were retired police officers claiming mental impairment. Acting on the knowledge that retired police officers often apply for gun permits to procure employment, the New York CDI unit was able to cross check gun permit applicants with the beneficiaries in question and discovered they had in fact applied for permits. Connecting these seemingly unrelated data elements provided the evidence needed to uncover an elaborate scheme to defraud SSA. Applying advanced technology to pooled data sources will enhance CDIs efforts to fulfill its primary mission of obtaining evidence that can resolve questions of fraud before benefits are ever paid. SSA's plan to develop a national common disability case processing system will be a significant boost to its fraud detection capabilities.

There is also promise in private industry volunteered data. For example, the banking industry agreed to provide the federal government with information on payroll deposits to help track

illegitimate unemployment insurance claims. According to those in the banking/financial community, two areas that typically provide huge opportunities for fraud detection are: (1) detailed transactional financial histories and (2) data sources that identify individuals who have fallen off the grid, who may have relocated, died or gone underground to avoid payment of debts. As a cautionary note, government use of proprietary databases will likely require the establishment of a "Chinese data wall" to ensure that the government is not inappropriately in possession of proprietary data and that use of such data is consistent with federal privacy laws.

SSA should also explore potential partnerships with other government agencies that are coordinating efforts to combat fraud, waste, and abuse. The Department of Health and Human Services and the Department of Justice joined forces to develop the Health Care Fraud Prevention and Enforcement Action Team (HEAT) with a focus on cracking down on the people and organizations who abuse the Medicare and Medicaid system. HEAT's mission includes gathering resources across the government to help prevent waste, fraud, and abuse in the Medicare and Medicaid programs. The HEAT network could be a possible resource that SSA can leverage in expanding its data sources.

SSA must prioritize current efforts to improve its IT infrastructure to accommodate new fraud detection technologies and strengthen information security measures.

GAO recently determined that SSA had made strides in modernizing its IT systems to address growing workload demands, but also faced challenges associated with these modernization efforts and in correcting internal weaknesses in information security. In the course of the Academy's current work with SSA to develop a long-term strategic plan, SSA has conveyed an interest in improving its IT infrastructure. As part of this effort, SSA should determine how databases throughout the Administration, regional offices, field offices and State DDS offices can be integrated. When aggregated, the data maintained by these offices serves as a powerful tool for deriving patterns indicative of fraudulent activity. Furthermore, information silos make it easier for fraudsters to succeed. Data integration will enhance SSA's ability to manage and protect information it is responsible for safeguarding.

SSA should incorporate clear warnings to claimants and their representatives on the consequences of defrauding the disability insurance program early in the application process.

Making applicants aware of SSA's heightened efforts and capacity for combatting fraud provides another level of deterrence. In addition to implementing the newest available fraud detection technology, application documents should include warnings on the consequences of defrauding the federal disability insurance program. These efforts should also include an explanation of what activities are considered fraud, applicable statutes for prosecuting fraud, and the consequential civil and criminal penalties. This information must be provided at the earliest stage of the disability application and reinforced throughout the claims process.

SSA must send a clear message to claimants and their representatives on SSA's capacity to verify the validity of information provided throughout the claims process. This should include information on partnerships developed for the purposes of combatting fraud, waste, and abuse such as the CDI Program's ability to pool resources from State DDS offices and State and local law enforcement agencies. SSA's *my* Social Security portal would be an additional platform to ensure wide distribution of this information to applicants. Additional activities aimed at sending a strong warning to potential fraudsters can be incorporated across SSA regional and field offices and State DDS offices, for example, widespread publication of updates on CDI's successes in detecting and preventing fraud.

SSA must develop a culture of prevention and detection that extends to all employees.

Fraud typically occurs with a systemic or management error that is exploited by fraudsters. SSA must prioritize development of a work environment with a clear mission of fraud prevention and detection to enhance its capacity for identifying vulnerable business processes. As SSA has stated, they have relied on field office and DDS employees as a "first and best line of defense against fraud." In addition to front line employees, SSA must follow through on its plan to extend fraud detection training to all SSA employees. The content of this training must be regularly updated and revamped to optimize its capacity for engaging employees. Furthermore,

employees must be educated about data analysis tools and other technologies that contribute to SSA's mission to combat fraud.

Training efforts should include rewarding vigilance among employees through recognition and a performance appraisal system. Recognition will foster a culture of detecting and reporting fraud and may inspire innovation among employees to develop new ideas on fraud prevention.

Additional ethics training for supervisors and employees that is focused on a mission of protecting the American taxpayer and individuals who are truly disabled will also bolster a culture of fraud prevention. Ethical training may also serve as a tool for deterring employees from facilitating fraudulent activities such as those that were allegedly involved in the Puerto Rico conspiracy.

Consideration should also be given to creating a senior level executive position whose primary responsibility is to oversee and manage SSA's fraud detection and prevention efforts. This will enhance SSA's ability to identify and responds more readily to vulnerable business processes and systematize continuous improvements of fraud detection efforts. The responsibilities for this position should include collaboration with the private sector to ensure that SSA keeps pace with the best and latest technology available.

Conclusion

SSA is responsible for managing the largest disability insurance program in the world, providing $12 billion in monthly benefits to 11 million workers and their families. An operation of this magnitude will always be a target for fraud and abuse, but SSA is on the right path to a more robust approach to mitigating the scale of facilitator fraud. Investing in new analytic tools, integrating and expanding its data sources, increasing applicant awareness of SSA fraud prevention efforts and the consequences of defrauding the federal government, and fostering a culture of fraud prevention among all employees will assist SSA in achieving its stated goals of strengthening its anti-fraud activities and continuing to earn the public's trust in its stewardship of the disability program.

Chairman JOHNSON. Thank you. Have you provided those suggestions to the administration?

Mr. SHARK. In my testimony I have.

Chairman JOHNSON. I see.

Mr. SHARK. Yes.

Chairman JOHNSON. Were you paying attention, Ma'am?

Ms. COLVIN. Yes.

Mr. SHARK. She was kicking me in the back.

Chairman JOHNSON. Thank you.

Mr. Royal, how does Unum identify claimants who may be faking illness, particularly mental illness?

Mr. ROYAL. Well, Mr. Chairman, I think that the first line of defense, which is our people who are handling the claims, is key to identifying those fraudulent activities. Our fraud training program, managed by the SIU that I referenced, arms those frontline employees with the education to identify red flags as they are processing claims. And each of the processes that they follow, which do vary by type of disability that you mentioned, is designed to support a fair and thorough analysis of the claim.

So for mental illness or behavior health type illnesses, some of those activities might include objective tests for malingering or fabrication, activities check and verification. We also perform records review by our in-house physicians. And so through that process if red flags are identified, there is encouragement to reach out and refer those claims to the SIU early as possible, because these claims are hard to substantiate at times, they are hard to disprove at times.

But it might be worth noting to the committee that behavioral health fraud accounted for about 15 percent of our total fraud last year. The most common is musculoskeletal disease, or neck pain, back pain, joint pain, that accounted for somewhere in the mid-30 percent.

Chairman JOHNSON. That is the stuff you can't identify, isn't it? How do you screen for bad doctors?

Mr. ROYAL. Well, you don't want to go——

Chairman JOHNSON. I don't want to go to one.

Mr. ROYAL. Our going-in position is that there are not bad doctors, but we know that there are cases of where there are facilitators of fraud. It is a sensitive issue because the escalation of the impact that a facilitator can have is much greater than an individual perpetrator or fraud that is conducting that fraud for one claim over a period of time.

So the way that we first prevent against identification of the doctors, for example, would be back to those treating physicians that I mentioned in our claims processes. Those folks are identified as integral antifraud personnel, so they receive the training that we give them to identify those red flags. And what they do in the handling of the claim will have a doc-to-doc call. Our own doctors that are educated in fraud awareness, and have the expertise in the field, will reach out and have conversations with treating physicians and discuss the claim and the situation. That puts them in a unique position to identify suspected fraud, and particularly where there is some suspicion around the doctors.

And they are trained, the physicians are, to make the referral to the SIU. That has happened, and when we have a referral on a facilitator claim it gets priority. When we will put that doctor into a database. We will search our claims for doctors, common doctors, commonality of doctors, and will allow resources to quickly look at those claims to see if there is additional concern.

Chairman JOHNSON. Thank you. You know, I think using the computers probably helps, doesn't it?

Mr. ROYAL. It does. All the information that we receive on a claim—again our process is designed to provide a fair but thorough review of the claim—but the information we do receive gets put into our databases. The model, the predictive model that we have developed, considers many attributes when it looks at and daily evaluates these claims.

So while the fraud model doesn't necessarily reports on batches of claims, it is designed to look at individual claims in the likelihood that they have potential fraudulent activity. Our fraud analysts that review those high scoring claims are in a much better position than our claims handlers to look across these highly suspicious claims that are being indicated by the model, because that is all they are doing, is they are looking at that and looking for that commonality across those claims.

Chairman JOHNSON. Mr. Zielinski, you all are trying to develop some similar type plan for Social Security, I understand. When will that tool be available for frontline employees?

Mr. ZIELINSKI. So, Chairman Johnson, we already have some tools that are available right now. Commissioner Colvin mentioned that for the direct deposit fraud, she was talking about those instances in which we have been able to prevent those through the door. So we already have a number of those tools available.

But she also specifically mentioned that utilizing the information from these cases that have already been established in a similar fashion to, as Mr. Royal described, we are going to be doing the same things. We are going to be proving out that model in a short window of time. And we could provide you with specifics for the record as to exactly when we are going to do those things.

[The information follows:]

Insert for Transcript Page 73—Anti-fraud Initiative Timeline

Timeline for Implementation of Anti-fraud Initiatives in the Social Security Administration's 30-Day Report

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
pp. 6,11,15	**Increase CDRs:** With the recent appropriations act, Congress provided us with funding to significantly increase the number of continuing disability reviews (CDR) that we are able to conduct. We estimate that the money spent on CDRs saves on average $9 per every dollar invested, including savings accrued to Medicare and Medicaid. *Objective:* Increase the amount of program savings. While the CDR process is not specifically designed to detect fraud, increasing CDRs could possibly allow us to detect more potentially fraudulent or suspicious activities.	*Schedule:* By the end of fiscal year (FY) 2014, we will complete over one-half million full medical CDRs, a more than 20-percent increase over FY 2013. With full funding of the President's FY 2015 budget, we will be able to complete 888,000 full medical CDRs in FY 2015, more than double the amount completed in FY 2013. *Responsible Component:* Office of Operations (Operations)
pp. 5,6,11	**Expand CDI Units:** Working with our Office of the Inspector General (OIG), we plan to expand the number of Cooperative Disability Investigations (CDI) units. According to the OIG, CDI units have contributed to Social Security Administration (SSA) savings of more than $960 million over the last 3 fiscal years. As the report shows, we provide most of the funding for these units and, in collaboration with the OIG, we plan to expand the CDI program by seven additional units beginning in FY 2014. We anticipate these seven units will be fully operational in FY 2015, increasing the total number of units from 25 to 32 nationwide. *Objective:* Enhance our ability to prevent and detect disability fraud.	*Schedule:* We expect that the first new unit to open will be the Baltimore CDI unit by the end of FY 2014, with the Detroit CDI unit to open in the first quarter of FY 2015. The remaining units are expected to open in the third and fourth quarters of FY 2015. They will be located in Birmingham, AL; Charleston, WV; Providence, RI; St. Paul, MN; and Washington, DC. This is an aggressive timeline as, based on experience, it typically takes 12 to 18 months from approval to having fully operational units. *Responsible Components:* Operations and OIG

Insert for Transcript Page 73—Anti-fraud Initiative Timeline

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
p. 5	**Anti-Fraud Training:** We will expand anti-fraud training to all SSA employees during FY 2014, with specific focus on lessons learned from Puerto Rico and New York City. SSA and disability determination services (DDS) front-line employees remain our best line of defense against those seeking to exploit the system. *Objective:* Enhance our ability to prevent and detect disability fraud.	*Schedule:* By the end of FY 2014, all SSA and DDS employees will complete anti-fraud training. *Responsible Component:* Office of Human Resources
p. 12	**Data Analytics:** We will develop analytical tools based on known cases of fraud and past allegations to determine common characteristics and patterns. We will apply these tools to help us uncover potential fraud or other suspicious behavior when we review initial applications or existing data on beneficiaries. We invited the OIG to participate in this initiative. *Objective:* Increase our ability to identify questionable patterns of activity in disability claims and prevent fraudulent applications from being processed.	*Schedule:* In February 2014, we established the inter-component Disability Fraud Predictive Analytics Project Team. The project team will conduct a pilot to utilize data analytics to enhance the agency's ability to detect and prevent disability fraud. We will conduct the pilot in two phases in FY 2014. The first phase will apply predictive analysis to our disability claims data to verify the ability of analytics and to our big data platform to identify disability case fraud. The second phase will utilize analytic tools to identify suspicious patterns of activity in disability claims. We will closely examine any identified potential fraudulent cases and if appropriate, we will refer them to the OIG for investigation. *Responsible Components:* Office of Systems and Operations

