



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
Acting Commissioner

Enclosure

**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.