SOCIAL SECURITY
Office of the Inspector General

April 5, 2012

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
B-317 Rayburn House Office Building
Washington, D.C. 20515

Attn: Kim Hildred

Dear Chairman Johnson:

This is in response to your letter dated March 22, 2012, in which you requested information related to the Social Security Administration's (SSA) Disability Insurance (DI) program, following your Subcommittee's January 24, 2012 Hearing on Combating Disability Waste, Fraud, and Abuse. I appreciate the opportunity to provide information related to this critical issue. Below are responses to your specific questions.

1. **How do you calculate projected savings for the disability programs and non-Social Security programs? You said that for every $1 invested in the Cooperative Disability Investigations (CDI) program, $14 dollars in disability-program savings results. I can understand how the CDI programs save disability funds, but explain more about other Federal and state savings.**

Please see the following calculations:

In pre-effectuation cases, SSA savings are calculated at a flat rate of $90,125 for each initial claim denied. This rate is calculated by multiplying the percentage of CDI investigations that result in a denial (83 percent) by the average lifetime disability benefit ($108,585).

In cases in which benefits are already being paid, SSA savings are calculated by multiplying the percentage of such CDI investigations that lead to Continuing Disability Reviews (CDRs) where the benefits are ceased or terminated (74 percent), by the total of: the monthly disability benefit amount, times 12 months times the average years a recipient or beneficiary remains on the disability rolls (5.06 years).

Non-SSA programs (Medicare and Medicaid) are also impacted by CDI investigations. Medicare and Medicaid benefits are often granted when a claimant receives disability. Conversely, if an ineligible claimant is denied SSA benefits due to a CDI investigation, Medicare, and/or Medicaid benefits are also denied. Medicare and Medicaid savings are calculated by the following methods:

- Medicare (Title II Initial Claims): The "Average Cost per Disabled Medicare Beneficiary" multiplied by three years.

- Medicaid (Title XVI Initial Claims): The "Charted Threshold Amounts" by state multiplied by five years.

- Medicare and Medicaid (Concurrent Initial Claims): the same calculation as above for Medicare and Medicaid is multiplied by two years, resulting in a total of five years claimed for non-SSA savings, in both disability programs.

2. What are the steps taken to open a new CDI unit? What factors are involved in the decision-making process?

Several factors are taken into account when pursuing CDI program expansion. The first factor is the availability of an approved budget for expansion. Upon confirmation of an available budget, the following criteria/factors are considered when determining whether to open a new CDI Unit:

- Is there a potential workload to support opening a unit (including a review of the number of disability claims filed in the area, the number of CDRs conducted in the area, and major sources of referrals in the area)?

- Does the Office of the Inspector General (OIG) Office of Investigations (OI) have a Special Agent available to serve as a CDI Unit team leader?

- Is there support and are employees available from the SSA, Disability Determination Services (DDS), and a state or local law enforcement agency?

- Is the state DDS meeting performance standards and budgeted workload goals?

- Is existing space available to house the unit or do additional funds exist to build out space (includes determining where the unit will be housed, proximity of the unit to SSA, the State DDS and the Office of Disability Adjudication and Review (ODAR) offices, and geographic areas of coverage for the unit)?

3. How does your office locate and partner with local law enforcement agencies? Is local law enforcement enthusiastic about these partnerships and willing to make resources available?

The Special Agent-in-Charge and/or the OIG/OI CDI Unit team leader canvass their local areas of jurisdiction to speak with state and local law enforcement agency officials regarding the CDI program and its mission and objectives. OIG addresses the importance of potential monetary savings to the state, such as Medicaid savings.

Based on the law enforcement agency's interest and support of the CDI program, as well as the availability of dedicated resources to the unit (2-3 investigators), a suitable law enforcement partner is selected. The partnership is then formalized through a Memorandum of Understanding (MOU), which is signed by all parties. In those situations in which the law enforcement partner is a local law enforcement agency, a contract is signed in lieu of the MOU. This contract is drafted by the SSA Regional Contracting Office and similar to the MOU, details the responsibilities of the law enforcement partner, to include the duties of the assigned investigators.

The availability and enthusiasm of local law enforcement agencies to collaborate with CDI varies by region and jurisdiction. Local priorities and budgets are currently a concern for many law enforcement agencies. Due to budget constraints, many agencies are unable to hire new personnel and need all of their current officers and investigators available to fulfill their primary mission. Having an officer's salary reimbursed by the SSA is not as appealing as it once was, because the local law enforcement agency, in effect, still loses staff.