Insert for Transcript Page 73—Anti-fraud Initiative Timeline

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
p. 12	**Specialized Fraud Units:** We are establishing a specialized fraud unit comprised of disability examiners dedicated to reviewing and acting on potential fraud cases. *Objectives:* Develop experts in working disability fraud cases. Compile data from the cases that will help us to develop further analytical tools to identify potential fraud	*Schedule:* There will be three disability anti-fraud units established in FY 2014. The New York Anti-Fraud Review Unit became operational in March 2014. The remaining two units, located in Kansas City, MO and San Francisco, CA will be in place before the end of FY 2014. *Responsible Component:* Operations
p. 13	**National Anti-Fraud Committee:** We are reinstituting the National Anti-Fraud Committee (NAFC), which will be co-chaired by the Inspector General and our Deputy Commissioner for the Office of Budget, Finance, Quality, and Management (OBFQM). *Objective:* Lead and support national and regional strategies to combat fraud, waste, and abuse. Support includes providing an open forum for senior executives to collaborate on fraud challenges and opportunities at a strategic level.	*Schedule:* The NAFC co-chairs held a planning meeting with support staff on March 6, 2014, to discuss the new committee charter, membership, baseline initiatives, and means for communicating the agency's anti-fraud effort. NAFC intends to meet on at least a quarterly basis and held its first full meeting on March 24, 2014. On March 7, 2014, the Acting Commissioner announced the availability of a dedicated mailbox for employees to make anti-fraud suggestions, which the NAFC will use to identify and sponsor new initiatives to help prevent and detect fraud. *Responsible Components:* OBFQM and OIG

Insert for Transcript Page 73—Anti-fraud Initiative Timeline

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
p. 13	**Submission of Evidence Regulation**: We propose to revise our regulations to require claimants to inform us about or submit all evidence known to them that relates to their disability claim—both favorable and unfavorable. We also propose to require a representative to help the claimant obtain the information or evidence that the claimant must submit, and we would extend the protections afforded by attorney-client privilege and attorney work product to non-attorney representatives as well. *Objective:* Address concerns that some claimants may withhold medical evidence that could be unfavorable to their claims.	*Schedule:* Proposed rule published in the *Federal Register* on February 20, 2014. (The public comment period closes April 21, 2014.) *Responsible Components:* Office of Retirement and Disability Policy (ORDP) and the Office of Legislation and Congressional Affairs
pp. 6,7	**Fraud Prosecution Project:** The Department of Justice (DOJ) is the Federal agency responsible for prosecuting defendants who have violated Federal law. However, due in part to a lack of prosecutorial resources, DOJ declines many cases for prosecution. For more than a decade, our Office of the General Counsel (OGC) has worked with OIG to develop the SSA Fraud Prosecution Project. To support this project, OGC has provided attorneys who serve as Special Assistant United States Attorneys (fraud prosecutors) in many of the Federal districts where we have regional offices and at Headquarters. There are currently 12 attorneys assigned to this project. *Objective:* Increase the number of prosecutions for crimes involving Social Security matters.	*Schedule:* By the end of FY 2014, we will have 12 additional agency attorneys assigned to this project, doubling the current number. *Responsible Component:* OGC

Insert for Transcript Page 73—Anti-fraud Initiative Timeline

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
p. 14	**Representative Payee Criminal Bar:** We seek only qualified individuals and organizations to serve as representative payees, and we take steps to ensure continued qualification and proper use of the benefits. We have completed a pilot of a policy change that we believe will help us identify payee applicants who have committed certain serious crimes and bar them from serving as payees. Felony convictions for any of 12 crimes will bar the individuals from serving as a representative payee. *Objective:* Help identify representative payee applicants who have committed certain serious crimes and bar them from serving as representative payees.	*Schedule:* Based on the pilot's results, we implemented the criminal bar policy nationally on February 28, 2014. We will brief the Subcommittee quarterly on our representative payee initiatives. *Responsible Component:* ORDP
p. 14	**Symptom Evaluation** (Research Effort)**:** We have asked the Administrative Conference of the United States (ACUS) to review the Social Security Act, current regulations, and our sub-regulatory policy regarding how decision-makers at all levels evaluate claimants' symptoms in disability claims. ACUS will also review a sample of related Federal case law, conduct additional research concerning symptom evaluation in other formats, review international perspectives, and gather stakeholder perspectives on our current standards for evaluating disability claimants' symptoms. *Objective:* This initiative's primary objective is to increase the objectivity of our individualized evaluation process. However, we believe this study may help us prevent fraud.	*Schedule:* We anticipate having a report from ACUS in August 2014. The ACUS report will determine our next steps in this area and the timeline for implementation. *Responsible Components:* ORDP and the Office of Disability Adjudication and Review

Insert for Transcript Page 73—Anti-fraud Initiative Timeline

PAGE REF.	INITIATIVE AND OBJECTIVE	IMPLEMENTATION SCHEDULE AND RESPONSIBLE COMPONENT(S)
p. 14	**Psychological Testing** (Research Effort): We have asked the Institute of Medicine (IOM) to perform a comprehensive review of psychological testing, including symptom validity testing. IOM will examine the relevance of psychological testing to disability determinations in claims involving physical or mental disorders. IOM will also provide us guidance that we can use to help adjudicators interpret the results of psychological testing. *Objective:* This initiative's primary objective is to increase the objectivity of our individualized evaluation process. However, we believe this study may help us prevent fraud.	*Schedule:* We anticipate having a report from IOM in June 2015. The IOM report will determine our next steps in this area and the timeline for implementation. *Responsible Component:* ORDP

6

Chairman JOHNSON. Thank you. Mr. Becerra, you are recognized.

Mr. BECERRA. Thank you, Mr. Chairman.

And thank you to all of you for your testimony. Mr. Royal, let me ask this, do you find the way Social Security has found that if you invest money on fraud detection, that you have a greater return on the money you spent in having to pay for those fraud busters?

Mr. ROYAL. Congressman, I don't know the specifics of how the Social Security Administration approaches and uses their dollars in terms of their IT spend or predictive analytic spend, but what has worked for us is a model that does continuously screen our claims to identify those that have likely or suspicious fraudulent activity. And while proprietary in specific number, we find that the rate of return on that is very high.

And in fact, the referrals that are made to our investigators that come from the model have a much greater likelihood of resulting in the identification of fraudulent activity than the referrals from the front line.

But don't get me wrong, the front line is extremely important. They are still the majority of the referrals and account for 70 percent of the ultimate fraud that we detect and report, but that 30 percent that comes from the model those referrals that result in that 30 percent, high likelihood of potential fraud.

Mr. BECERRA. So, I know that Social Security has indicated in the past that they have a 17 to 1 return, a 9 to 1 return on some of their fraud busting techniques. Sounds like you are seeing similar type results with whatever your techniques are.

Mr. ROYAL. Yes, sir.

Mr. BECERRA. Great.

Mr. Zielinski, can you tell us a little bit more about what the Social Security Administration is doing to prevent the fraud. Because I know there is always the concern that if you don't try to detect it early you have to chase it later on and it is tougher and costs a lot more money. I wonder if you could tell us what you are doing that is similar to the private sector is doing to try to prevent the fraud before it ever occurs.

Mr. ZIELINSKI. You bet. Congressman Becerra, there are a few things. Commissioner Colvin mentioned some things already that are more on the business side in terms of the training and other things, so I am going to stick to the IT pieces that we are undertaking.

Again, we mentioned the direct deposit fraud. In a very similar fashion as we have identified these cases coming through, we have analysts, and you really do have to rely on those analysts to be able to tell you what they are seeing from the data. We use the data to create scenarios that allow us to recognize those scenarios coming through, and we have prevented very many cases from being paid at all in the first place.

Mr. BECERRA. That is the predictive technology?

Mr. ZIELINSKI. That is the predictive technology, absolutely. What we are also doing from a technology standpoint is we are also working with partners from across the Federal Government. We have met with a number of sources and what we are looking to do is a few things there. We are looking for best practices, but we are also looking for sources of information that are there and readily available.

Commissioner Colvin mentioned that we do use information from CMS that we use to recognize for doctors, where there is already a pattern there. So we are looking for those types of data sources. And as we build our models, again we utilize our frontline folks

who have knowledge of this to be able to tweak and improve those models over time.

We also have prepayment reviews for our disability claims. So we mentioned the CDI units and recognizing those patterns. But even as we are making those medical decisions, there is an additional review that takes place before any payment is issued.

So, those are just some of the things that we have done utilizing technology and being able to select and sample and score for the probability of error or problem to prevent those cases from taking place.

Mr. BECERRA. And I had posed the question to Commissioner Colvin previously, but I wonder if you could give us your take. In the legislation that we introduced today, we do call for an increase in financial penalties that would be assessed by Social Security for fraud committed by people who should know better than to engage in that activity. Do you think that would be helpful to SSA as it goes about the process of detecting fraud?

Mr. ZIELINSKI. Well certainly, sir, any tools that we have in our tool belt that would help us to combat and deter, and Commissioner Colvin mentioned that once people see the strengths of those penalties it is something that serves as additional deterrent, and I echo what she told you earlier.

Mr. BECERRA. What about the issue of banning practitioners who engage in these bad practices, a doctor who knowingly submits fraudulent medical documentation so that someone can qualify to receive these disability benefits? Should we ban those doctors from being able to participate in giving us evidence that helps determine whether someone is disabled or not?

Mr. ZIELINSKI. Well, certainly from the IT perspective, the more information that we have in and about any of the players that are in the process, it is a valuable and valid information. And that sort of information really allows us to be able to stop some of those things at the front door. So those are effective deterrents and can be used in an IT model to help prevent those things.

Mr. BECERRA. Thank you all for your testimony.

And by the way, because I have referenced that bad doctor, but it is not just doctors, and the Chairman and I were discussing this. We should go after anyone along that chain of the process who engages in this type of activity that ultimately takes money away from the taxpayers. I wouldn't use as colorful language as the Chairman has used, but I think we all agree, every one of us agree that we should descend on any of these folks who are perpetrating this kind of fraudulent activity to folks who paid their tax dollars to get these benefits in the future.

Thank you all for your testimony.

Mr. Renacci, you are recognized.

Mr. RENACCI. Thank you, Mr. Chairman.

And I would to thank you all for your testimony today. Dr. Shark, you mentioned six recommendations. Can you narrow those down to maybe two or three which would cover the low-hanging fruit that maybe the Social Security could be doing?

Mr. SHARK. Well, I think they are moving in the right direction. I can narrow it down to two. One is the human factor and the ability for that frontline person, which has been I think well described

as the gatekeeper who is going to see something coming in, they are going to see the most suspicious thing at the very beginning.

The second part is more problematic, and that is the technology piece. You know we are talking about where we really want to be, and to me it is how do we get to a point, and at what point will that be? Will it be in the year 2015, will it be this year? In other words, what is the ultimate road map?

To me every application should be screened and tested based on these different models. They should not be flagged red. They should be done green, red, yellow, different kind of things for different kind of deficiencies that may be found and to be totally integrated into the culture.

And so what I am hearing is these fixes, but I am not hearing this timeline of when this will happen, whether it will be a totally integrated system that will review things. In the report I read there are 54 databases that is being consolidated into one. That will go a long way in helping.

But ultimately I think it is, like, what is this vision? And the technology vision is we have to use predictive analytics. We have to use things to plot what is going on and where, to look at the chain of interactions so that technology can help us and pinpoint things before they occur or slightly thereafter. And it is that blueprint that I am not seeing yet. I am seeing some really good fixes, but I am not seeing that longer term this is where we want to be and this is what it is going to look like.

Mr. RENACCI. Mr. Zielinski, I know you have talked about more money and I want to remind you what happened with Social Security concerning IT money. Since fiscal year 2001, Social Security stockpiled over $1.3 billion in an information technology reserve fund of unspent money. The Congress agreed on a bipartisan basis to rescind $500 million.

And again, that might predate you and might predate the Acting Commissioner, so I am trying to find out—it appears back then there was not this push for IT. Why weren't those dollars spent? And what would make us believe that if you had those dollars you would spend them today, since you already had them?

Mr. ZIELINSKI. So Congressman, I appreciate the question. I don't have specifics as to why those funds were not spent. I was not involved in the discussions or the decisions, so unfortunately, I can't answer that question for you.

I will say that Commissioner Colvin has taken a much more specific approach towards strategic planning, and I think as we are moving forward the types of plans that Mr. Shark talks about in putting in place, those are the things on which we are focused so that we will be able to show and demonstrate precisely where we are making those investments and how we are going to spend those dollars and to what purposes, which areas within our mission those are going to be spent.

So Commissioner Colvin has mentioned in her written testimony about the strategic planning that we are doing now, and in fact we are engaged with NAPA in some of that strategic planning. And those are the sorts of things that we will see in that plan. So, you know I have confidence and I believe that we have—the commissioner is really pushing forward with that strategic planning.

Mr. RENACCI. Okay. One of the thing I noted in an audit raised some questions about the data, Social Security's data, including the fact that you have multiple databases. How many databases does Social Security have? How connected are they and what challenge do you have in creating and implementing, you know, data analytics based on all of that?

Mr. ZIELINSKI. So I can't answer the specific question. I don't have the exact number of databases. We have a series of databases. Some are called master files. Those are ones from which we issue payments and maintain systems programs. And then there are other databases specifically to processing the workloads.

In terms of being able to bring data together, there is a lot of technology that is available today that allows us to be able to bring data from multiple sources together to be able to combine that in ways for specifically these reasons.

So, we are using tools today, pulling data from many different locations, bringing that together to be able to do the data analytics. So, the challenge isn't necessarily in and around the number of databases, it is really again getting back to having the analytical support, really knowing what patterns we are looking for and being able to implement that, sir.

