United States Government Accountability Office

Report to Congressional Requesters

November 2014

SSA DISABILITY BENEFITS

Enhanced Policies and Management Focus Needed to Address Potential Physician-Assisted Fraud

GAO-15-19

GAO Highlights

Highlights of GAO-15-19, a report to congressional requesters

November 2014

SSA DISABILITY BENEFITS

Enhanced Policies and Management Focus Needed to Address Potential Physician-Assisted Fraud

Why GAO Did This Study

SSA relies on medical evidence to determine whether the millions of new claimants each year qualify for disability benefits. This evidence—and those who provide it—have been the subject of intense scrutiny as questions have been raised about the potential for fraud schemes that include falsified medical evaluations. GAO was asked to study physician-assisted fraud in SSA's disability programs.

GAO reviewed (1) how well SSA's policies and procedures are designed and implemented to detect and prevent physician-assisted fraud, and (2) the steps SSA is taking to improve its ability to prevent physician-assisted fraud. GAO reviewed relevant federal laws and regulations, visited 5 of the 54 DDS offices that were selected to obtain geographic and office structure variation, and analyzed DDS data to identify whether federally sanctioned physicians (as of the end of January 2014) may have submitted evidence on behalf of claimants. GAO also interviewed SSA officials, as well as private disability insurers and others knowledgeable about SSA's programs to identify key practices for fraud prevention.

What GAO Recommends

GAO recommends SSA identify ways to remove potential disincentives for detecting and referring potential fraud, enhance its training efforts, evaluate the threat of physician-assisted fraud, and ensure that new and existing fraud efforts are coordinated. SSA agreed with four of our five recommendations, partially agreed with one, and noted plans to address all of them.

View GAO-15-19. For more information, contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov

What GAO Found

The Social Security Administration (SSA) has policies and procedures in place for detecting and preventing fraud with regard to disability benefit claims. However, GAO identified a number of areas that could leave the agency vulnerable to physician-assisted fraud and other fraudulent claims:

- SSA relies heavily on front-line staff in the offices of its disability determination services (DDS)—which have responsibility for reviewing medical evidence—to detect and prevent potential fraud. However, staff said it is difficult to detect suspicious patterns across claims, as directed by SSA policy, given the large number of claims and volume of medical information they review. Moreover, DDS offices generally assign claims randomly, so staff said it would only be by chance that they would review evidence from the same physician.
- SSA and, in turn, DDS performance measures that focus on prompt processing can create a disincentive for front-line staff to report potential fraud because of the time it requires to develop a fraud referral. Four of the five DDS offices GAO visited count time that staff spend on documenting potential fraud and developing fraud referrals against their processing time. Some staff at these DDS offices said this creates a reluctance to report potential fraud.
- The extent of anti-fraud training for staff varied among the five offices GAO visited and was often limited. SSA requires all DDSs to provide training to newly hired staff that includes general information on how to identify potential fraud, but does not require additional training. The five DDS offices GAO visited varied in whether staff received refresher training and its content—such as how to spot suspicious medical evidence from physicians—and staff at all levels said they needed more training on these issues.
- SSA has not fully evaluated the risk associated with accepting medical evidence from physicians who are barred from participating in federal health programs. Although information from these physicians is not necessarily fraudulent, it could be associated with questionable disability determinations.

SSA has launched several initiatives to detect and prevent potential fraud, but their success is hampered by a lack of planning, data, and coordination. For instance, SSA is developing computer models that can draw from recent fraud cases to anticipate potentially fraudulent claims going forward. This effort has the potential to address vulnerabilities with existing fraud detection practices by, for example, helping to identify suspicious patterns of medical evidence. However, SSA has not yet articulated a plan for implementation, assigned responsibility for this initiative within the agency, or identified how the agency will obtain key pieces of data to identify physicians who are currently not tracked in existing claims' management systems. Furthermore, SSA is developing other initiatives, such as a centralized fraud prevention unit and analysis to detect patterns in disability appeals cases that could indicate fraud. However, these initiatives are still in the early stages of development and it is not clear how they will be coordinated or work with existing detection activities.

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Abbreviations

ALJ	Administrative Law Judge
CDI	Cooperative Disability Investigations
DDS	Disability Determination Services
DI	Disability Insurance
HHS	Department of Health and Human Services
LEIE	List of Excluded Individuals and Entities
ODAR	Office of Disability Adjudication and Review
OIG	Office of the Inspector General
SSA	Social Security Administration
SSI	Supplemental Security Income

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

November 10, 2014

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United States Senate

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

The Social Security Administration (SSA) provides cash benefits to millions of Americans with disabilities who are unable to work, with total payments estimated to exceed $200 billion in fiscal year 2015. To determine whether claimants qualify for disability compensation, federal law requires evidence of a medically determinable impairment, which SSA obtains from the claimant's medical providers or by paying for its own medical evaluations. This medical evidence—and those who either provide or review it—has been the subject of intense scrutiny as some alleged fraud schemes have recently been uncovered.

These alleged schemes not only include physicians, but typically consist of other individuals who are knowledgeable about SSA's disability programs and eligibility criteria.[1] For example, in August 2013, 75 individuals in Puerto Rico were arrested and indicted for Social Security fraud. It is alleged that a former SSA employee serving as a representative for the claimants colluded with several physicians to provide documentation of non-existent impairments in return for kickbacks from claimants who were granted benefits. While the full extent and nature of physician-assisted fraud is difficult to measure, each fraudulent claim allowed by SSA has the potential to cost the government several hundred thousand dollars over the life of the claimant and places an additional financial burden on these programs at a time when SSA

[1] Several of the cases that allege physicians assisted claimants in fraudulently obtaining disability benefits are still under investigation, limiting our ability to report on the nature and outcome of these specific cases.

estimates that its disability trust fund will be depleted and unable to pay full benefits to individuals starting in 2016.

Given the potential harm that physician-assisted fraud can cause to SSA's disability programs, you asked us to study this topic. In this report, we examine (1) how well SSA's policies and procedures are designed and implemented to detect and prevent physician-assisted fraud,[2] and (2) the steps SSA is taking to improve its ability to prevent physician-assisted fraud.

To address these objectives, we reviewed relevant federal laws and regulations and SSA program documentation including policies, procedures, training manuals, and performance plans, as well as reports and testimonies from SSA and SSA's Office of the Inspector General (SSA OIG) on fraud detection and prevention efforts. We evaluated SSA's efforts against its own policies and procedures, federal internal control standards, and other promising fraud detection and prevention practices that include data analytics. In our previous work, we identified promising fraud analytics practices,[3] which we validated with disability insurance companies to ensure they were relevant to our review. We also interviewed SSA officials across headquarters' components, SSA OIG officials, and national organizations that represent SSA managers and disability examiners. Additionally, we interviewed individuals from the private insurance industry and other organizations knowledgeable about fraud analytics and the disability determination process to identify key practices for fraud analytics and assessed whether SSA is incorporating these practices as it begins to develop its own analytics.