4. **You say in testimony you have units in 22 states. What are the current CDI program expansion plans? Do you have any projections on how much fraud could be prevented in the Disability (DI) program if you had CDI units in every state? How much additional funding would you need?**

We are currently working on establishing a CDI Unit in Philadelphia, Pennsylvania, but further expansion sites for this fiscal year (FY 2012) have not been discussed. Historically, expansion is based on the availability of funding from the SSA, the availability of personnel and resources from the SSA, the OIG, and the local DDS, and finding a viable law enforcement partner.

With respect to how much fraud could be prevented if we had a unit in every state, the OIG can only investigate allegations of fraud that we receive and that are reported. In locations where there is no CDI Unit, the local DDSs do not have an avenue to refer cases with possible fraud indicators, as these pre-effectuation cases do not have a monetary loss to the government. In addition, we are limited by our investigative resources as to which allegations we investigate. Each allegation is reviewed and triaged at the local level. In FY 2011, the OIG received 44,440 allegations related to disability fraud. The OIG opened 7,196 cases in FY 2011; of these, 2774 were TII disability fraud cases (38.55 percent). In our CDI program, for FY 2011, we closed 3,885 cases, 3,383 of which (87 percent) saw benefits either terminated or denied.

The average start up cost for a new CDI Unit varies depending on whether current office space exits and how much renovation the space needs. The average cost to run a unit is approximately $821,000 per year.

5. **In your testimony, you recommended that one way to combat waste, fraud, and abuse in the DI program would be to reduce the complexity of the Social Security Administration's (SSA) programs, without sacrificing their intent. Can you give some examples of what could be simplified and how?**

One example includes simplifying the rules for determining if disabled beneficiaries have earnings that affect disability benefits. Even if SSA received earnings data—such as Federal payroll information—more frequently, Agency staff still needs to review the earnings. SSA cannot simply stop benefit payments because it is notified that a beneficiary is working. For instance, because earnings reported to SSA may include amounts that are not related to current work—such as bonuses, termination pay, and sick pay—SSA must evaluate the earnings to determine whether they represent earnings from substantial gainful activity performed after entitlement to disability benefits began, or whether the earnings exceeded the "countable earnings" threshold. SSA must also assess trial work and other work incentive provisions. This review—a work CDR or Supplemental Security Income (SSI) redetermination—is a labor-intensive process, and the staff resources required compete against the Agency's need to complete other priority workloads.

Another example would be to exempt the SSA OIG from the *Computer Matching and Privacy Protection Act* (CMPPA). The CMPPA contains several useful and practical exceptions, specifically exempting matches performed for routine uses, law enforcement purposes, statistical reviews, and Congressional investigations, among others. However, with regard to any computer matches that are performed that primarily affect benefit determinations, a formal computer matching agreement (CMA) pursuant to the CMPPA is still required. The main objective of many of our audits and investigations is to ensure that only eligible individuals receive payments from SSA; thus, the CMPPA requires a computer matching agreement during many of our work efforts. All computer matching agreements must go through an exacting and lengthy approval process within the Agency before receiving final approval from SSA's Data Integrity Board. This process typically takes more than a year (and sometimes years) to complete. An amendment to CMPPA will increase the effectiveness of the OIG in detecting fraud, waste, and abuse by authorizing computer matches without the need for a CMA, thereby, facilitating savings of taxpayer resources through the prevention and recovery of improper payments of SSA program benefits.

The Department of Health and Human Services (HHS) and its OIG received an exemption as part of the enacted healthcare reform legislation; *i.e.* the *Patient Protection and Affordable Care Act*, Pub. L 111-148. Section 6402(b)(2) of the legislation amended the Privacy Act to exempt "matches performed by the Secretary of Health and Human Services or the Inspector General of the Department of Health and Human Services with respect to potential fraud, waste, and abuse, including matches of a system of records of non-Federal records." *See* 5 U.S.C. § 552a(a)(8)(B)(ix).