Mr. RENACCI. Dr. Shark, one last question. Looking from the outside in, are we doing enough for training of our frontline staff to detect this fraud?

Mr. SHARK. Well, absent technology, probably not. I think they are doing the best they can with the tools they have today. The only thing I would add to that is kind of think in a creative way some better rewards for those people up front because they are so important. Everyone acknowledges that. And the question is what can we do more to empower them to really feel emboldened, to look for things to be very, very vigilant and careful. Because they are our first line.

So the missing piece is what kind of reward can we give them? We are not talking about money here, but we are talking about recognition. Part of their review process, maybe something on their wall. But something to really show how important these people are to us.

Mr. RENACCI. Thank you.

I yield back, Mr. Chairman.

Chairman JOHNSON. Thank you.

Mr. Kelly.

Mr. KELLY. Thank you, Mr. Chairman, thank you.

Chairman JOHNSON. Do you care to question?

Mr. KELLY. Yeah, just real quick, because I am really interested how it happens in the private sector. And I know there is quite an incentive to do it differently in the private sector, because it really determines whether you continue in the private sector or go and change direction with what you are going to do with the rest of the your life.

Mr. Shark, you made a references to it, and I think Mr. Royal. I was looking at the size of your company. You work with 175,000 businesses worldwide and you cover more than 22 million people. I am looking at how you do that. I mean, I think because we are talking now about do we need to increase funding to SSA to help

them do their job or can we somehow slim it down to a point where they are actually more effective. And I know there are things we can talk about later on about how we are going to do that.

But from a private sector, what you do see? Mr. Renacci just said from the outside in. What do you see that if you were taking over and you were the CEO just walking into this business, what would be the first thing that you would look at? And I think data analytics are absolutely critical. What would be the number one thing? I don't think we need to keep throwing money at it. I think we need to learn to live with less, do more with less, but technology is the answer to that, is it not?

Mr. ROYAL. Congressman Kelly, I think that is a big opportunity. I think that we are all asked to do more with less. I am asked that every year, every quarter when I meet with folks, and I think the predictive analytics tool, while it requires investment, does provide that broad coverage of looking at claims. It looks at the subtle changes in claims as information comes in. Things that the claims handlers can't necessarily see. There are some things that they can see that a computer model can't, and vice versa.

So I think that there is an opportunity that with the use of that technology to get that broader coverage.

Mr. KELLY. So when you make an investment, you are going to make an investment but you want to get a real positive return on the investment, could Social Security do the same thing? Every year you go into a bid process and you have to earn the people who work with you, the people that you contract with, you have to earn their business.

But we don't have that same model and this is not a knock at SSA, this is just the way it works. But we do have the ability to really cull this down, make it more effective and more efficient. There is no reason why we can't do this, is there?

Mr. ROYAL. Well, the profile obviously of the business is different. We offer a number of different products and that carries different challenges in them. I think that there are opportunities to take those opportunities, and one of those opportunities is maintaining a healthy collaboration between the public and the private sector.

Private disability has an opportunity to take some of the burden off of governmental programs by providing income replacement early on in the process so they are not having to look for other safety net programs, and the private disability insurance companies also help to promote return to work so that they actually get on—they are on the rolls less of a time.

So not only is there efficiencies in the organization, but efficiencies working together from a industry, public and private, that will increase the overall economic welfare valuable of disability insurance.

Mr. KELLY. Mr. Shark, then, how do you incentivize from the Social Security level? How would you incentivize the people that are on the staff? What you would use? I know for Mr. Royal it is you keep your job. But for people in SSA how do you do that? What makes that person come to work every day, throw their feet out over of the bed, getting up and getting dressed and going to work

and want to go to work, and know that there is a light at the end of the tunnel? How would SSA do that?

Mr. SHARK. Well, I think they are in a better position to answer that than I would. But from the outside looking in, I would say that—you know, people love recognition. If I can't get a raise, how can I be recognized? And if that is part of your job description, that is what they are supposed to be doing to begin with. So there is an expectation.

But going beyond the norm, there could be some levels of recognition that might be an award, some kind of thing they would put on their wall, some kind of thing that goes into their review process, it could lead to a promotion, and they should be the champions, also the ones training others when they have found something. So it is kind of giving them the incentive through ego recognition for their performance.

Mr. KELLY. That is the answer. It is ego.

Mr. SHARK. Yes.

Mr. KELLY. I mean, compensation is one thing.

Mr. SHARK. Yes.

Mr. KELLY. But recognition for doing a good job is a lot more important.

Mr. SHARK. And we take that for granted, because we know what we can't do. We know we cannot give them a financial raise, but this is something that can be done.

Mr. KELLY. My experience since I have been here 3 years, we bring these folks in here. We all work together. We work for the same people.

Mr. SHARK. Yeah.

Mr. KELLY. And all of a sudden we get out this hammer and start beating them: You are not doing the right job, you are not doing the right job.

Mr. SHARK. Yeah.

Mr. KELLY. So whenever they commit like we are doing today, how can we work with you?

Mr. SHARK. Yeah.

Mr. KELLY. What can we do to help you be better at what you do? Because if we do that, then the American people win.

Mr. SHARK. Yes.

Mr. KELLY. It has nothing to do with Congress beating down the SSA or taking people who we think are doing a fraudulent thing. It is a matter of getting it to a point where the taxpayer gets the best return on his or her investment. It is incredibly important.

Mr. SHARK. Right.

Mr. KELLY. So I agree with you. In my business, recognition by far.

Mr. SHARK. I do the same.

Mr. KELLY. Compensation only goes so far.

Mr. SHARK. Yes.

Mr. KELLY. Recognition lasts a lot longer.

Mr. SHARK. Yes.

Mr. KELLY. So that is one of the things that perhaps SSA could take out of this meeting, or could talk with you.

But I do, I want to thank you all for being here. This is incredibly important. What I always keep going back to, I think there is

a disconnect when it comes to the Government. The people I represent back home say the Government needs to do this. Well, the Government works for you. You have to switch that around and understand the revenue comes from hard-working American taxpayers. That is who funds everything. We have to give them a better return on their investment.

So, Mr. Chairman, thanks for having this meeting and all of you, thanks so much for what you do. SSA, good to have you here again with us today.

Thank you.

Chairman JOHNSON. I think this was a good meeting and I appreciate you staying here.

And you too, Commissioner. You have heard these panels and we appreciate the testimony. I think now that the subcommittee has examined and provided feedback to Social Security's plans to stop crimes against the taxpayers, I think the Commissioner will make her plan implementation one of her top priorities, which she already has done. I think the American people deserve nothing less.

I hope we can stop the fraud that goes on in this agency and grab it by its roots. And I appreciate you being here today, all of you. Thank you.

And the committee stand adjourned.

[Whereupon, at 11:49 a.m., the subcommittee was adjourned.]

[Member Questions for the Record follows:]

The Honorable Carolyn Colvin

SOCIAL SECURITY
The Commissioner

June 6, 2014

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

Dear Mr. Chairman:

Thank you for your March 20, 2014 letter requesting additional information to complete the record for the February 26 hearing on preventing disability scams. Enclosed you will find the answers to your questions. I am providing responses on behalf of Deputy Commissioner William Zielinski and myself.

On March 27, we sent you the timeline for implementing our anti-fraud initiatives that you requested during the hearing.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Carolyn W. Colvin

Carolyn W. Colvin
Acting Commissioner

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE, MD 21235-0001

Questions for the Record
For the February 26, 2014 Hearing
On Preventing Disability Scams

Questions for Acting Commissioner Carolyn W. Colvin

1. **What is the most important action your agency has taken to stop the fraud and abuses seen in Puerto Rico, New York, and West Virginia, from happening in other parts of the country?**

   As I stated during the January 16 and February 26, 2014 hearings, I take my responsibility seriously for detecting and preventing any potential fraud. Our employees share the same view and actively identify instances where they believe fraud may occur or has occurred. We have a robust anti-fraud training curriculum for our employees to equip them with the skills to identify and report fraud.

   I mentioned in the February 26 hearing that many efforts are underway to further enhance our fight against fraud. I want to highlight the recent renewal of our National Anti-Fraud Committee co-chaired by our Inspector General and our Deputy Commissioner for Budget, Finance, Quality, and Management. In fact, they held their first Committee meeting on March 24.

   The goal of the Committee is to lead and support our national and regional strategies to prevent and combat fraud, waste, and abuse. We identified a number of baseline initiatives to combat fraud, and the Committee will ensure these initiatives are implemented. For example, we will expand our Cooperative Disability Investigations (CDI) units from 25 to 32 by the end of fiscal year (FY) 2015 and add staff to existing units. As I mentioned at the hearing, a CDI unit identified the fraud cases in New York. According to our Inspector General, CDI units contributed to agency savings of more than $960 million over the last 3 fiscal years.

   On March 31, we established a centralized fraud prevention unit in New York City to identify potential fraud and detect fraud trends that can be applied to disability cases nationwide. This unit consists of experienced disability examiners who will collaborate with our systems personnel to help build data analytics to detect and prevent fraud at the earliest possible point in the disability decision-making process.

2. **Your agency estimates the re-reviews in Puerto Rico will cost up to $6 million. How much will the re-reviews in the New York case cost?**

   The grand jury in the New York County case remains active and the criminal investigation is ongoing. We cannot estimate the costs of the reviews until after those activities have concluded. We have begun to review a limited number of cases arising out of the active grand jury investigation and will continue to review additional cases as the investigation unfolds.

3. How are employee actions to detect fraud accounted for in the agency's work measurement system?

Our *Annual Performance Plan for Fiscal Year 2015, Revised Performance Plan for Fiscal Year 2014, and Annual Performance Report for Fiscal Year 2013* establishes agency-level priorities and includes goals and objectives focused on program integrity, reducing improper payments, and fraud prevention and detection. You may access it at www.socialsecurity.gov/performance/2015/FY2015-APP-APR.pdf. Our agency-level performance measures that specifically address fraud prevention are as follows:

- 2.2a – Implement a fraud and integrity unit to protect the public's data;
- 2.2b – Enhance our security features and business processes to prevent and detect fraud; and
- 5.3b - Explore the use of emerging technologies by establishing a testing lab to promote research and development of innovative technology solutions that provide more effective and flexible ways for the public to conduct business with us online and for our employees to complete their work.

As I have consistently said, our front-line employees are our best line of defense against fraud and abuse. All of our employees are responsible for detecting and reporting potential violations of the law, developing sufficient evidence to establish any violation, reporting violations, assisting our Office of the Inspector General (OIG) in developing violations, and providing other support as needed.

We capture employee actions to detect fraud in our Fraud Information Tracking System (FITS), which houses data on fraud referrals made by our field offices to OIG, and hotline referrals transferred to the field office for development. The chart below shows fraud referrals for the last 5 years.

Fiscal Year	Fraud Referrals
FY 2009	44,919
FY 2010	47,764
FY 2011	49,757
FY 2012	69,774
FY 2013	83,827

Our Office of Disability Adjudication and Review is working with our Office of Operations to be able to use FITS to more effectively track fraud-related referrals.

4. **Of employee bonuses awarded in fiscal year 2013, what percent were given to employees based on their efforts to detect or prevent fraud?**

   We reviewed employee awards for FY 2013. We awarded eight Senior Executive Service performance bonuses in FY 2013, all of which were related to performance and accomplishments directed at detecting or preventing fraud. Due to budgetary considerations, we did not make any monetary awards to line employees in FY 2013.

5. **Conspiracy schemes also affect Social Security number holders. The Congress recently passed a law ending the publication of the Death Master File that Social Security produces and sends to the Commerce Department that then sells it to subscribers. All access to current deaths is to end March 26, 2014 in order to prevent identity thieves from stealing Social Security numbers of the deceased and using them to file for a fraudulent tax refund. As Acting Commissioner, how are you working with the Commerce Department, the Office of Management and Budget and the Internal Revenue Service to insure the protection of personal information of the deceased?**

   We compile the Death Master File (DMF) to respond to Freedom of Information Act (FOIA) requests. The file serves no program purpose for us. In order to comply with the high volume of DMF-related FOIA requests, we contracted with the National Technical Information Service (NTIS), part of the Department of Commerce (DOC) that functions as a national clearinghouse for government data, to make the file available to the public. The Bipartisan Budget Act of 2013 exempted from FOIA death information about individuals who died in the last 3 calendar years and tasked the DOC with a number of new responsibilities with respect to the DMF.

   The law requires the DOC to create a new certification program under which only persons having a legitimate business purpose for the information may have access to the file containing information on deaths occurring in the last 3 calendar years. Therefore, the general public will have access only to a file containing deaths that occurred at least 3 calendar years prior to the request.

   Our role in implementing the new law is a supporting one. We have continued to supply DOC with the DMF, on a reimbursable basis, so that DOC can distribute the DMF to certified persons as required by the new law. In addition, we have been working with NTIS and the Office of Management and Budget to provide advice and feedback as described below. In December 2013, for example, NTIS reached out to us to ask for our thoughts on implementation of the new legislation. This contact triggered a series of interagency meetings. We discussed several issues with NTIS throughout the month of January 2014, including:

   - the NTIS' draft regulation;
   - the history and purpose of the DMF;
   - our plans for improving our death reporting process and the accuracy of the DMF; and;

- the technical, resource, and contractual issues related to creating two files—one for immediate release to certified persons through the new DOC program and one for the delayed release of older death information available under FOIA.