[2] For the purposes of this report, we define physician-assisted fraud as any instance in which a physician colludes with a claimant or other interested parties to provide false medical evidence in support of a Social Security disability claim. This could include organized schemes where attorneys or third-party representatives funnel their clients to physicians with the intent of receiving false medical evidence in support of claims. We are not including instances where a claimant exaggerates an ailment to a physician in order to obtain a medical diagnosis. We define physicians as individuals such as doctors, psychologists, optometrists, podiatrists, speech language pathologists, chiropractors, physicians' assistants, and other medical sources, or entities such as clinics or hospitals that submit accepted medical evidence in a claim for SSA's Disability Insurance or Supplemental Security Income programs.

[3] GAO, *Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness*. GAO-13-104 (Washington, D.C.: Oct. 15, 2012).

To gain additional perspectives on how SSA policies are implemented and any challenges to detecting physician-assisted fraud, we conducted site visits to 5 of the 54 Disability Determinations Services (DDS) offices in Alabama, California, Illinois, Maryland, and West Virginia. We selected these sites to obtain variation in regional office and DDS operations (e.g., case management systems, office structure, and case processing). Given the key role that SSA OIG Cooperative Disability Investigations (CDI) units[4] play in identifying potential fraud, we selected offices in states with and without a CDI presence. During our site visits, we interviewed DDS management, medical relations professionals, disability examiners, and medical consultants. Additionally, we interviewed officials in the corresponding regional offices, including those who oversee initial and appeals determinations, as well as CDI unit staff. We conducted additional interviews with the Michigan DDS which has its own fraud unit and the NY regional office which oversees two DDSs—New York and Puerto Rico—where recent instances of fraud allegedly occurred.

Additionally, we conducted in-depth testing of data from two states to identify whether SSA is following its requirement not to allow certain sanctioned medical providers to conduct exams on behalf of the agency. We also sought to identify the extent to which sanctioned doctors may be providing medical evidence on behalf of claimants. We matched provider data from two of the states we visited—California and Illinois—with the Department of Health and Human Services OIG's List of Excluded Individuals and Entities. This list identifies federally-sanctioned medical providers, and SSA regulations prohibit DDSs from using these providers to conduct exams on behalf of the agency. We selected California and Illinois because we were able to more readily obtain lists of vendors and because they use two different case management systems, allowing us to identify differences in what information is captured by DDSs. We obtained lists of providers as of February 2014 for California and April 2014 for Illinois and matched these against a list of providers who were sanctioned as of the end of January 2014. The results of our data matching are not generalizable to other states or to the wider population of disability claims. We conducted electronic testing and interviewed knowledgeable officials to assess the reliability of these data. We determined that they were

[4] SSA OIG's CDI units investigate disability claims that have been identified as suspicious by state disability examiners. The program currently consists of 27 units covering 23 states and the Commonwealth of Puerto Rico.

sufficiently reliable for our purposes. See appendix I for a detailed description of our scope and methodology.

We conducted this performance audit from July 2013 to November 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

SSA's Disability Programs

SSA administers two main programs under the Social Security Act that provide benefits to individuals with disabilities—Disability Insurance (DI) and Supplemental Security Income (SSI). Individuals are generally considered disabled if they are unable to do their previous work, and considering age, education and work experience, engage in any other kind of substantial gainful work and their disability has lasted or is expected to last at least 1 year or is expected to result in death.[5] See table 1 for additional key features and requirements of the DI and SSI programs.

[5] 42 U.S.C. §§ 423(d), 1382c(a).

Table 1: Overview of Disability Insurance and Supplemental Security Income Programs

	Disability Insurance (DI)	Supplemental Security Income (SSI)
Purpose	Provides benefits to persons who become unable to work because of disability.	Provides benefits for disabled, blind, or aged people who have low income and limited resources.
Work requirement	Requirement depends on age of claimant, but is generally 40 quarters of coverage.[a]	No prior work requirement.
Number of recipients (estimated fiscal year 2015)	11 million	8.5 million
Benefits paid (estimated fiscal year 2015)	$147 billion[b]	$60 billion[c]
Medical Benefits	DI beneficiaries qualify for Medicare health benefits after 2 years.	Most states automatically enroll SSI recipients in Medicaid, according to SSA.

Source: GAO analysis of relevant federal laws and SSA data. | GAO-15-19

[a] Generally, individuals need 40 work quarters (credits) to qualify, 20 of which must have been earned in the 10 years prior to becoming disabled. Individuals may earn up to four work credits per year, and the amount of earnings needed for a credit is calculated using the national average wage index. In 2014, $1,200 is needed for each credit.

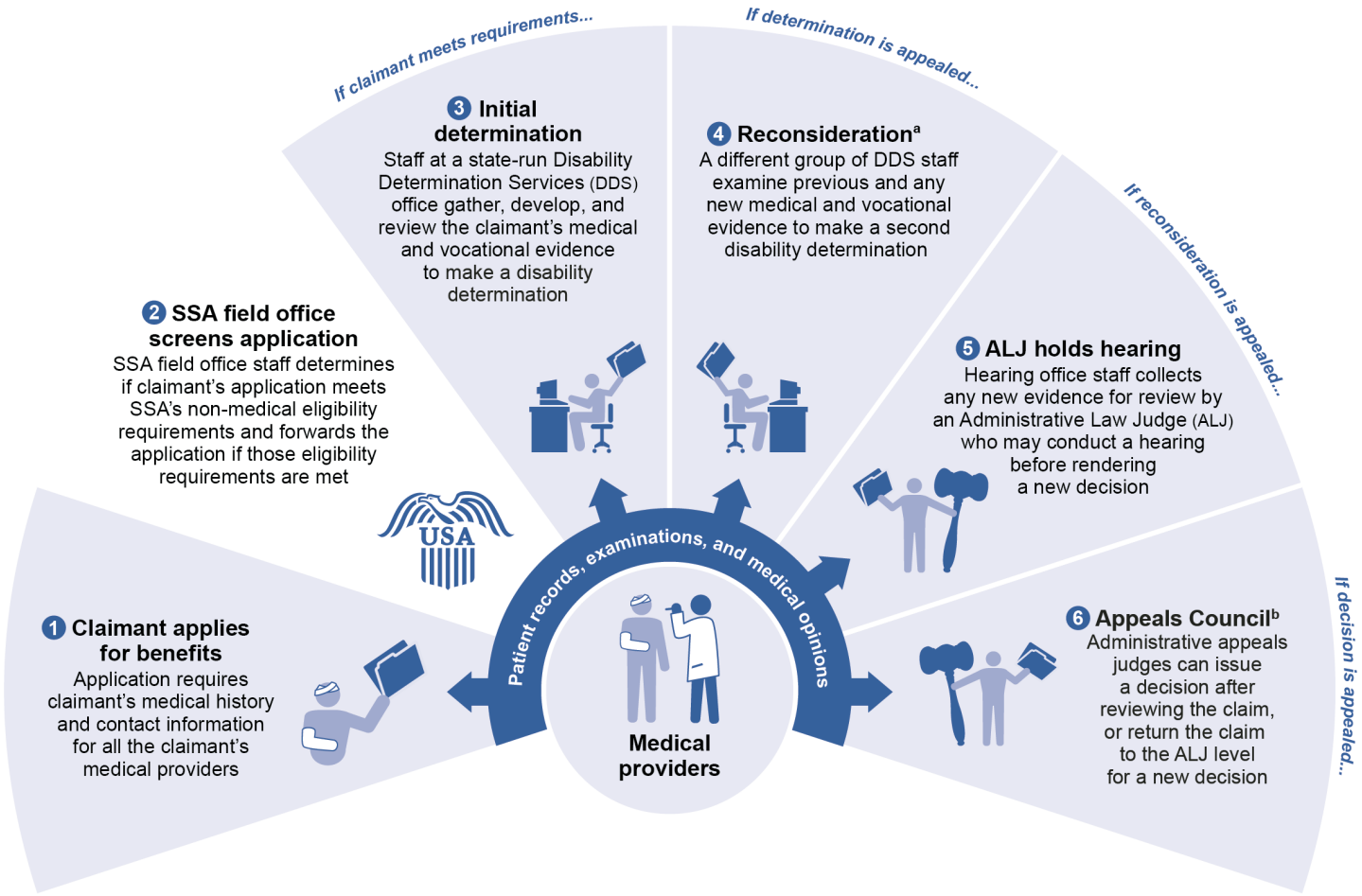
[b] This includes both persons with disability and their family members who receive benefits.