Both SSA OIG and HHS OIG are charged with combating waste, fraud, and abuse in vital and important Federal benefit programs. Just as Congress determined that an exemption to the CMPPA would be invaluable to the HHS and its OIG in its efforts to combat waste, fraud, and abuse in HHS's programs and operations; so, too, would a similar exemption assist the SSA OIG to combat fraud, waste, and abuse more efficiently and effectively within SSA's programs and operations.

6. You also recommended establishing an integrity fund. How would an integrity fund operate in order to increase the funds available for integrity efforts?

One proposal is to amend the *Social Security Act* to authorize SSA and its OIG to receive a percentage of the overpayments collected yearly by SSA to fund program integrity related activities. These activities include, but are not limited to, CDRs (both periodic medial reviews and those triggered by

work activity), full and limited issue SSI redeterminations, CDI Units, and Office of the General Counsel prosecutors. Together, these activities have resulted in preventing improper payments, as well as recovering millions of dollars in Social Security benefits improperly paid.

Under this Program Integrity Fund proposal, SSA would receive up to 25 percent and SSA OIG up to five percent of the overpayments recovered during a fiscal year. (For FY 2010, SSA collected approximately $3.144 billion in overpayments.) This funding would be used to supplement, not supplant, current funding and would provide additional resources to both SSA and OIG to combat waste, fraud, and abuse within SSA's programs and operations. Amounts provided for these stewardship activities from this fund would be off-budget and not scored.

An alternate method for funding an integrity fund would be to use a percentage of payments prevented (as opposed to overpayments collected). SSA and its OIG could each receive a percentage of prevented payments or savings from a claimant not getting on the rolls during the application process. For example, CDI Units focus on preventing claimants from getting on the disability rolls. In FY 2011, our investigators reported about $329 million in projected savings from programs such as the CDI program.

Finally, SSA conducts CDRs, which result in savings by taking disability beneficiaries who no longer meet SSA's criteria for benefits off the rolls. In SSA's February 15, 2011 annual CDR report to Congress for FY 2009, the Agency estimated the present value of future benefits thus saved for the Old-Age, Survivors, and Disability Insurance (OASDI), SSI, Medicare, and Medicaid programs to be $4.6 billion

7. **Do you have any suggestions for funding more efforts to prevent fraud, waste, and abuse in the DI program?**

We believe the proposed integrity fund would allow for more efforts to prevent fraud, waste, and abuse in SSA's programs. See answer 6 above.

8. **What can you tell us about the accuracy of continuing disability reviews?**

As of February 2012, SSA had a 97.5 percent accuracy rate according to the quality assurance review of full medical CDRs. However, historically, SSA estimates about 25 percent of initial CDR cessations are overturned on appeal. We have an audit planned that will analyze the reasons beneficiaries are ceased after a CDR but are overturned after appeal or returned to the rolls on a new application for disability. We will share the results of our review with you once it is completed.

9. **Your office recently published a report on high-dollar overpayments in calendar year 2010 and discovered seven such overpayments even though the SSA did not report any. Why was your office able to identify high-dollar overpayments when the SSA did not? What changes should the SSA make to ensure that all high-dollar overpayments are identified?**

The OIG was able to identify high-dollar overpayments using a different approach from the Agency. SSA relied on the cases selected during its sampling process for its Stewardship reviews. Each month, the Office of Quality Performance (OQP) selects a statistically valid national sample of Title II and Title XVI beneficiaries who received a payment in that month to redevelop the case and ensure the payments

were accurate. The Agency used that national sample to determine if an overpayment meeting the high-dollar criteria existed. This approach used only a sample of cases and included several limitations, which resulted in no high-dollar overpayments being identified.

The OIG designed a methodology, which used Computer Assisted Auditing Techniques to obtain data for one segment of the Master Beneficiary Record for all instances in which a potential high-dollar overpayment existed. Our process used data from overpayments already identified and posted on an individuals' record by the Agency associated with the reporting quarter. We further analyzed the results to identify individual cases that met the criteria for being reported as a high-dollar overpayment. As a result, the OIG identified seven cases, and the Agency confirmed that six Title II cases might have met the criteria to potentially be reported as high-dollar overpayments.

Thank you for the opportunity to address these issues, and for your continuing support of our vital work. I trust that I have been responsive to your request. If you have further questions, please feel free to contact me, or your staff may contact Misha Kelly, Congressional and Intra-Governmental Liaison, at (202) 358-6319.

Sincerely,

Patrick P. O'Carroll, Jr.
Inspector General