In February 2014, we and other stakeholder agencies, such as the Department of the Treasury, provided comments on NTIS' draft "Request for Information" soliciting public comment on the establishment and implementation of the certification program, and in early March, we provided comments to NTIS' on its proposed interim final rule. On March 26, 2014, NTIS published their interim final in the Federal Register, Volume 79, Issue 58.

Questions for Deputy Commissioner Bill Zielinski

1. **As the Chief Information Officer, part of your job is to bring an agency wide perspective to the table. Before new policies and programs are rolled out, please describe how decisions are made regarding the data collection needed to prevent fraud. Will this process change going forward and if so, how? Also, please discuss how you have mapped out holes in your current data and ways to get what you need.**

   We use a variety of continuous monitoring processes to determine agency information needs around fraud and program integrity. Examples of such processes include Quality Assurance processes, our Audit Trail System, audit findings and recommendations (e.g., Federal Information Security Management Act, OIG, and Government Accountability Office), public reports, and OIG investigations. These continuous monitoring processes provide a rich source of information regarding vulnerabilities or threats from fraud. We analyze these processes and the data they yield to identify the potential for fraud, abuse, and error within agency programs. Based on these analyses, we decide what data to collect, where changes can be made to existing systems or processes, and where automation can be applied to prevent fraud or error in the programs. While we have used many of these processes for many years, and they have proven to work extremely well, there is always a need to review and update our detection and prevention programs to keep pace with new threats and leverage new and emerging technologies. Our staff uses data from agency repositories to determine emerging data needs. Along with data collected by the agency for purposes of program administration, we also look for external data sources that can assist in the detection and prevention of error and fraud in our programs. Examples include Medicare/Medicaid Non-usage data, financial data, and earnings data.

2. **What specific role will your office have in the agency's planned use of data analytics, as described in the Acting Commissioner's plan, to prevent and detect disability fraud?**

   The Office of the Chief Information Officer is leading the effort to expand our use of data analytics to enhance our ability to detect possible fraud. My office will apply analytics tools that can determine common characteristics and meaningful patterns of fraud based on data from past allegations and known cases of fraud. We will apply these tools when reviewing business applications or existing data on beneficiaries for potential fraud or other suspicious behavior. With these predictive tools, we will increase our capability to identify suspicious patterns of activity in disability claims and prevent fraudulent applications from being

processed. During the remainder of FY 2014, we will test the value of these analytical tools in the disability process to determine their effectiveness in detecting and preventing possible fraud. If our tests determine that these tools will help us detect and prevent fraud, we plan to start implementing them as early as FY 2015.

3. **In your testimony, you highlight the work at the hearings level to employ data analytics tools. For instance, the hearings operation is able to determine when a particular Administrative Law Judge is paired with a particular claimant representative, if the approval rate is statistically different. What lessons have you learned from these initiatives? How will those lessons be applied to other stages of the disability process? How will you expand data analytics to improve the timeliness, accuracy, and consistency of decisions at all levels?**

Our Office of Disability Adjudication and Review has been increasingly successful in using data analytics as a part of a strategy to improve the disability adjudication process. This strategy includes capturing and analyzing data to find anomalies requiring further study, conducting focused reviews of anomalies, and then working with other Agency components to determine appropriate actions. These actions may include recommending policy changes, enhancing training and feedback to individual employees, and making referrals to our OIG.

These efforts have coincided with a significant drop in the percentage of "outlier" administrative law judges (ALJ), defined as those allowing greater than 85 percent or fewer than 20 percent of their cases. The percentage of outlier ALJs dropped from 20 percent in FY 2007 to 3.6 percent in FY 2013. In addition, as we improved training, feedback, and policies, we have seen a decline in the rate at which the Appeals Council grants review of ALJ decisions from 29 percent in FY 2007 to 19 percent in FY 2013. The Appeals Council has also been successful in using data analytics to increase the productivity of its employees and reduce the average age of cases pending review.

Acting Commissioner Colvin directed expansion of the hearings operation data analytics approach to other disability process areas to teach other components how to follow that data analytic model for making data driven decisions. Classes are underway for employees of the other components. The ultimate goal of this approach is to improve the accuracy, timeliness, and policy consistency of agency decisions.

The hearings operation model has taught us that we can use data analytics to discover patterns of activity and sequences of events that can be indicative of fraudulent actions. Members of my office have met with many different offices in the agency to discuss sequences of events that can help us identify fraud at different levels of the application process. The analytics tool we are developing will, in part, use the information we have gained from analyzing the events that occurred in the hearings operation to identify fraud and improve the accuracy of our disability decisions at all levels.

In addition to the hearings operations model that focuses on improvement of the disability adjudication process, the Acting Commissioner has also created a cross-component group that will target, identify and, where possible, prevent disability fraud using predictive data

analytics. She has also given the Chief Strategic Officer the lead to coordinate and improve data analytic efforts throughout the agency.

4. **How have you reached out to industry leaders and how do you plan to use their expertise when developing data analytics capabilities?**

Industry leaders are among the variety of information sources we leverage to evaluate emerging technologies. We have had many discussions, presentations, and demonstrations with industry leaders to refine our vision regarding data analytics capabilities within our agency. We use the information we get from these industry leaders to determine best-of-breed products and processes. We also reach out to other agencies to learn what products and vendors they have used, as well as to vendors for demonstrations of key capabilities of their products.

Over the last several months, we have met with industry leaders in data analytics to identify a tool that we can use in conjunction with our back-end Big Data environment to detect disability fraud. We have now identified a vendor we will work with to implement such a tool. By the end of FY 2014, we will determine if the tool could have identified the disability fraud events in New York, Puerto Rico, and West Virginia. Also by the end of FY 2014, we plan to be using this tool to identify the risk level of particular disability claims.

In addition, we are moving forward in developing a data analytics laboratory. In order to ensure we develop this laboratory using the standards and processes relied on in the data analytics industry, we have met with various industry leaders. We have and will continue to visit such laboratories, including the data analytics lab at the Centers for Medicare and Medicaid Services.

[Public Submissions for the Record follows:]

Coalition Against Insurance Fraud

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* * * * * * * * * *
Dennis Jay
Executive Director

A national coalition of consumers, government agencies and insurers dedicated to combating all forms of insurance fraud through public information and advocacy.

House Ways and Means Committee
Subcommittee on Social Security Hearing on
Preventing Disability Scams
February 26, 2014

Dennis Jay
Executive Director
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Chairman Johnson and members of the Social Security subcommittee, I am Dennis Jay, executive director for the Coalition Against Insurance Fraud. I am submitting the following statement in response to the subcommittee's hearing on disability fraud.

The Coalition is a broad-based national alliance of insurers, consumer groups and government organizations dedicated to combating all forms of insurance fraud through public education, research and advocacy. We are recognized as one of the leading anti-fraud organizations in the nation. The Coalition works closely with legislators, insurance regulators and federal and state agencies, including the Department of Health and Human Services and Department of Justice. We seek to strengthen efforts to target fraud against America's insurance systems, whether they are private or public programs.

This hearing opens the door for the Ways and Means Committee to seriously look at how to identify and combat disability fraud schemes. The Coalition appreciates the opportunity to comment and help the subcommittee focus on key issues that will enhance anti-fraud efforts. We suggest the federal government consider:

- **Adopting some of the techniques and strategies employed by private insurers.** The private sector increasingly has become more adept in countering anti-fraud schemes, whether they involve claimants, medical providers or others. Some of the disability insurers we work with have volunteered their time to share techniques and strategies with their government counterparts. Private insurers have created specific structures to look at internal claims to help identify fraud schemes before suspect claims are paid. Such anti-fraud infrastructures may have methods that are transferrable to government programs, and should be explored.

- **Using new technologies to identify suspected claims.** An increasing number of payers — including private insurers, Medicare and state health programs — are employing emerging technologies such as predictive analytics, pattern recognition and social media scanning to help identify fraudulent activity at the outset of the claims process. This helps stop schemes before the insurance money is paid out and often gone for good.

• **Sharing anti-fraud intelligence.** The federal government should consider creating a mechanism to work closely with private insurers to share intelligence and data on suspect claims. The Health Fraud Prevention Partnership (HFPP) is a prime model of such a public-private partnership. The Coalition worked with HHS and others to create the HFPP to work collaboratively to combat health insurance fraud. The public and private sectors recognize that providers who defraud Medicare and Medicaid also likely target private health insurers. The HFPP was created in 2012, and already has shown a marked success in sharing intelligence and strategies that are helping to hone anti-fraud programs. A similar public-private partnership on disability fraud could help prevent and reduce fraud within Social Security and other federal disability programs.

• **Sponsoring aggressive public outreach and awareness.** Educating consumers about the extent and severity of fraud along with creating awareness of the penalties for committing disability fraud will help deter the crime and encourage people to report fraud. Existing outreach programs by the public and private sectors have raised consumer knowledge about fraud, and are lowering the public's tolerance for this crime. Both of these successes have aided prevention and detection efforts. The same could be done on a national level for disability fraud. In addition, the Social Security Administration may wish to study the Senior Medicare Patrol program as a model for educating consumers and increasing reporting of disability fraud.

• **Creating robust reward programs**. Several states have established reward programs that encourage consumers to join in the anti-fraud effort. These programs have proven successful in identifying and targeting fraud schemes. One key to the reward programs is that they tend to be robust in their implementation. The mere existence and promotion of such programs create deterrence to committing fraud. A reward program targeting disability schemes will encourage consumers to become more engaged in anti-fraud efforts.

• **Strengthening penalties against providers.** Stronger penalties against medical providers are essential to combatting disability fraud. The recent Long Island Rail Road disability fraud cases were facilitated by medical providers who were either party to or masterminds of the schemes. Corrupt providers seem to believe that the chances of getting caught are slim, and that even if their schemes are detected, prosecutions are rare and penalties are minor.

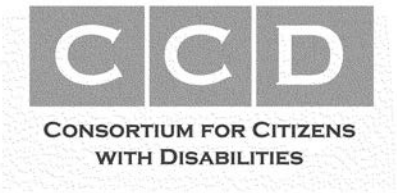
The Coalition strongly supports efforts to target dishonest healthcare providers who use their medical licenses to commit fraud. Holding a medical license is a privilege bestowed by the state. If a provider abuses that privilege, then the license should be revoked. In addition to strengthening criminal and civil fraud penalties, we suggest that the Office of Inspector General establish stronger ties with state medical boards to ensure that licensees who defraud Social Security are disciplined.

• **Reviewing federal statutes.** A thorough review of all applicable statutes should be conducted to uncover potential obstacles to investigating disability applications and claims. Our experience in conducting such reviews at the state level has helped facilitate law enforcement's efforts to combat fraud.

In summary, fully functioning public and private disability programs provide an essential service to Americans. These programs provide needed assistance to those who suffer chronic illness and injury, and give peace of mind to all by helping protect their financial security. Policymakers and program sponsors should do all they can to ensure the financial viability of these programs, keep costs in check and promote fairness.

We commend the subcommittee for taking up this issue, and offer to assist the federal government every way we can.

Consortium for Citizens with Disabilities



Statement for the Record

Hearing on Fighting Social Security Disability Fraud

Subcommittee on Social Security
House Committee on Ways and Means

February 26, 2014

Submitted on behalf of the Co-Chairs of the Consortium for Citizens with Disabilities Social Security Task Force:

Jeanne Morin, National Association of Disability Representatives
TJ Sutcliffe, The Arc of the United States
Rebecca Vallas, National Organization of Social Security Claimants' Representatives
Ethel Zelenske, National Organization of Social Security Claimants' Representatives

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The Consortium for Citizens with Disabilities (CCD) is a working coalition of national organizations working together to advocate for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of the 57 million children and adults with disabilities in all aspects of society. The CCD Social Security Task Force focuses on disability policy issues in the Title II disability programs and the Title XVI Supplemental Security Income (SSI) program.

The Co-Chairs of the CCD Social Security Task Force submit this Statement for the Record of the February 26, 2014, House Ways and Means Social Security Subcommittee hearing on Fighting Social Security Disability Fraud.

Approximately 100 former police officers, firefighters and others were recently indicted in New York City for allegedly fraudulently obtaining Social Security Disability Insurance benefits. The allegations are extremely troubling, and if true, these individuals' actions are nothing short of deplorable.

We condemn any misuse of the Social Security disability programs. Any individual who seeks to abuse vital programs like Social Security does so at the expense of the millions of

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disabled workers for whom benefits provide essential economic security -- and must be brought to justice.

We encourage anyone who suspects abuse of the Social Security disability programs to report it via Social Security's hotline 1-800-269-0271 or online at www.oig.ssa.gov.

At the same time, we must take care not to paint Social Security's disability programs with the brush of the few who aim to defraud it, without putting them in the context of the millions of individuals who receive benefits appropriately and for whom Social Security is a vital lifeline.

Social Security's disability programs are a core component of our nation's Social Security system, which keeps millions of hardworking Americans and their families out of poverty. Extremely strict eligibility requirements mean that fewer than four in ten applicants are approved for disability benefits, even after all stages of appeal. Demonstrating eligibility requires extensive medical evidence, and many individuals are denied benefits despite significant disabilities and chronic illnesses. Benefits are modest but vital – averaging just over $500 per month for Supplemental Security Income and approximately $1,130 per month for Social Security Disability Insurance (SSDI). For many, disability benefits make it possible to secure stable housing and purchase food, life-sustaining medications, and other basic necessities. Disability benefits can be the difference between life and death for many Americans.