[c] This includes federal benefits and state supplementary payments per month.

SSA's process for determining medical eligibility for disability benefits is complex and can involve several state and federal offices. The determination process—which is the same for both DI and SSI claimants—involves an initial determination at a DDS office. SSA funds the 54 DDSs, which are operated by state agencies, to process disability claims in accordance with SSA policies and procedures.[6] If a claim is denied, claimants have several opportunities for appeal within SSA, starting with a reconsideration at the state level; then a hearing before an administrative law judge (ALJ); and finally at the Appeals Council, which is SSA's final administrative appeals level. Claimants can generally submit new medical evidence throughout the disability determination process. Claimants must file any further action in federal court. Claims at all levels for which the claimant is determined to be eligible for DI or SSI, also called favorable claims, are forwarded to other SSA offices for payment. (See fig. 1.)

[6] There are 54 DDSs located in 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

Figure 1: Social Security Administration's Disability Determination Process



Source: GAO analysis of Social Security Administration (SSA) information. | GAO-15-19

[a] In 1999, SSA eliminated the reconsideration step in 10 states (Alabama, Alaska, Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, Pennsylvania, and in the Los Angeles area of California) as part of the Prototype Initiative. In these states, claimants who wish to appeal their initial DDS determination must appeal for review before an ALJ.

[b] If parties are not satisfied with the Appeals Council decision, they may pursue the matter further in federal district court.

Development of Medical Evidence

Generally, DDSs are required to develop a complete medical history for each claimant for at least a 12-month period prior to the application. SSA guidance directs DDSs to request medical evidence records from all providers who treated or evaluated the individual for the alleged or documented impairment during this time period. For example, a DDS may

request laboratory reports; X-rays; doctor's notes; and other information used in assessing the claimant's health and functioning from many types of providers, including physicians or psychologists, hospitals, or community health centers. According to SSA, DDSs generally pay providers for these records in accordance with required state fee schedules.

In claims where the evidence gathered is insufficient to make a determination or where no evidence is present, the DDS may order its own tests or evaluations—called consultative examinations—from medical providers. SSA regulations specify the types of providers who can perform consultative exams and require DDSs to recruit, train, and oversee these providers in their states.[7] State DDSs pay providers to conduct exams and set the rates of payments for these exams.[8] SSA's regulations prohibit DDSs from purchasing consultative exams from medical providers who are excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other federal or federally-assisted program, which includes providers on the List of Excluded Individuals and Entities maintained by the Department of Health and Human Services (HHS) Office of Inspector General (OIG).[9] SSA regulations also prohibit the agency from purchasing exams from certain providers whose license to practice has been revoked by any state licensing authority. HHS is legally required to exclude from participating in federal health care programs individuals and entities convicted of certain criminal offenses, such as defrauding Medicare, Medicaid, or other federal or state health programs; patient abuse or neglect; and felony convictions related to controlled substances.[10] This function is performed by the HHS OIG. The OIG also has discretion to exclude individuals and entities based on a number of other grounds—

[7] 20 C.F.R. §§ 404.1513, 404.1519g, 404.1519s, 416.913, 416.919g, 416.919s.

[8] Rates paid for consultative examinations may not exceed the highest rate paid by federal or other agencies in the state for the same or similar type services. 20 C.F.R. §§ 404.1624, 416.1024.

[9] See 20 C.F.R. §§ 404.1503a, 416.903a.

[10] 42 U.S.C. § 1320a-7(a).

both related and unrelated to programmatic fraud.[11] SSA instructs DDSs to review the HHS list and verify medical licenses and credentials before using the services of any consultative exam provider. DDSs are also required to review the list for each existing exam provider at least annually. DDSs are not required to check the status of the claimant's treating physician or other medical providers that submit evidence since they are obtaining existing medical records and not paying for medical services.

Fraud Identification and Referral Process

SSA has guidance on how examiners should document and report suspected fraud. According to SSA's policy, fraud generally occurs when an individual makes or causes to be made false statements of material facts or conceals such facts for use in determining rights to benefits, with the intent to defraud. SSA employees should gather enough information to either remove suspicion or determine that there is potential fraud. They are also expected to develop the referral with as much information as possible, including who allegedly committed fraud, how, when, and why. If they determine that potential fraud exists, they should refer it to the SSA OIG. For states with a CDI unit, cases can be referred directly to the CDI. SSA and the OIG jointly established the CDI Program, in conjunction with DDSs and state or local law enforcement agencies, to effectively pool resources and expertise and prevent fraud in SSA's disability programs. The Units investigate disability claims under DI and SSI programs that state disability examiners believe are suspicious.[12]

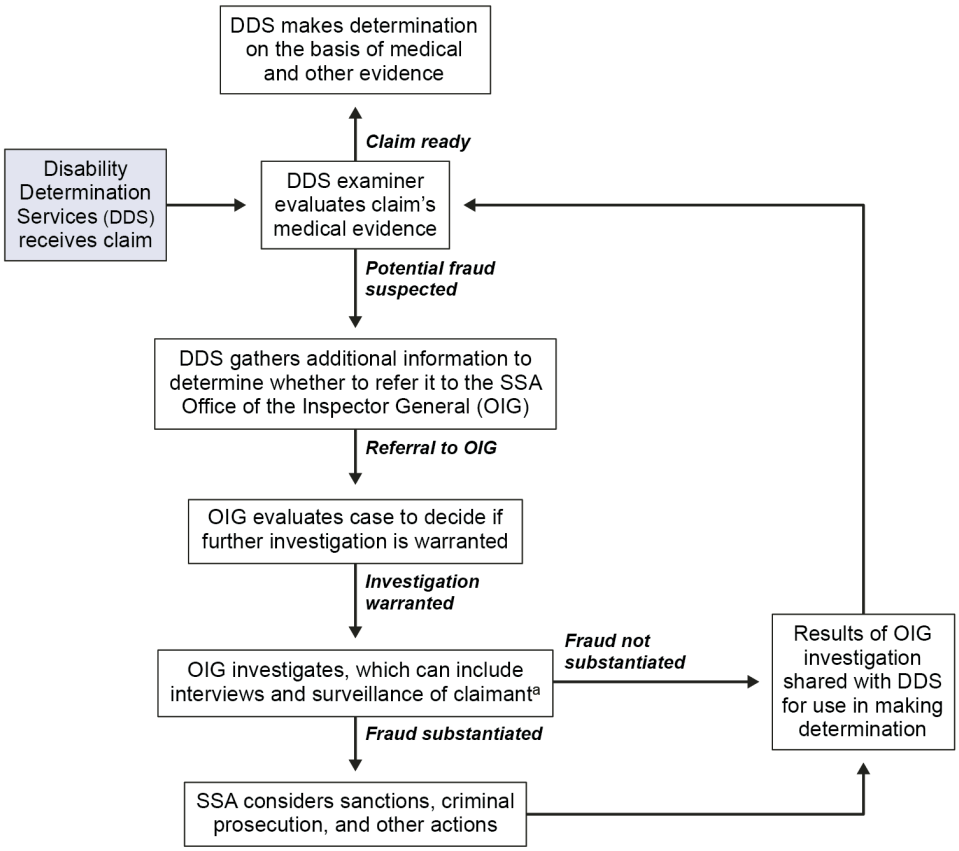
Referral processes can vary by DDS. For example, some DDSs may require management approval before referring a case to the SSA OIG. Once a case is referred to the SSA OIG, that office determines whether it

[11] Examples include misdemeanor convictions related to health care fraud; fraud in a program funded by any federal, state, or local government agency; suspension or revocation of medical license for reasons related to professional competence, professional performance, or financial integrity; defaulting on health education loans or scholarships; or engaging in unlawful kickback arrangements. 42 U.S.C. § 1320a-7(b).

[12] CDI units also receive fraud referrals from SSA's Office of Disability Adjudication and Review, private citizens, anonymous sources, and other law enforcement agencies.

will investigate the case.[13] Investigations often happen in coordination with other federal, state, and local agencies. See figure 2 for an overview of SSA's fraud referral process.

Figure 2: Social Security Administration's Fraud Detection and Referral Process



Source: GAO analysis of Social Security Administration (SSA) policies. | GAO-15-19

[a]OIG may work with local, state, and other federal entities to investigate fraud allegations.

[13] In fiscal year 2013, the OIG reported that it received 141,088 fraud referrals, with about 75,656 coming from SSA employees across components (e.g., field offices, DDSs, appeals). The OIG does not report on the number of allegations received from each component. The number of referrals that included physicians is not completely known because the OIG's data does not consistently capture the type of person suspected of fraud.

SSA's program operations manual outlines high risk factors that employees, such as DDS and field office staff, should consider when reviewing cases, including several related to medical evidence. Such risk factors include identifying patterns of similar medical histories across claims, conflicting medical evidence, and anomalies such as claimants providing medical evidence from physicians in a different geographic area without the appearance of a logical reason for doing so.

Despite Anti-Fraud Policies and Procedures, SSA Remains Vulnerable to Potential Physician-Assisted Fraud

Staff Reported Difficulty Identifying Potential Fraud and Lack Sufficient Incentives and Training

SSA relies heavily on front-line staff in DDS offices—those who are responsible for reviewing medical evidence—to detect and prevent potential physician-assisted fraud.[14] The employees in the five DDS offices we visited, however, said that they are not well-positioned to identify signs of potential fraud, such as similar medical evidence across multiple claims. Further, the performance measures used by the agency and the DDSs may serve as a disincentive for front-line staff to spend additional time documenting and reporting fraud allegations, and limited training also reduces front-line staff's ability to identify such fraud.

Identifying Patterns of Potential Fraud

Although SSA relies on front-line staff as their first line of defense to detect potential fraud, it can be difficult for them to identify potential fraud in claims. Instead of systematically using data systems or analytics to

[14] Throughout this report, we use the term front-line staff to mean examiners and medical consultants who review medical evidence to make disability determinations at the DDS level. We recognize that field office and other SSA staff also play a critical role in identifying potential fraud. However, our report focuses primarily on the DDS role because DDS staff are responsible for reviewing medical evidence.

detect patterns of potential fraud, SSA's guidance instructs front-line staff to identify suspicious patterns of medical evidence—such as boilerplate or similar language from the same physician across multiple claims—as well as other factors that may indicate potential fraud. However, SSA regional officials, DDS management, and front-line staff said that it is difficult to detect these patterns because staff may review claims originating anywhere in the state or across a large geographic area, leaving it in part to chance that staff would see evidence from a single physician on more than one claim. As a result, DDS staff stated that they must rely on coincidence—such as the receipt of consecutive claims with evidence from the same physician—to be able to identify a suspicious pattern. Additionally, single applications are generally seen by multiple staff in the course of development and determinations. DDS and SSA regional officials stated that, irrespective of how claims are distributed amongst staff, the volume of claims and associated medical evidence they review makes it difficult to detect patterns of potential fraud. Front-line staff are expected to review multiple claims every day, each of which may be supported by medical evidence from multiple physicians. One DDS director stated that the sheer number of physicians who submit medical evidence make it challenging to identify suspicious patterns from any one physician.

Possible Disincentives to Identify and Report Potential Fraud

SSA and DDS performance measures incentivize processing claims quickly and may pose a barrier to front-line staff's willingness to develop referrals and report potential fraud. SSA assesses DDS performance, in part, based on the length of time it takes to process claims.[15] In turn, all five DDSs we visited assess front-line staff on the speed by which they process claims. According to SSA, disability applicants file at vulnerable times in their lives and the agency and DDS offices focus on making timely and fully considered objective decisions on applications and develop performance measures in support of this objective. Our previous work has found that there are positive aspects of aligning individual performance expectations with organizational goals.[16] We have also noted the importance of balancing quality and timeliness goals, with the

[15] SSA regulations set performance standards for the DDSs based on their initial processing time and the performance accuracy of claims. 20 C.F.R. §§ 404.1641, 416.1041.