The SSDI program provides vital and much-needed economic security and access to health care for individuals whose impairments are so severe that they preclude substantial work. We recognize the importance of ensuring that Social Security disability payments are only made to people who are entitled to receive them and that the amount of the payments are accurate. The Social Security Administration (SSA) does a good job of ensuring that payments are accurate. Acting Commissioner Colvin pointed out in her testimony at the February 26, 2014 Subcommittee hearing that SSA has one of the lowest error rates in the government, with a less than 1% rate of inaccurate payments for the SSDI program. Although this low error rate is good compared to other government agencies and programs, we believe that more needs to be done to prevent overpayments and are concerned that recent appropriations decisions will undermine these efforts.

The co-chairs of the CCD Social Security Task Force strongly support the Social Security Fraud and Error Prevention Act of 2014 (H.R. 4090), introduced on February 26, 2014, by Subcommittee Ranking Member Becerra, and co-sponsored by Representatives Levin, Rangel, Doggett, Thompson, Crowley and Schwartz. H.R. 4090 would provide SSA with the tools it needs to prevent fraud before it happens, ensure that the agency has adequate administrative resources to implement critical safeguards, and expand the agency's authority to investigate and punish fraud. We support this approach to ensure program integrity and believe that it comports with CCD's Disability Program Reform Principles (available at http://www.c-c-d.org/fichiers/CCD_Disability_Program_Reform_Principles3-2012.pdf) as well as CCD's longstanding positions, as set forth in previous testimony and statements for the record submitted to this Subcommittee.

SSA Requires Adequate Resources for Program Integrity

SSA must have sufficient resources to meet the service needs of the public and ensure program integrity. SSA's administrative budget is only about 1.4 percent of benefits paid out each year. With the baby boomers entering retirement and their disability prone years, SSA is experiencing dramatic workload increases at a time of diminished funding and staff. For the two years prior to fiscal year (FY) 2014, Congress appropriated $421 million less for SSA's program integrity efforts (such as medical and work continuing disability reviews and Title XVI redeterminations) than the Budget Control Act of 2011 (BCA) authorized. Over the three years prior to FY 2014, SSA received nearly $1 billion less for its Limitation on Administrative Expenses (LAE) than the President's request, and lost over 11,000 employees since FY 2011.

We are encouraged that the recently enacted budget bill for FY 2014 includes full funding of the FY 2014 BCA level for SSA's program integrity reviews. This will allow SSA to significantly increase continuing disability reviews (CDRs).

Adequate LAE is essential to preventing service degradation and ensuring that SSA can provide timely and accurate payments and perform necessary program integrity work, including:

• **Disability claims processing.** Adequate resources support claims processing and disability determinations at the initial levels so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Inadequate staffing at field offices and state Disability Determination Services (DDS) leads to increased workload at the hearing level. Disability claims may be less thoroughly developed, leading to incorrect denials of benefits and more appeals. Additionally, the significant progress made in recent years at the hearing level in reducing average wait times until hearings and shrinking the disability claims backlog has eroded due to the lack of needed resources.

• **Pre-effectuation and continuance reviews[1] of DDS determinations**. As required by the Social Security Act, SSA conducts pre-effectuation reviews of at least half of all DDS initial and reconsideration allowances for Title II (Social Security) and Title XVI (Supplemental Security Income) adult disability benefits. SSA also reviews a number of DDS Title II CDR determinations that result in continuation of benefits. For every dollar spent in FY 2011 on these reviews SSA estimates a lifetime savings of about $11 in Title II and Title XVI benefits.[2]

• **Disability Determination Services quality review**. SSA has implemented multiple levels of quality review at the DDS level. For example, SSA requires all DDSs to have an internal quality assurance function, and also operates an Office of Quality Performance (OQP) which conducts quality assurance reviews of samples of initial and reconsideration determinations of the DDSs.

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[1] "Pre-effectuation" refers to reviews conducted before benefits are authorized to be paid. Accordingly, "continuance reviews" and "post-effectuation reviews" are conducted after benefit authorization.
[2] Social Security Administration, June 27, 2013, Annual Report on Social Security Pre-Effectuation Reviews of Favorable State Disability Determinations, Fiscal Year 2011.

• **Review of Administrative Law Judge (ALJ) decisions in a manner consistent with law.** While ALJs have qualified decisional independence, they are required to follow SSA laws, regulations and policies. SSA has implemented a quality review process for ALJ decisions. In FY 2011, the SSA Office of Disability Adjudication and Review (ODAR) established a new Quality Review (QR) initiative and opened four new Branches in the Office of Appellate Operations. The QR Branches review a computer-generated sample of unappealed favorable ALJ decisions (over 7,000 in FY 2012), pre-effectuation, and then refer cases to the Appeals Council for possible review. If the Appeals Council accepts review, it can remand or issue "corrective" decisions, which may involve changing the favorable ALJ decision to a "partially" favorable decision or to an unfavorable decision. There is also some post-effectuation review of ALJ decisions. While these ALJ decisions cannot be changed, post-effectuation review enables targeted examination of compliance with agency policies and policy guidance and additional training as needed to ensure high quality decision-making.

• **CDRs and redeterminations.** SSA is required by law to conduct CDRs in all cases where the beneficiary's condition is expected to improve, or where improvement is considered possible, to ensure that benefits are paid only as long as the individual remains eligible. SSA estimates that every $1 spent on medical CDRs saves the federal government $9, but reports a current backlog of 1.3 million CDRs. We are hopeful that the additional resources in the FY 2014 budget will allow SSA to significantly increase the number of medical and work CDRs and SSI redeterminations it is able to conduct. Work CDRs are discussed in more detail below.

• **Cooperative Disability Investigations (CDI).** SSA and the Office of the Inspector General (OIG) jointly established the CDI Program in 1998. Twenty-five CDI units across the U.S. investigate individual disability applicants and beneficiaries, as well as potential third parties who facilitate disability fraud. SSA or DDS personnel make referrals to a CDI unit for investigation, and CDI units also accept reports from the public via a toll-free telephone hotline and an online web form. Investigations uncovering fraud or attempted fraud can result in a denial, suspension, or termination of benefits, civil or criminal prosecution, and/or imposition of civil monetary penalties, and/or sanctions on claimant representatives for violation of SSA's ethical standards. Since the program's inception in FY 1998, CDI efforts have resulted in $2.2 billion in projected savings to SSA's disability programs, with more than $860 million just over the last three years, as Acting Commissioner Colvin noted in her testimony for this hearing.

Delay in Processing Work CDRs Due to Inadequate Staffing Results in Significant Overpayments and Hurts People with Disabilities

An SSDI beneficiary who goes to work is required to report his or her earnings to SSA so that a work CDR can be performed and benefits can be adjusted when appropriate. If the earnings report is processed in a timely manner, the benefits are adjusted and no overpayment results. However, if SSA lacks the staff to process earnings reports in a timely manner, the beneficiary is likely to receive an overpayment. The longer the delay in processing, the larger the overpayment will be. According to January 2012 testimony by Acting Commissioner Colvin before this Subcommittee,[3] SSA has allocated additional

[3] "Securing the Future of the Social Security Disability Insurance Program: Combating Waste, Fraud, and Abuse," Subcommittee on Social Security, House Committee on Ways and Means, January 24, 2012.

resources to work CDRs, targeting cases with the oldest earnings reports – those more than a year old. During the hearing, she stated that it takes more than 270 days on average for SSA to complete a work CDR. Every month that passes from the time that a beneficiary reports earnings before a work CDR is completed increases the likelihood of a large overpayment.

This delay in processing of earnings reports often has a very detrimental impact on people with disabilities. When beneficiaries faithfully notify SSA of earnings or other changes that may reduce their benefit payment amounts, as noted above, it may be months or years before SSA sends an overpayment notice to the beneficiary, demanding repayment of sometimes tens of thousands of dollars of accrued overpayments. It is shocking to beneficiaries to receive these notices, when they reasonably assumed that SSA had processed the information they submitted, and it is challenging, if not impossible, for someone subsisting on benefits alone to repay the overpayments. Many individuals with disabilities are wary of attempting a return to work out of fear that this may give rise to an overpayment, resulting in a loss of economic stability and health care coverage upon which they rely.

SSA needs to develop a better reporting and recording system and promptly adjust benefit payments –thus preventing these overpayments. It is important to note that, in and of themselves, **overpayments do not indicate fraud or abuse as beneficiaries are encouraged to work if they are able.** The problems arise when reported earnings are not properly recorded and monthly overpayments are not properly adjusted. SSA must have adequate resources and staffing to allow the agency to reduce both the backlog and processing time of earnings reports.

* * *

Conclusion

The Social Security Administration works hard to ensure program integrity, but it requires adequate resources to do so. It has been deprived of adequate administrative resources to conduct necessary program integrity work for several years. We look forward to working with Congress to enable the Social Security Administration to ensure that benefits are paid to the right person, in the right amount, and at the right time — and to implement the array of critical safeguards that exist in current law.

IBM

Written Statement for the Record
Committee on Ways and Means, Social Security Subcommittee
United States House of Representatives

For a Hearing on: Improper Payments in Social Security Disability Programs
Held on February 26, 2014

Andrew Maner, Managing Partner, US. Federal, IBM Global Business Services

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

Than you for the opportunity to provide IBM's comments on how the Social Security Administration (SSA) can reduce improper payments and improve operations of SSA disability programs.

1 Introduction

Over the past 75 years, IBM has worked as a trusted partner with SSA in implementing many generations of leading-edge technology. From the new IBM Type 77 Collators (developed by IBM specifically for the new Social Security Board) in the1930s, through SSA's first electronic computing device (the IBM 604 Electronic Calculator) and first large-scale computer (the IBM 705) in the 1950s, and SSA's workhorse case processing system (the IBM AS400/Content Manager) in the 1990s, all the way up to the first uses of modern analytics and predictive modeling after the turn of the 21st century (the Quick Disability Determination [QDD] and Compassionate Allowances [CAL] projects), SSA has turned to IBM for innovative solutions in its most difficult challenges.

IBM encourages greater emphasis, focused funding, and accelerated information technology (IT) and systems modernization through greater use of analytics. By employing "scoring engines" and other data analytics, like those developed for QDD and CAL, the quality, speed, and accuracy Social Security Disability Insurance (SSDI) and Supplemental Security Incomes (SSI) decisions and claims review can be greatly improved. Analytics tools will also help identify improper payments, and patterns of fraud and abuse, to alert investigators and provide deterrence.

Over the last six months, IBM has engaged with SSA technology staff and thought leaders on the most effective use of predictive analytics for detection of disability improper payments and cognitive computing, such as modifying, for disability examiners and ALJs, IBM's Watson decision support system. Engagements have included:

- Sponsoring an industry briefing in August 2013 at SSA Woodlawn,
- After extensive discussion with SSA thought leaders, submitting a proposal to establish an SSA/industry/academic Virtual Center for Program Integrity, and
- In coordination with the new SSA Deputy CIO, developing an advanced technology workshop for SSA technology and program staff, including a view of SSA operations in 2030 that includes cognitive computing.

IT-enabled Analytics

The disability determination process can be long and difficult. Complex eligibility rules and many layers of review with multiple handoffs make the disability programs costly to implement and difficult to manage.

According to recent Congressional hearings, including this hearing, inconsistencies in decision outcomes erode public faith in the programs. Improving program consistency, speed, and accuracy will reserve limited funds for those applicants most in need.

Data Predictive Modeling

Creating a **predictive modeling system** to support the SSA disability decision process at the Examiner and Administrative Law Judge (ALJ) levels would:

1. Allow SSA to analyze the data from decisions made by Examiners and ALJs;
2. Provide a foundation of institutional knowledge across all offices, states, and regions;
3. Significantly improve Examiner and ALJ decision quality and consistency; and
4. Predict fraud and eligibility, and the value of streamlined process improvements.

SSA could benefit from the experience of the Center for Medicare and Medicaid Services (CMS) in standing up its Center for Program Integrity (CPI) Fraud Prevention System (FPS), which, during Fiscal Year (FY) 2012, its first year of operation, prevented, or identified for follow-up, $115.4 million in improper payments through the use of predictive modeling analysis. The FPS is an increasingly effective primary tool of CMS CPI as part of the Health Care Fraud and Abuse Control (HCFAC) program. HCFAC resulted in recovery of $4.2 billion in FY2012.

Predictive modeling can improve today's Examiner and ALJ decisions. However, the larger challenge of overhauling the examiner and ALJ systems can be accomplished through the use of a cognitive computing system, which would transform the entire SSA disability determination process by increasing accuracy, consistency, and speed, and saving billions of dollars over time.

Watson™ Decision Support in Disability Determination

Today, one of SSA's biggest challenges is its disability claims processing systems, a challenge reflected clearly in the Agency Strategic Plan, Strategic Goal #1, to Deliver Quality Disability Decisions and Services. Addressing this goal, SSA intends to reduce waiting time for decisions and reduce case backlogs, improve disability policies, procedures, and tools, and expedite cases for the most severely disabled. (See Agency Strategic Plan, Securing Value for America, Fiscal Years 2013-2016, Social Security Administration. http://www.socialsecurity.gov/asp/plan-2013-2016.pdf) IBM is ready to help SSA achieve this strategic goal by deploying the newest and most innovative tools available.