[16] GAO, *Results-Oriented Cultures: Insights for U.S. Agencies from Other Countries' Performance Management Initiatives*, GAO-02-862 (Washington, D.C.: Aug. 2, 2002).

potential for unintended perverse incentives.[17] When potential fraud is suspected, SSA policy states that staff should develop evidence to support their suspicions and prepare referral forms that explain the basis for their concern. During our site visits, some front-line staff stated that they do not report suspicious physicians or potential fraud because developing the evidence to report the allegation adversely affects their ability to process claims promptly. Only one DDS we visited lessened the potential disincentives to reporting suspected fraud by not counting the time spent developing allegations of fraud against the employees' claims processing time. This DDS also provided recognition to staff when their fraud allegation resulted in conviction or a denial of benefits. Front-line staff we met with at this DDS stated that this recognition incentivized them to be more vigilant about identifying and reporting suspicious claims.

SSA's focus on timeliness may also create a disincentive for front-line staff to report sources of questionable information in claims that they have denied. SSA guidance directs DDS staff to report all suspicious claims, even if the claim is denied.[18] However, staff in three of the five DDSs we visited said they may not always report potentially fraudulent information to the OIG if there is already sufficient evidence to make a denial because of the additional time required to process the fraud referral. One DDS director stated that denied claims are typically not reported to the OIG because an investigation would be redundant and wasteful considering that it would produce the same result—a denied claim. Nevertheless, there is merit in reporting these denied claims with suspicious evidence because they could either be appealed or the claimant could reapply at a later date and there may not be any indication to the subsequent reviewer that suspicious evidence exists. Moreover, without these referrals of

[17] For examples of how performance measures can potentially create perverse incentives, see GAO, *Federal Transit Programs: Federal Transit Administration Has Opportunities to Improve Performance Accountability*, GAO-11-54 (Washington, D.C.: Nov. 17, 2010) and GAO, T*ax Administration: IRS Needs to Further Refine Its Tax Filing Season Performance Measures*, GAO-03-143 (Washington, D.C.: Nov. 22, 2002).

[18] SSA guidance instructs front-line staff to refer all fraud or similar fault issues for investigation even when staff disregard the questionable evidence or make a determination based on other evidence. Staff should not initiate further development solely to resolve these potential issues, but should refer all questionable issues after the disability determination has been made. "Similar fault" is involved in situations in which an incorrect or incomplete statement material to the determination is knowingly made, or information that is material to the determination is knowingly concealed.

suspicious claims, SSA is missing key information that could help them identify patterns of potential physician-assisted fraud.

DDS staff in some of the offices we visited also told us that they were reluctant to report potential fraud because of a perceived lack of communication from the OIG regarding the status or outcome of their fraud referrals. According to the OIG, the office communicates the status of investigations to DDS management approximately 1 month after the fraud referral is received. However, staff in four of the five DDSs we visited stated that the communication they receive from the OIG is inadequate. For example, some staff reported that when cases were denied for investigation, the OIG did not sufficiently explain the reason for the denial. In some instances, staff never received a response about the status of their referral. Some front-line staff we spoke to said that they would report more cases of potential fraud if they received better feedback on the outcome of their referrals.

Lack of Training on How to Identify or Report Potential Fraud

Staff from four of the five DDSs we visited stated that the anti-fraud training they received was infrequent, insufficient, and that additional training was needed. As part of their new employee training, front-line staff receive a short segment of anti-fraud instruction. This training defines fraud and provides an overview of SSA's anti-fraud policies and procedures. However, subsequent anti-fraud training is not mandatory and varies by state. Federal internal control standards state that management needs to identify appropriate knowledge and skills needed for various jobs, such as identifying and preventing potential fraud, and provide appropriate training.[19] SSA does not require DDS employees to receive training on fraud identification or reporting beyond their initial training courses and SSA officials stated that DDSs are primarily responsible for determining the training needs of their staff. We found that additional anti-fraud training at the five DDSs we visited often occurred infrequently or not at all. Without additional training, front-line staff may not have the skills and knowledge to identify and report potential fraud. For example, front-line staff at one DDS had not received any anti-fraud training since their initial basic training and stated that they did not know how to identify or report potential fraud. At another DDS, some staff indicated they had not received training in several years.

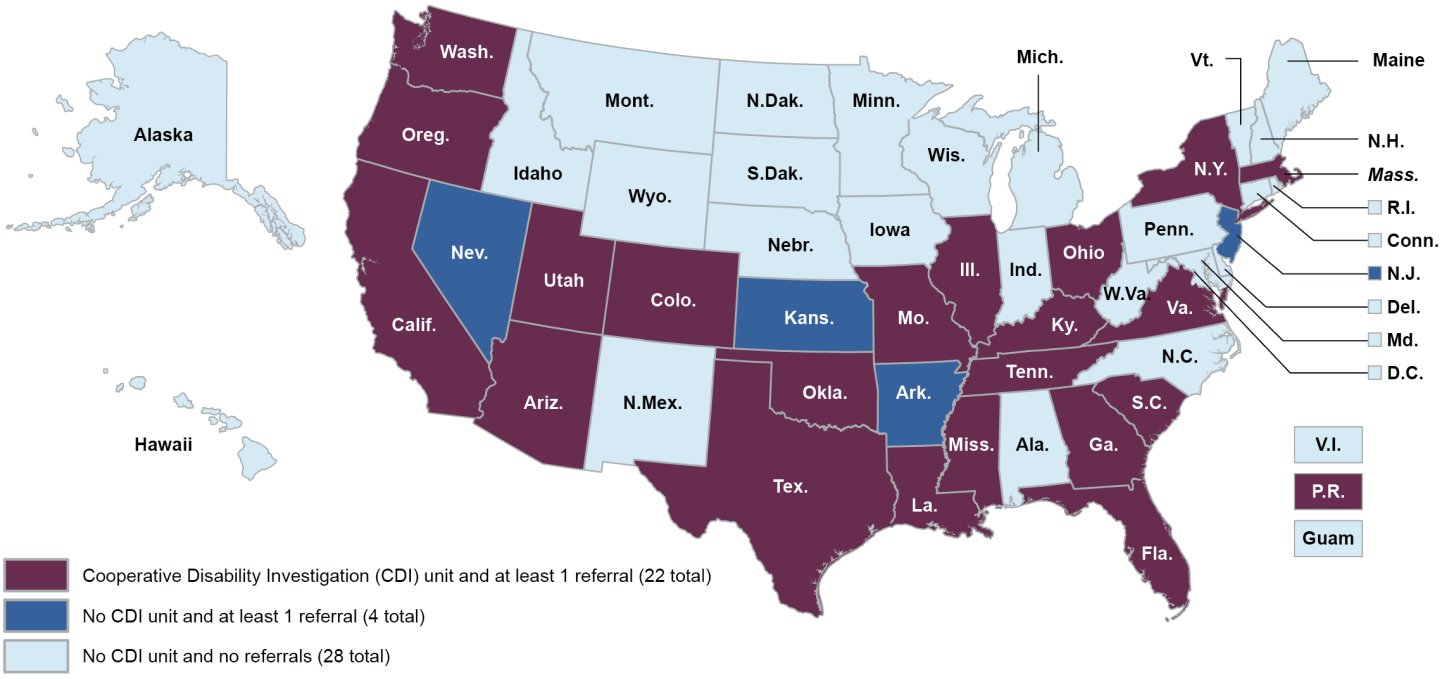
[19] GAO/AIMD-00-21.3.1.

Data we reviewed suggests that DDSs in states with CDI units are likely to receive more training on how to identify and report potential fraud, contributing to more referrals from these DDSs. According to OIG data, 28 of the 32 states and territories without a CDI unit did not refer any suspicious claims to the OIG in 2013 compared to an average of 216 referrals from DDSs in states with a CDI unit, including the Commonwealth of Puerto Rico (see fig. 3 for CDI unit and fraud referral information).[20] Front-line staff in the two states we visited with CDI units—California and Illinois—also noted the benefits of additional anti-fraud training, including a better understanding of the fraud referral process. Further, Illinois officials said that the number of suspicious claims referred by staff increased after receiving training from the CDI unit. Nonetheless, DDS staff in both states said that training was not provided regularly and that they would like to receive additional training that includes examples of fraud investigations—such as cases in which medical providers and others may have colluded to help claimants obtain benefits—and strategies to prevent similar events from occurring in the future. OIG officials stated that they are reluctant to provide additional training to states without established CDI units because they do not have the resources to investigate the expected increase in fraud referrals from those states.[21]

[20] Our analysis is based on 2013 data, at which time there were 25 CDI units in 21 states and Puerto Rico.

[21] According to SSA, the agency is working toward opening CDI units in six additional states and the District of Columbia, bringing the total number of units to 32. One of these new units was opened in August 2014 in Detroit, Michigan. A second unit opened in Baltimore, Maryland in September 2014. In addition, SSA is expanding the capacity of several of the existing 25 units by increasing the number of law enforcement investigators in the units.

Figure 3: Range of Fraud Allegations from State Disability Determination Services, 2013



Source: GAO analysis of Social Security Administration Office of the Inspector General data; National Atlas (base map) | GAO-15-19

Note: The figure represents fraud allegations reported to the Social Security Administration (SSA) Office of Inspector General from Disability Determination Services in calendar year 2013. Fraud allegations reported by other SSA components were not included in the data.

SSA Policies and Procedures Allow Some Sanctioned Physicians to Provide Medical Evidence

Potential vulnerabilities exist in how DDSs screen and use medical evidence from sanctioned physicians. SSA regulations prohibit DDSs from purchasing consultative exams from medical providers who are currently barred from participation in federal or federally-assisted programs.[22] To comply with these regulations, SSA instructs DDSs to screen medical providers who conduct consultative exams against a list of sanctioned providers maintained by the Department of Health and

[22] See 20 C.F.R. §§ 404.1503a, 416.903a.

Human Services Office of Inspector General.[23] Regarding medical records, federal law generally requires SSA to review all available evidence and make every reasonable effort to obtain medical evidence from the claimant's treating physician and other treating health care providers.[24] However, under the Social Security Act, the agency is required to disregard any evidence reviewed when there is reason to believe that fraud or "similar fault" is involved with the determination.[25] The agency is also required to exclude from participation in SSA programs, representatives and health care providers convicted of violations of specific criminal offenses related to SSA programs.[26] Such offenses include making false statements related to DI or SSI applications. SSA regulations set forth factors for how medical evidence should be considered and weighted by DDS staff when making a disability determination.[27] DDSs that we visited do not, however, screen physicians who submit medical evidence on behalf of a claimant against the sanctioned list and therefore front-line staff do not know whether the medical evidence they are basing their disability determination on came from a sanctioned physician. While being on the sanctioned list does not mean that a physician submitted fraudulent evidence to SSA, it could be an indicator that the claim includes questionable evidence.

[23] The HHS OIG excludes individuals and entities from federal health care programs and maintains the list of excluded individuals and entities, also known as the sanctioned list. Physicians may be sanctioned for numerous reasons, including health care fraud or suspension of a medical license. In addition to reviewing the sanctioned list for physicians that conduct consultative exams, SSA policy requires DDSs to verify their medical providers' current licensure and credentials with the State Medical Board. Throughout this report, we generally use the term "sanctioned" to refer to individuals on the HHS list, or individuals who are prohibited from providing services in the SSI or DI programs under SSA regulations.

[24] 42 U.S.C. §§ 423(d)(5)(B), 1382c(a)(3)(H)(i).

[25] 42 U.S.C. §§ 405(u), 1383(e)(7).

[26] 42 U.S.C. § 1320b-6.

[27] 20 C.F.R. §§ 404.1527, 416.927. In particular, SSA will consider any factors brought to the agency's attention, or of which the agency is aware, which tend to support or contradict the medical opinion. Some of the other factors that the agency will consider in evaluating medical opinion evidence include: (1) the examining relationship; (2) treatment relationship; (3) supportability of the opinion with medical signs and laboratory findings; (4) consistency of the medical opinion with the record as a whole; and (5) whether the source is a specialist.

After matching vendor files from California and Illinois against the sanctioned list, we found that neither state purchased consultative exams from sanctioned physicians since 2010.[28] In the same time period, however, at least 37 sanctioned physicians in these states provided medical evidence to the agency on behalf of claimants and 22 of these physicians provided such evidence after they had been sanctioned, potentially affecting the validity of those claims (see table 2).[29] Our results demonstrate that, in some instances, SSA is accepting medical evidence from potentially questionable and unreliable physicians.[30] We identified sanctioned physicians who were convicted of health care fraud or other program-related crimes who submitted medical evidence on behalf of claimants. For example, one physician, who was placed on the sanctioned list in 2011 for smuggling over $1 million in foreign misbranded and unapproved drugs into the United States and administering them to his patients, submitted evidence for at least 33 disability claimants in the past 2 years. Such information could be useful to front-line workers in that they would be able to better determine whether more scrutiny of the medical evidence may be warranted, potentially resulting in a reduced risk of fraud. Further, front-line staff said it would be helpful to have a list of suspicious physicians available when reviewing claims. One DDS created such a list that includes physicians who DDS staff identified as providing suspect evidence—such as a pattern of exaggerated medical findings—in the past. However, frontline staff who we spoke with said they were unaware of this list.

[28] Vendor files are maintained by each DDS and lists the individuals or entities who were paid for conducting consultative examinations or providing medical evidence in support of disability claims.

[29] There may have been sanctioned physicians who conducted consultative exams or submitted medical evidence to these DDSs on behalf of a claimant that we were not able to identify due to limitations of our analysis. We identified sanctioned physicians by their Social Security or tax employer identification number as recorded in the DDS vendor files. However, SSA and DDS staff told us that this personally identifiable information may not be captured in the vendor files if they work for clinics, hospitals, or other institutions. As a result, we may not have identified sanctioned physicians who work in these institutions, but DDS officials in California and Illinois stated that they match the names of all physicians who conduct consultative exams and work for institutions against the sanctioned list.