IBM® Watson™ is IBM's leading-edge technology that has been successfully adapted to address important business issues in many industries, including medicine and healthcare. Although Watson™ initially made a name for itself by defeating the top Jeopardy! Champions on television, this technology has been further refined and improved, resulting in its deployment in a wide variety of more practical uses. Watson™ has addressed the challenges of cancer diagnosis and treatment at Memorial Sloan Kettering Cancer Center, Cleveland Clinic, and at the M.D. Anderson Cancer Center, and improved utilization management at WellPoint. These, and other current uses, are described in more detail in Section 4. Given the strong similarities between the SSA disability decision process and the processes (such as medical diagnosis) that Watson™ addresses now in the real world, IBM strongly believes that Watson™ can address current issues with the SSA disability determination process to improve the consistency, accuracy, and speed of its disability determinations. IBM® Watson™ represents an initial step into a new era of cognitive computing. Examples of the revolutionary new capabilities that can be applied to the SSA disability decision process include:

- Natural Language (Processing (NLP)—which can help decision makers understand the complexities of the mass of structured and unstructured data associated with disability claims

- Panels of responses—based on the relevant evidence gleaned from the relevant data within the vast troves of SSA data

IBM® Watson™ does not make decisions. Rather, it serves as an unbiased advisor to decision makers, using the power of cognitive computing to augment the decision makers' own capabilities. IBM® Watson™ is not a replacement for any system currently operating and generating data at SSA—it is a cognitive learning intelligence that can take the current information and bring together reference material, historical and predicted trends, and enable insights that are possible only from this revolutionary new technology. It can transform the disability determination process by helping SSA to make decisions more consistent, more accurate, and faster.

2 How Watson™ can be Applied to SSA Disability Determination Operations

As SSA Deputy Commissioner, Bill Zielinski, noted in his testimony, SSA has much of which to be proud for the sheer volume of operations that it supports and the valuable assistance it provides to disabled Americans. The SSA disability determination process, however, remains complicated and time-consuming due to intricate eligibility rules, the inherent subjectivity of the evaluation, and other factors. In addition, processing disability claims can involve many layers of review with multiple hand-offs from one person to another, which make the disability programs costly to administer. Other major problems with SSA's current system for determining eligibility for disability benefits include:

- The length of time it takes to process a claim to completion
- The variability in decision outcomes among different state Disability Determination Services (DDSs), among different Office of Disability Adjudication and Review (ODAR) offices, and between DDSs and ODAR
- The high rate at which decisions are reversed on appeal
  [See *Improving the Social Security Disability Decision Process,* The National Academies Press, 2007. http://www.nap.edu/catalog.php?record_id=11859]

These problems have resulted in high case backlogs, high case processing costs, and loss of confidence in SSA disability programs. The good news is that these problems can be solved. New and emerging technologies can extend the capabilities of Examiners and ALJs and the services they support.

IBM® Watson™ is a cognitive computing system that can be used in an advisory capacity to assist and support the SSA disability decision process. Cognitive computing systems learn and interact naturally with people to extend what either man or machine could do on their own. They help human experts make better decisions by penetrating the complexity of unstructured information and Big Data. IBM® Watson™, by ingesting a vast array of information—claim documents, determination process library, legal reference material, medical evidences, etc. can help reduce backlogs and accurately provide a confidence level with any decision made to approve, disapprove, or request more information at any point in the process. Additionally, data modeling can provide the disability decision makers at all levels with insights into best practices, and quickly identify decisions that are outside of the best practices.

This capability can use the existing systems already serving SSA, and not require replacement or redundancy; however, IBM® Watson™ could help identify existing redundancy in systems or processes. A Watson™ cognitive computing-based decision support system can provide the foundation for more consistent, accurate, and timely disability determinations.

Provide Recommendations to Users Based on Extensive Data

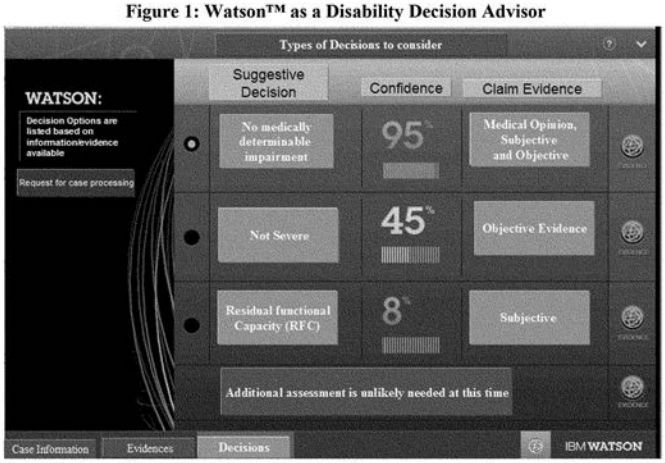
A Watson™ cognitive computing decision support systems uses Natural Language Processing (NLP) rapid analysis to interact naturally with SSA users and greatly expand the amount of information that a decision maker can take into consideration. It can help users make better informed decisions by harnessing the vast and complex data and information that is available within SSA, as well as from external sources. The structured data in SSA and external systems, plus the extensive unstructured data

within medical and other records submitted to SSA and other internal and external materials, can be assessed by SSA staff for decisions. A standard approach for considering the available information results in decisions that are more consistent across the locations and the individuals who are involved in making decisions.

Provide Alternatives and Confidence Ratings

A Watson™ cognitive computing decision support system understands concepts by decomposing expressions of an idea through Natural Language Processing (NLP) and then combining the results with context and the probability that certain terms in the passage convey certain meanings. Human confidence is proportional to the evidence that supports decisions. Similarly, a Watson™ system determines probabilities for disability decision points and uses reasoning algorithms to test hypotheses. It establishes a level of understanding and decomposes the decision against its probable intent. It can recompose the elements of the decision in various ways, each of which can be tested. The combinations can then be used to drive new discovery and insight, and to provide improved insight in future cases in ways that human never thought of. As illustrated in Figure 1, Watson™ advisor evaluates evidence from multiple claims against the SSA legal reference library and suggests decisions with a confidence level associated with each decision.

Figure 1: Watson™ as a Disability Decision Advisor



Embed Continuous Improvement in the Process

A Watson™ disability determination support system improves over time as it builds knowledge and learning, including disability terminology, processes, and its users' preferred methods of interacting. The system includes key disability domain expertise and adds to its knowledge base over time.

Reduce the Length of Time it Takes to Process an Application and the Backlog of Applications

Watson™ can assist adjudicators to develop insights based on analysis of large sets of free text from medical records and other sources (for example applicant self-reported and claims data, disability literature, policy documents). These insights inform the disability evaluation and can be used to help the

decision maker determine pertinent case facts and findings and, ultimately, whether an application should be approved or denied. These insights can help SSA staff determine areas to focus on and what problems to focus on with an individual applicant. They provide suggestions about what alternative options to consider.

Standardize Outcomes

A Watson™ decision support system can help reduce the variability in decision outcomes among different offices, or even different decision makers by using powerful NLP, machine learning, and analytic capabilities to help make case findings and to identify problems that should be addressed and resolved in making decisions. The user can identify and view the source data relied upon by the system to make recommendations. Adjudicators can thus determine the best course of action for a given applicant.

Reduce the Rate of Reversal on Appeal

Many unfavorable initial disability determinations are overturned on appeal and approved. The initial decision could be enhanced to improve accuracy by leveraging the capability to analyze an applicant's entire record for data and other information that is relevant to the case findings and conclusions, but may not have been fully considered by an earlier decision maker. The system determines the most important areas of focus for each case. Identifying, aggregating, and displaying pertinent data allows SSA staff to focus on the key evidence and information most relevant to the case.

Other Potential Benefits

A Watson™ disability determination system can use powerful NLP, machine learning, and analytic capabilities to help with other important disability case processing goals. For example;

- Rapid access to and assimilation of complete case data leading to identification and analysis of patterns and circumstances that lead to divergent findings and conclusions and that contribute to divergent decisions at different levels of review.
- Prioritization and triage of applications to improve case processing efficiency. Quick Disability Determination and Compassionate Allowance are examples of ways to triage the incoming applications. A Watson™ solution could expand the triage approaches to include identification of high potential for denial or potential problematic cases for alternative processing.
- More reliable methods for identifying applications that may be fraudulent, applicants who may benefit from return to work programs, and/or decisions that should be subject to quality review or other follow-up.
- Methods to identify potential improper payments, for example, by uncovering individuals or organizations that submit similar or identical medical reports or who are involved with unusually large numbers of allowance cases.

3 How Does IBM® Watson™ Work?

IBM® Watson™ identifies patterns in diverse and complex information sources to gain critical insight and to enhance decision making. Watson™ is based on Deep Question-Answering (DeepQA) technology that understands natural human language. It can analyze an almost limitless range of topics and make informed judgments about those topics by understanding vast amounts of structured and unstructured data. For healthcare providers, Watson™ can provide critical and timely information to help medical staff diagnose and treat patients. The same DeepQA technology can be applied to provide critical and timely information to help SSA staff make decisions in the disability determination process.

Innovations

The link below illustrates bending the knowledge curve with IBM Watson™:

- http://www.youtube.com/watch?v=fl-K_KmUSbQ

Watson™ analyzes a "corpus" or body of data that consists of unstructured information such as text

books, guidelines, how-to manuals, FAQs, benefit plans, electronic health records, and news. Watson™ ingests the entire corpus to curate content into a form that can be analyzed very rapidly. It focuses on whether the corpus content is appropriate, and sifts out information that is out of date, irrelevant, or derived from potentially unreliable sources.

Watson™ answers questions by decomposing the question, determining potential responses in the corpus, and then examining the responses in hundreds of ways. It determines a degree of confidence in its interpretation of the question and potential answers. Figure 2 illustrates the process that Watson™ uses to respond to a question.

Cognitive Computing

A Watson™ cognitive computing system mimics how humans reason and process information. Unlike traditional computers programmed to calculate rapidly and perform deterministic tasks, it can analyze information and then draw insights from that analysis by using probabilistic analytics. It learns from its own interactions with data, in effect continuously reprogramming itself.

Watson™ can transform how organizations think, act, and operate by:

- Using NLP to assess and evaluate language over unlimited topics and then making informed judgments
- Combining natural language processing, hypothesis generation and evaluation, and dynamic learning for a powerful, fast, and accurate solution
- Understanding complex unstructured data
- Applying advanced analytics to weigh and evaluate responses
- Learning based on outcomes to get smarter with each iteration and interaction

Natural Language Processing

Traditionally, digitized information has been structured and stored in tables or searchable and accessible cells in databases. In addition to this structured data, 80% of the world's data today is unstructured. Within healthcare, some of the most valuable information in Electronic Medical Records (EMRs) is captured in clinicians' notes. NLP allows for querying this text-based information from medical records, policy documents, and any other relevant text.

Data Corpus

It can take a long time for humans involved in disability determinations to read and synthesize case materials to make findings, conclusions, and a decision on an application. Analyzing the complete corpus empowered by Watson™ cognitive computing technology can reduce the time it takes to review a case by providing relevant and up–to-date insight gleaned from analyzing the corpus.

Iterative Internal Questions and Answers to Refine Results

Watson™ cognitive computing allows an iterative question and answer loop to provide more refined information with each iteration. This iterative process refines the system's confidence in a particular set of answers or suggestions for future queries.

Machine Learning

Watson™ machine learning allows the system to learn from the feedback from its users. It adapts quickly to the insight from users about the specific populations they serve and continuously improve the responses that provides.

Watson™ Technology to Improve SSA Disability Process

Watson™ has transformational technologies for deep unstructured question and answer analysis, content analysis, and evidence-based reasoning that elevate the power of structured data analytics. NLP and machine learning can leverage SSA's unstructured disability claims and beneficiary information, as well as information from external sources.

Innovations

SSA & IBM: 75 Years of Innovations

- 1930s IBM Type 77 Collators
- 1950s IBM 604 Electronic Calculator
- 1990s IBM AS400/Content Manager
- 2000s Quick Disability Determination (QDD) and Compassionate Allowances (CAL) projects

Benefit to SSA: IBM provides leading edge technologies help SSA meet operational goals

Queries and systematic analysis can assess unstructured data such as medical and expert notes, journal articles, and disability literature. A specific Watson™ solution for SSA can be designed to handle questions that produce a small set of prioritized answers—for example, concerning a beneficiary's disability circumstances—that can be explored to further understand the extent of disability and the evidence that supports it. SSA staff use their judgment to evaluate the responses provided by the Watson™ system. Analysis of large volumes of unstructured text to support the decision making process can potentially reduce the time required to make decisions and improve the consistency of the decisions.

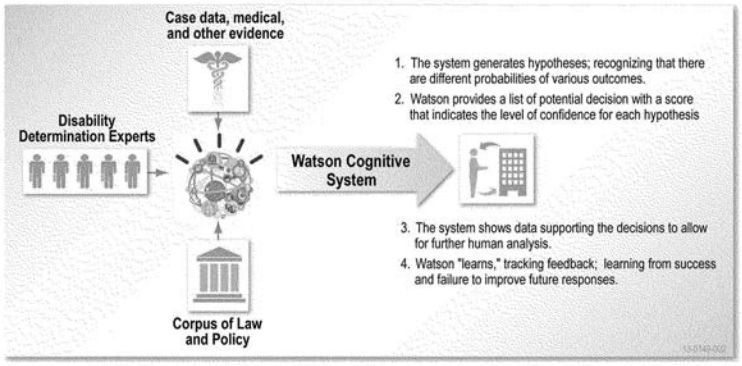
The *Watson™ overview* in Figure 3 suggests the Watson™ advisor interaction with many business users and interface with existing applications and services, and is envisioned to provide its own services for other applications. Sources of internal SSA and external information that could be included in a disability determination solution are listed in Table 1.

IBM Watson™ has advanced unstructured data analytics, NLP, and work-load optimization. These capabilities can be applied to answer disability determination queries based on the specific case facts along with a body of knowledge in the corpus. Watson™ can learn from past cases and guidelines and develop increasingly sophisticated expertise in disability determinations. Understanding the meaning and context of human language and rapidly processing information to find precise answers to complex questions can transform how computers support SSA programs.

Table 1: Structured and Unstructured Information for Watson™ Analysis

Disability Determination Reference Materials	Disability Determination Case Materials
Regulation Basis Code (RBC)	Disability Case Processing System (DCPS) data
Applicable Law and Regulations	DDS Case Processing Data (Iron Data and MIDAS)
Social Security Rulings	eCAT data
Listing of Impairments	Applicant background data (e.g., age, employment history, marital status, financial resources)
Applicable case law	Applicant disability data (e.g., impairments, treatment, tests, limitations)
SSA operating instructions and procedures	Applicant work history, education, and training
Medical Dictionaries	Other information related to the alleged disability
Disability Dictionaries	Other disability benefits
Historical Case Data	Medical records, exams, test results
	Case notes

Figure 3:Watson™ Overview



4 Examples of Watson™ in Healthcare

Healthcare has been one of the focus industries for the initial Watson™ solutions. Since its introduction, Watson™ has become 240% faster and 75% smaller. Watson™ can now run on a single server, which is the size of four stacked pizza boxes, onsite or through the cloud. There are many use cases for using Watson™ cognitive computing to improve healthcare research and delivery. Some early implementations of Watson™ in healthcare are the WellPoint utilization management solution, the Memorial Sloan-Kettering cancer diagnosis system, and systems at the Cleveland Clinic, and the MD Anderson Cancer Clinic.

Innovations

The link below illustrates the IBM Watson™ Demo for Oncology Diagnosis and Treatment:

- http://www.youtube.com/watch?v=HZsPc0h_mtM

WellPoint Utilization Management

IBM worked with WellPoint to develop a new approach to utilization management (UM): using the cognitive system IBM® Watson™ to provide approval suggestions to nursing staff based on clinical and patient data. WellPoint trained Watson™ with 18,000 historical cases. The UM system uses hypothesis generation and evidence-based learning to generate confidence-scored recommendations that help nurses make decisions.

The project started with a pilot in which WellPoint used Watson™ for 1,500 real-life cases, with very favorable results. Less than 1 year after beginning the pilot, the system went into production at five provider offices. *"The power of Watson™ to bring information and data together, [and] make it relevant where decisions are being made, turns it into knowledge at the point where it can make a difference,"* says Lori Beer, WellPoint executive vice president.

Benefits that WellPoint has realized include:

- Nurses make faster UM decisions about treatment requests
- Accelerate healthcare preapprovals, which can be critical when treatments are time-sensitive
- Incorporate more information (unstructured data) in the streamlined decision process

Memorial Sloan-Kettering Cancer Center

Memorial Sloan-Kettering Cancer Center (MSKCC) worked with IBM® to develop a solution for cancer

diagnosis. Beginning with breast and lung cancers, the solution consolidates clinical expertise, molecular and genomic data, and a vast repository of cancer case histories. *"Watson's capability to analyze huge volumes of data and reduce it down to critical decision points is absolutely essential to improve our ability to deliver effective therapies and disseminate them to the world,"* says Dr. Craig Thompson, president and CEO of MSKCC.

The solution includes supporting evidence with every suggestion, both to provide transparency and to aid in the doctor's decision-making process. Watson™ points out areas in which more information is needed and updates its suggestions as new data is added. Ultimately, Watson™ is expected to facilitate access to the best of oncology's collective wisdom. *"What Watson™ is going to enable us to do is take that wisdom and put it in a way that people who don't have that much experience in any individual disease can have a wise counselor at their side at all times and use the intelligence and wisdom of the most experienced people to help guide decisions,"* says Dr. Larry Norton, deputy physician-in-chief for breast cancer programs and medical director for MSKCC.

Benefits that Memorial Sloan-Kettering has achieved include:

- Support for evidence-based suggestions for oncologists' decisions
- Incorporates patient data and massive volumes of medical literature, including journal articles, physicians' notes, and NCCN guidelines and best practices to provide recommendations
- Continued improvement as new oncology techniques, treatments and evidence are developed

Innovations

The link below illustrates the IBM Watson™ and WellPoint:

- http://www.youtube.com/watch?v=_TNE5uMH_q4

Cleveland Clinic Lerner College of Medicine of Case Western Reserve University

After a year-long research collaboration with faculty, physicians and students at Cleveland Clinic Lerner College of Medicine of Case Western Reserve University, IBM Research has unveiled two cognitive computing technologies that can be used by Watson, and are expected to help physicians make more informed and accurate decisions faster and to cull new insights from electronic medical records (EMR). The projects known as "WatsonPaths" and "Watson™ EMR Assistant" will create technologies that can be used by Watson™ in the domain of medicine.

With the WatsonPaths project, IBM scientists have trained the system to interact with medical domain experts in a way that's more natural for them, enabling the user to more easily understand the structured and unstructured data sources the system consulted and the path it took in offering an option. The Watson™ EMR Assistant project aims to enable physicians to uncover key information from patients' medical records, to help improve the quality and efficiency of care.

"*Through our research collaboration with Cleveland Clinic, we've been able to significantly advance technologies that Watson™ can leverage to handle more and more complex problems in real time and partner with medical experts in a much more intuitive fashion. These are breakthrough technologies intended to assist future versions of Watson™ products*." said Eric Brown, IBM Research Director of Watson™ Technologies.

University of Texas MD Anderson Cancer Clinic

The MD Anderson Cancer Clinic uses the IBM Watson™ cognitive computing system for its mission to eradicate cancer. Following a year-long collaboration, IBM and MD Anderson will showcase a prototype of MD Anderson's Oncology Expert AdvisorTM powered by IBM Watson. Watson's cognitive computing power is being leveraged to help patients by enabling clinicians to uncover valuable insights from the cancer center's rich patient and research databases.

Innovations

The link below illustrates IBM's Breakthrough: Watson™ May Help Beat Cancer:

- http://www.youtube.com/watch?v=HkEOJnn_zlg

MD Anderson's Oncology Expert Advisor powered by IBM® Watson™ is designed to integrate the

knowledge of MD Anderson's clinicians and researchers, and to advance the cancer center's goal of treating patients with the most effective, safe, and evidence-based standard of care available. Starting with the fight against Leukemia, MD Anderson's Oncology Expert Advisor is expected to help MD Anderson clinicians develop, observe, and fine-tune treatment plans for patients, while helping them recognize adverse events that may occur throughout the care continuum. The cognitive-powered technology is expected to help researchers advance novel discoveries.

MD Anderson's Oncology Expert Advisor is accessible to the cancer center's network of clinicians through a computer interface or supported mobile devices. This provides clinicians—and in turn, patients—with immediate, worldwide access to MD Anderson's expertise and resources, and to IBM Watson's technology prowess in quickly extracting crucial insights from large volumes of complex data.

5. Summary

IBM is leading the Cognitive Systems Era. We are transforming how organizations use information and make decisions.

Watson™ technology can be applied to the SSA disability determination process to provide a "trusted advisor" to those who make disability decisions. Watson™ provides not only recommendations but information that supports those recommendations. Each recommendation is scored based on relevance. The individual using Watson™ evaluates the information presented and ultimately decides whether to use some, all, or even none of that intelligence. Watson™ makes data fully transparent so users can examine the sources of recommendations if the wish. While users are not obligated to use and act on the intelligence generated by Watson, they can incorporate the results into the decision-making process, balancing and/or augmenting their own existing knowledge and expertise.

Watson™ can benefit SSA and its decision makers in myriad ways. Watson™ can improve decisions by enabling increasing levels of insight at each step of the disability decision-making and review processes and SSA can use Watson™ to provide more consistent, accurate, and timely disability determinations. Watson™ is designed to augment human intelligence; not replace it. These capabilities can support the Social Security Administration disability determination process by:

1. Reducing case processing time and costs by helping decision makers take control of the vast quantities of information and data that needs to be reviewed and analyzed
2. Reducing the variability in decision outcomes among different state Disability Determination Services (DDSs), among different ODAR offices, and between DDSs and ODAR by providing a rigorous, consistent framework for case adjudication
3. Reducing the high rate at which decisions are appealed and reversed on appeal by improving the decision quality at the initial determination step and providing a higher confidence level in case outcomes

As a result, SSA can expect significant cost savings, reduced case backlogs, greater decision consistency, more transparency, and greater accountability throughout the agency.

After working together for almost 8 decades, and reviewing the new SSA Strategic Plan released in March 2014, IBM recommends cognitive computing technology as a critical enabler to transform the Disability Determination program and IBM recommends creating an enterprise-wide Virtual Center for Program Integrity (VCPI) that has six technology sectors solely focused on countering fraud. These VCPI technology sectors are interchangeable and will stay current as the technology evolution continues and provides significant cost efficiency over time.

James Goodman

A lawsuit was filed last week by an ALJs against the SSA exposing the cynical attempt to gain control over the decision process, so as to prevent the necessary scrutiny for the prevention of fraud. (See attached complaint filed in the U.S. District Court, SD Florida)

COMPLAINT-LJB v SSA (12-21-20...

This is news that will be circulated in the usual manner with the SSA getting its position into the press reports skewed in the Agency's favor. You may be interested in the most current situation existing among the SSA and its ALJs. It is quite revealing to consider the statements of the former Commissioner in answer to the ALJ lawsuit filed this past week. This Commissioner was directly responsible for the excess created in his tenure, and his opposition to allowing ALJ to responsibly handle the many fraudulent matters presented to them. It has now come to light with the imposition of sanctions against those trying to do their jobs. The four cases against ALJs is only cover for the pressure brought about using quotas against ALJs who take the time to scrutinize and examine cases carefully. The SSA has placed "policy" hurdles which has obstructed decision making which is a subject so long and detailed that it cannot be addressed in a single comment. This is a whole other matter which has been quietly covered up while pressuring ALJs to meet quotas and comply with policy directly attributable to the perpetuation of fraud. Meanwhile, while the controversy was brewing over the West Virginia ALJ/ Eric Conn situation. The Social Security Administration quietly transferred most of the cases in question for re-hearing to favored ALJs in other regions around the country known to be "payors". The six ALJs to whom the cases were transferred had similar statistics as the West Virginia ALJ, and were known to have the highest production rates, and the highest rates of favorable decisions,

What Former Commissioner Astrue Really Thinks About "Dozens of Bad Actors - Lazy and Sloppy Judges", Saving $100's of Millions, and a Government Representative Program

"In the last few years we also disproved the four-decade-long mythology that the Merit Systems Protection Board would not seriously discipline administrative law judges, and we removed more judges—4—than all previous Commissioners combined—3. However, by taking a stand on judges who assault women and infants, distribute pornography from government computers, and steal by holding two federal jobs, we have received dozens of resignations from bad actors who did not want to experience public exposure for their actions. The arrogance that leads a person to do such things also correlates highly with poor decision-making, so when [we] took a tough stand on conduct we got the bonus of losing a lot of lazy and sloppy judges. As a result, we probably have the fewest number of outlier judges who refuse to follow agency policy that we have ever had, a change that is saving the trust funds hundreds of millions of dollars each year."

- Straight Talk about "Disability Reform, Michael J. Astrue, SSAB Forum,

March 8, 2013

Compare the thoughtful testimony of former acting CALJ Hatfield about improving the disability program and former Commissioner Astrue's diatribe in his presentation to the SSAB.

Below is Commissioner Astrue's view of the Government Representative pilot presented to the SSAB.

"When Congress gets serious about addressing the 2016 insolvency of the trust funds, there will be bad ideas floating around too. The one that has the most currency baffles me, which is another try at making hearings adversarial. I was stunned when I first answered questions before Congress on this proposal because none of its proponents knew that the agency had piloted this proposal in the 1980's and that it failed miserably. It was expensive—probably several hundred million dollars to implement fully in today's dollars—and it made no difference in outcomes while simultaneously undermining public confidence in the agency. Moreover, a primary rationale for the pilot, that government reps could find medical evidence that judges could not, will be unsupportable within five years when we enter the new world of electronic medical records."

On the other hand, Judge Hatfield participated in the pilot program. He thought it was a "success" and history was being revised by the agency.

A non-adversarial Trust Representative in the hearing room would also have prevented the abuses of Judge Daugherty in West Virginia, which occurred on Astrue's watch.

Rounding off, Judge Daugherty paid 1000 claims a year for at least seven year (2005-2011) at a 99% rate. If paid at a rate of 66% (which is higher than the prevailing over those seven years) for each year, one-third of the claims were questionably paid, which is 330 claims per year.

Using a of $100,000 figure for the annual cost of an attorney, that would employ 990 attorneys for each year of the seven years.

[Present value of disability award $300,000 x 330 a year = $99,000,000 a year / $100,000 a year = 990]

Over a seven year period, most of the time while Astrue was Commissioner, the saving could have been $693,000,000.

[Present value of disability award $300,000 x 2310 (330 x 7) = $693,000,000 for one judge over seven years.]