[30] As noted earlier, SSA is statutorily obligated to consider all available evidence regardless of the provider's status, with some exceptions.

Table 2: Sanctioned Physicians Who Submitted Medical Evidence, Calendar Years 2010- 2014

State Disability Determination Services (DDS)[a]	Sanctioned physicians submitting medical evidence after being placed on the sanctioned list	Sanctioned physicians submitting medical evidence before being placed on the sanctioned list[b]
California	19	7
Illinois	3	8

Source: GAO analysis of state DDS vendor data and Department of Health and Human Services, Office of Inspector General's sanctioned provider list. | GAO-15-19

Note: Total number of sanctioned physicians who submitted medical evidence could be an undercount. DDS vendor files may only collect information for the individual or entity they pay for the medical record – which may be a clinic, hospital or third-party company that manages medical records or payments on behalf of physicians – instead of the name of the individual physician who developed the medical record. In these instances, the vendor data would not allow us to determine if a sanctioned physician submitted the medical evidence used in a disability claim. Additionally, we did not attempt to determine whether identified physicians committed disability fraud.

[a] California data are for providers who submitted evidence as of August 2014 and Illinois data are for providers who submitted evidence as of June 2014.

[b] These physicians were not sanctioned at the time they submitted medical evidence to SSA on behalf of a claimant.

SSA faces barriers to identifying and addressing the potential risks associated with medical evidence submitted by sanctioned physicians. According to SSA officials, the agency has explored whether it would be beneficial to consider physicians' licensing status when making a disability determination. The agency identified several logistical barriers to checking licensure status for all physicians who submit medical evidence, and also cited complex policy implications that they believe could result in increased appeals and potentially disadvantage claimants, among other challenges. For example, SSA would have to determine when and what evidence from a physician to exclude and the type of sanctions to consider, among other things. The SSA OIG also reported in 2013 on hurdles regarding screening evidence against the sanctioned list.[31] According to SSA's OIG, SSA and the DDSs request more than 15 million health records from over 500,000 physicians every year. Further, the SSA OIG also reported that because the sanctioned list generally contains the names of individual physicians, a sanctioned physician who provides

[31] Social Security Administration, Office of the Inspector General, *Quick Response Evaluation Report, Sanctioned Medical Providers and Medical Evidence of Record,* A-01-13-23064 (Feb. 8, 2013).

medical evidence on behalf of a claimant may not be detected by the DDS if they work for a hospital or clinic.[32] We found similar limitations with the data that DDSs currently collect. For instance, SSA does not require DDSs to routinely and uniformly record the names and addresses of physicians who submit medical evidence on behalf of claimants. As a result, DDSs collect inconsistent and incomplete data on medical providers, which limits SSA's ability to identify sanctioned physicians. For example, hospitals or similar institutions that employ hundreds of individuals may have only one source recorded in DDS vendor files.

Despite these barriers, as SSA moves forward on key information technology initiatives, the agency has an opportunity to assess several risk factors, including whether sanctioned physicians are providing medical evidence, and the likelihood that such evidence could be fraudulent. Federal internal control standards state that agencies should identify and analyze the relevant risks from external sources, such as potentially questionable evidence from sanctioned physicians.[33] SSA is in the process of transferring state vendor information from 54 distinct DDS data systems into a National Vendor File that will include information on all medical providers whom the agency pays for medical evidence.[34] Such a consolidation may present an opportunity for the agency to better assess the threat of sanctioned physicians submitting medical evidence on behalf of claimants and reduce the administrative cost of identifying such physicians on a DDS by DDS basis. Having national-level data could help SSA better determine risk factors for potential fraud as well as what medical evidence should be subject to additional scrutiny. Additionally, consolidating vendor data gives the agency an opportunity to gain a better understanding of the inconsistencies in the information collected at the DDS level and determine whether it should implement more uniform data collection and policy requirements.

[32] Social Security Administration, Office of the Inspector General, *Quick Response Evaluation Report, Sanctioned Medical Providers and Medical Evidence of Record,* A-01-13-23064 (Feb. 8, 2013).

[33] GAO/AIMD-00-21.3.1.

[34] The National Vendor File is a data warehouse that stores medical and non-medical information from DDSs. As of July 2014, the file included data from 20 DDSs.

SSA Has Launched Several Initiatives to Better Detect Fraud but Faces a Number of Implementation Challenges

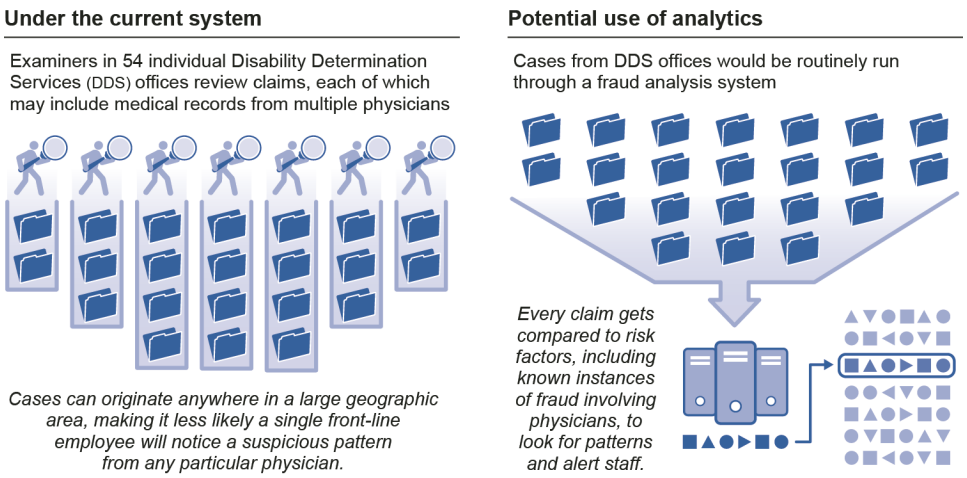
SSA Is Developing a Fraud Analytics Model, but Lacks an Implementation Plan

Recognizing that it must do more to systematically detect potential fraud, SSA is in the early stages of exploring the use of computerized tools to enhance its efforts. Known as predictive analytics, these are automated systems and tools that can help identify patterns of potentially fraudulent claims—such as patterns of suspicious behavior involving physicians and claimants—before claims are paid. A system such as this would give SSA the ability to systematically check large numbers of claims for potential fraud in addition to using front-line staff to spot suspicious patterns in claims. Staff from SSA's Office of Information Security began this analytics effort in February 2014 and piloted these capabilities in two stages. In the first stage, SSA developed its initial computer model and identified existing sources of data within the agency. SSA tested and refined its model by using recent cases of alleged fraud in Puerto Rico, New York, and West Virginia to determine whether it would have detected characteristics of potential fraud in those cases. SSA reported that it completed this stage in May 2014 and that its efforts were successful. In the second stage, SSA will explore purchasing a tool from a vendor and using analytics to spot suspicious claims in other locations. SSA will also explore purchasing data—such as arrest records—from an external vendor to integrate into its system that could help SSA to identify links between disability claims, physicians, and attorney representatives through social network analysis[35] that may not be apparent from existing SSA data. For example, SSA staff said these data could identify individuals who are seemingly unconnected but who shared an address in the past. External data also proved to be helpful in the recent case of suspected fraud in New York, where investigators made use of local

[35] Social network analysis involves the use of public records and other data to demonstrate social linkages between individuals and entities to draw connections between parties potentially involved in fraud schemes.

government data to determine that beneficiaries made false statements when applying for benefits. SSA told us that while it completed its second phase of testing, which consisted of a preliminary risk-scoring model for disability claims, significant work remains to be done before it has a working analytics system in place. See figure 4 for an illustration of how a predictive model would differ from SSA's current approach.