If a non-adversarial Trust Representative could save $693 million over seven

years, almost $100 million each year, with regard to one abusive judge, would it still be a miserable failure as former Commissioner Astrue believes or would it be a success as former CALJ Hatfield believes?

The West Virginia Times used even more alarming figures in its October 22, 2012 article on Judge Daugherty:

"The [US Senate] subcommittee began their fact-finding inquiries after local and national media exposed how former Huntington WV Judge David Daugherty had circumvented SSA disability procedures when he and lawyer Eric C Conn were allegedly mass approving SSA disability appeal cases with little to no court hearings, conflicting medical evidence or proper judicial consideration.
Daugherty is also accused of re-directing other Eric Conn cases to himself that were already assigned to other judges. During the time period between 2005 to 2011, Daugherty's overall approval rate averaged 96 to 98% compared to national average of 40%. Daugherty was approving 100% of cases where Eric Conn represented the claimant."

This would mean a 54-58% difference or a minimum $1,134, 000,000 over seven

Michael Gilbert

These materials are for the House Committees on Ways and Means Subcommittee on Social Security/Oversight and Government Reform Subcommittee on Energy Policy, Health Care, and Entitlements [SOCIAL SECURITY DISABILITY PROGRAM REFORM]:

25 Theses in Social Security Disability Case Processing

REGARDING THE SOCIAL SECURITY DISABILITY ADJUDICATION PROGRAM [ODAR]

PART I: UNVALIDATED AGENCY ALJ PROCESSING QUOTAS LEAD TO BILLIONS OF DOLLARS IN UNWARRANTED ENTITLEMENT OBLIGATIONS

DID YOU KNOW?

1. Average case sizes in some regions require judges [ALJs] to read at a minimum, over a 400,000 pages of evidence per year just to meet the minimum disposition requirements of SSA? (This is the equivalent of more than 1333 novels per year).
2. Consequently, the data available strongly suggests that judges are not reading (and cannot possibly read) all the evidence? Many assume the decision drafting attorney-writer will.
3. The decision drafting attorney-writers DO NOT read all the evidence? They assume the judge did.
4. That SSA has never validated the workplace duties of ALJs with any objective metrics?
5. That SSA has never tested any ALJ to ensure that any given ALJ knows the regulations in this specialized area of law AND can apply those rules to a given set of facts?
6. These disconnects amount to billions of dollars in entitlement obligations based upon failure to read, let alone properly evaluate claims?

Metrics provided upon request.

PART II: ADJUDICATION AND EVIDENCE DEVELOPMENT RESTRICTIONS IMPOSED ON ALJS

DID YOU KNOW?

SSA Judges are expressly PROHIBITED from:

1. Ordering an $89 malingering test [MMPI]? This is true even though:
    a. The medical evidence contains significant evidence of malingering and the testing is expressly requested by the:
        i. Medical expert;
        ii. Consultative examiner;
        iii. Treating source doctor, or the representative.
    b. It can save $300, 000 in lifetime benefits, and *is expressly provided for* in our regulations.
    c. Experts note over 50% of adult Disability Determination Service (DDS) claimants fail some form of Symptom Validity Testing in every jurisdiction studied. Over 40% of adult DDS claimants are found to meet conservative guidelines for symptom *invalidity*. *See*, American Academy of Clinical Neuropsychology Response to Notice of Proposed Rulemaking for the Revised Medical Criteria for Evaluating Medical Disorders. November 2010.

2. Ordering an $18 dollar, criminal history record on a claimant, but must rely upon the claimant's veracity about their criminal history? This is true even though their impairments may be expressly barred by regulation when they arise as part of the commission of a felony.
3. Accessing public websites such as local court databases to access the claimant's criminal history or public SOCIAL MEDIA websites [FACEBOOK, MYSPACE] of claimants?
4. Ordering a physical capacities exam, or PCE, even when expressly requested by a doctor, and even though it is the gold standard of evaluating an ability to perform work-like functions?
5. Providing more than 40 pages from the medical file (that may be over 1000 pages) when ordering a consultative exam?
6. Reporting attorney misconduct to the local bar no matter how egregious?
7. Applying a sanction for any act or omission made during the hearing process – either against the claimant or their attorney?
8. Drawing an adverse inference when claimants and representatives ignore specifically requested information requests?
9. Reporting criminal activity of claimants, discovered during the hearing process to local authorities or other federal agencies – tax fraud, VA disability fraud, failure to carry mandatory auto insurance?
10. Crosschecking third party witnesses' statements with the statements made by this same witness contained within their own pending application for disability benefits?
11. Crosschecking a claimant's statements with a statement they made in the third party witness's pending disability claim? [Claimants often "cross-vouch" for each other in their respective pending applications].
12. Ordering production of documents, timely discovery or request for admissions from the claimant – the person requesting disability?
13. Directing the claimant take a drug test, even when the doctor recommends it, the claimant agrees, and even when the prominent feature in the case is substance abuse?
14. Setting a deadline for submission of evidence in order to close the record of the proceeding?

PART III: LACK OF STANDARDIZED PROCEDURAL SAFEGUARDS AND UNWARRANTED COSTS

DID YOU KNOW?

1. There are no real procedural rules in place to properly administer the adjudicatory hearing process?
2. SSA PAYS for attorney representatives to travel to the hearing regardless of whether the claimant is disabled or not?
3. SSA PAYS to buy the claimant's medical records even when the claimant has an attorney AND even when the claimant is not indigent?

4. It is not uncommon for representatives to withdraw at the 11th hour, triggering: delay, expense of experts (who are entitled to being paid, given the late notice), and mandatory continuances?
5. Medical experts get a flat fee of $160. They are paid this fee to review the voluminous file AND to testify at the hearing. Considering the size of these files, it is very likely that many of these medical experts simply skim the record.

PART IV: SOLUTION:

Please exercise oversight responsibilities to restore/establish the integrity of these vital programs. The following solutions create the foundation for meaningful goals, permanent core competencies of ALJs, procedural accountability of representatives/claimants with timely processing, and significantly improve the likelihood that vital entitlement resources are directed to those who truly meet the criteria:

1. Amend the Act[1] to expressly direct the OPM and the SSA to conduct an objective validation study of the ALJ workplace procedures, including metrics **tied to case size and applying the applicable regulations/rules.** (ALJ's must read the entire record whenever a case cannot be approved based solely upon the objective medical evidence. *See*, SSR 96-7p). Validation is essential to establish a baseline production goal applicable across the country – as case size varies, (the volume of evidence to consider), so does the goal. The SSA has been setting policy and providing sworn testimony about case production based solely upon unvalidated anecdotal models – this is sophistry. The SSA keeps myriad metrics, but does not keep a single metric on average case size; this is a critical and fundamental flaw that undermines any attempt to reform the system. An annual quota of 500-700 cases per year *without any notion of individual disability case size* resolves to *reductio ad absurdum* in the face of even meager metrics demonstrating that actual case size in any given office is greater than about 180-200 pages. However, detailed metrics of the last 850+ cases demonstrate that the average case file is *four times this amount*.
2. Amend the Act to expressly direct the OPM and the SSA to begin objective testing of all ALJs to ensure they are competent to hold hearings and issue decisions. (Assuming a case value of $300,000 and an individual ALJ SSA quota of 500 cases per year means a single ALJ has the potential to obligate 150 million dollars per year in entitlement obligations). The American people have a right to know that their ALJs are performing their jobs with competency. There is significant objective evidence that in many cases, competency is not the norm. *See*, "Math for ALJs." *See*, the Senator Coburn study. The Administrative Procedure Act does not prevent testing core competencies, only performance appraisals. Congress should direct through

[1] SSA is an executive agency. While Congress can provide oversight – that oversight has been ineffectual as these matters represent long-term dysfunction in the disability adjudicatory model. The most effective way to correct the root of these matters is through amending the Act. Both of the undersigned ALJs have significant leadership and litigation experience, but each has less than 5 years' experience with the SSA. Their outside experiences (military) and elsewhere bring fresh eyes to these matters and represent a view distinct from SSA management, the ALJ union, and academic commentators.

amendment that the passing of objective testing be a condition of employment. The testing should be based upon the work place validation above.

3. Amend the Act to expressly direct the SSA to provide for a cohesive and enforceable set of procedural rules.
4. Amend the Act to expressly direct the SSA to provide for the ordering of tests and evidence that enhance credibility analysis, and crosscheck statements contained in other disability files.

These suggestions are not discussed or raised by SSA management because the agency is not interested in objective validation because the true size of these cases will demonstrate that 500-700 cases per year is impossible in the vast majority of jurisdictions. **The ALJ union will not support** validation, as it will lead to objective measures by which ALJs can be held accountable – through objective testing and certification. Objective certification is not the same as performance evaluations; therefore, it would not violate the APA. Similar to security clearances, *objective certification can be a condition of employment*.

Validation is routinely done in the employment context;[2] OPM has the capacity to perform it with outside assistance. The military judicial model does have objective testing before certifying officers as competent to handle criminal trials. This model ensures that those ALJ unable to handle the validated core requirements of the job are no longer employed. This model certifies *objectively*, what is necessary to properly adjudication a case in accordance with the regulations, AND ensures that ALJs who hold hearings, 1) know the law; and 2) can apply the law and procedures to reach just outcomes in disability hearings. These two steps, validation and certification, will drastically correct the unsustainable disparity between pay and deny rates of the ALJ corps. It will bring accountability. The individual ALJ must demonstrate (*objectively*) core competencies before holding hearings and committing taxpayers dollars. The agency is accountable in that the validation of the adjudicatory model will demonstrate that the various regulations, SSRs and policies, when applied against the volume of evidence, require significantly more than the suggested "2.75 hours per case" to properly adjudicate.

Procedural rules are essential to the functioning of any adjudicatory model. The failure to have binding procedural rules is the deepest failure of agency leadership. This is not a new program. Moreover, ALJs' ability to ferret out credibility concerns continues to be more restricted, despite the overwhelming empirical evidence that shows that validity testing is essential. The ability to test credibility is essential to evaluating any case involving subjective statements of limitations.

These matters provided under 5 USC 7211. These are not unsubstantiated anecdotal allegations, citation to regulation and agency policy can be provided upon request, as can specific examples and metrics.

Although the undersigned are both ALJs in the SSA Tacoma WA office, these are made in the personal capacity, and do not represent the opinions of SSA or any other organization.

s/s Michael Gilbert; s/s Scott Morris

[2] Judge Gilbert holds an LLM in Labor and Employment law, cum laude.

National Organization of Social Security Claimants' Representatives

NATIONAL ORGANIZATION OF
SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES
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Executive Director
Barbara Silverstone

Written Statement for the Record
on behalf of the
National Organization of Social Security Claimants' Representatives

Hearing on Fighting Social Security Disability Fraud

Subcommittee on Social Security
House Committee on Ways and Means

February 26, 2014

Submitted by:
Barbara Silverstone, Executive Director

* * *

These comments are submitted on behalf of the National Organization of Social Security Claimants' Representatives (NOSSCR) as a Statement for the Record of the February 26 2014, House Ways and Means Social Security Subcommittee hearing on Preventing Social Security Disability Fraud.

Founded in 1979, NOSSCR is a professional association of attorneys and other advocates who represent individuals seeking Social Security disability or Supplemental Security Income ("SSI") benefits. NOSSCR members represent these individuals in legal proceedings before the Social Security Administration and in federal court. NOSSCR is a national organization with a current membership of more than 4,000 members from the private and public sectors and is committed to the highest quality legal representation for claimants.

In January 2014, a group of approximately 100 former police officers, firefighters and others were indicted in New York City for allegations of fraudulently obtaining Social Security Disability Insurance benefits, as part of what is being described in news reports as a concerted action over several years. The allegations are extremely troubling and are receiving close scrutiny by the Social Security Administration and law enforcement.

NOSSCR condemns any misuse of the Social Security disability programs. If true, the allegations are beyond reprehensible. Any individual who seeks to abuse the Social Security disability programs casts a shadow over the millions of Americans with significant disabilities and severe illnesses who are entitled to receive these benefits, and for whom benefits are a vital lifeline. Any individual who receives, or seeks to receive, benefits based on fraudulent evidence should be brought to justice.

As an organization that fights for the economic security of American workers with disabilities and their families, we are alarmed when unscrupulous behavior jeopardizes the integrity of a program that provides crucial benefits to the disabled workers for whom our members advocate daily. We support efforts of SSA and Congress to ensure that the program is structured to ferret out fraudulent activity.

The Social Security Administration (SSA) works hard to ensure program integrity, and thankfully fraud is extremely rare – but even one instance of abuse is unacceptable. SSA has been deprived of the administrative resources it requires to conduct necessary program integrity work for several years. Congress must provide SSA with sufficient administrative resources to ensure that benefits are paid to the right person, in the right amount, and at the right time — and to implement the array of critical safeguards that exist in current law.

NOSSCR strongly supports the Social Security Fraud and Error Prevention Act of 2014 (H.R. 4090), introduced on February 26, 2014, by Subcommittee Ranking Member Becerra, and co-sponsored by Representatives Levin, Rangel, Doggett, Thompson, Crowley and Schwartz. H.R. 4090 would provide SSA with the tools it needs to prevent fraud before it happens, ensure that the agency has adequate administrative resources to implement critical safeguards, and expand the agency's authority to investigate and punish fraud. We support this approach to ensure program integrity.

NOSSCR also supports the Statement for the Record submitted by the Co-Chairs of the Consortium for Citizens with Disabilities Social Security Task Force.