Figure 4: Example of How Predictive Analytics Can Be Used to Detect Potential Fraud



Source: GAO analysis of Social Security Administration plans. | GAO-15-19

Alleged New York City Disability Fraud Scheme

In early 2014, 130 disability beneficiaries and four middlemen were indicted for allegedly defrauding Social Security. The beneficiaries, many of whom were former firefighters and police officers, were supposedly coached by these middlemen on how to fail mental health exams, and many of the disability applications had nearly identical descriptions of mental ailments. In return for their assistance, the middlemen are reported to have received payments of up to $45,000 for helping to obtain unwarranted benefits. This investigation continues, but the OIG reports that the amount of benefits received by the beneficiaries named in the indictments is almost $30 million.

Source: GAO review of publically available OIG documents.

SSA's analytics efforts have potential, but we have concerns regarding the agency's ability and capacity to implement such a system on a large scale going forward. For example, SSA does not consistently collect some data that may aid in its analytics effort. As part of its analytics efforts, SSA plans to look for relationships between physicians who provide medical evidence and potentially fraudulent claims. However, as we noted earlier, SSA and DDS officials told us that existing data systems often do not identify individual physicians. Instead, the systems may capture the hospital or clinic that provided medical records, or in some cases, a third-party company that manages medical records or payments on behalf of physicians. An SSA official working on analysis efforts noted that SSA currently lacks the ability to distinguish between individual physicians and clinics or hospitals. Without the ability to consistently identify individual physicians, SSA's ability to detect potential physician-assisted fraud may be hampered. SSA must also contend with obtaining physician data from a number of case management systems. For

example, the agency is in the process of transitioning DDSs from five different legacy case management systems to a unified Disability Case Processing System that will be used by all DDSs.[36] SSA officials stated that the National Vendor File that will be linked to this system has the ability to capture individual physician license numbers. This vendor file currently only collects the same information as the DDS's existing legacy systems, which may or may not include this information because SSA does not require DDSs to collect unique identifiers for physicians. Further, while SSA is also pursuing external data sources to perform social network analysis, its ability to fully make use of this information could be limited by its inability to readily identify the physicians involved in disability claims.

Alleged Puerto Rico Disability Fraud Scheme

In August 2013, 75 individuals in Puerto Rico were indicted for disability fraud. This included a claimant representative (and former Social Security employee), three physicians, and 71 claimants. The representative allegedly conspired with three doctors to fabricate and submit false medical evidence to support unwarranted disability claims for his clients. According to the Department of Justice (DOJ), these physicians received kickbacks of between $150 and $500 to submit false medical evidence to SSA, and the representative received a lump-sum payment. Although the investigation continues, 34 of the 75 individuals charged have pled guilty as of March 2014.

Source: GAO review of publically available OIG and DOJ reports.

Moreover, SSA has yet to detail how it will first operationalize any analytics efforts into its ongoing business practices and then investigate potential leads generated. Officials we spoke with at the Centers for Medicare & Medicaid Services (CMS)—who implemented their own fraud analytics program in 2011—and several private disability insurers told us that analytics are helpful for determining which claims are at risk for potential fraud and where to focus investigative resources. However, they noted that organizations cannot rely on analytics alone to determine whether fraud is occurring and that considerable staff resources are often needed to develop leads that result from the initial analysis. For instance, officials at one private disability insurer said that analysts may spend half a day examining a claim before deciding whether additional investigation is warranted. This sentiment was shared by participants at a 2013 GAO forum on data analytics who noted that having knowledgeable staff was critical for interpreting the results of analytics and identifying investigative leads.[37] However, we and the SSA OIG have previously reported on challenges facing SSA, including declining staff levels at DDSs and

[36] The development of this system has been delayed and may not be operational as planned in fiscal year 2016.

[37] GAO, *Highlights of a Forum: Data Analytics For Oversight and Law Enforcement*. GAO-13-680SP (Washington, D.C.: July 15, 2013).

difficulty in meeting SSA performance goals.[38] We also recommended that SSA develop a long-term plan to address service delivery challenges, including those related to human capital and information technology initiatives.[39] The agency has noted the benefit of using data analytics to prevent fraud and has mentioned data analytics in its Strategic Plan, 2015 budget request, and Information Resource Management Strategic Plan. However, these agency documents do not provide concrete steps or identify the needed resources to make this undertaking successful. Additionally, staff working on the analytics pilot told us that SSA has yet to determine which component of SSA will ultimately have responsibility for following up on leads. One analytics firm cautioned that analytics cannot just be a software tool, but must fit into a larger cultural change regarding fraud and how business is conducted. It added that an organization that jumps into analytics without a clear plan and goals risks failure.

Alleged West Virginia Disability Fraud Scheme

SSA is investigating claims stemming from West Virginia. According to a staff report from the Senate Committee on Homeland Security and Government Affairs, an attorney conspired with an SSA administrative law judge (ALJ) to allow disability benefits for undeserving claimants. As part of this alleged scheme, the ALJ's office would schedule exams with doctors favored by the attorney. The attorney is said to have provided pre-filled medical forms to these doctors, which often contained similar language. The ALJ was placed on administrative leave and later retired, and the attorney continues to practice disability law.

Source: GAO review of SSA testimony and staff report from the Senate Committee on Homeland Security and Governmental Affairs.

Additionally, without more details on its plans, it is unclear whether SSA can adhere to key practices that organizations must use to successfully implement fraud analytics. We identified these practices in past work and by interviewing other organizations that have implemented analytics (see table 3).[40] In its early efforts, SSA has so far followed some key practices. For example, SSA has publicized its efforts, including announcing its plans during a congressional hearing. SSA has also consulted with other organizations, such as CMS, which already have analytics in place. Agency officials identified other steps they have taken that align with these key practices, but when we requested additional details on how it will carry out these efforts, SSA did not yet have any concrete plans.

[38] For example, GAO, *Social Security Administration: Long-term Strategy Needed to Address Key Management Challenges*. GAO-13-459 (Washington, D.C.: May 29, 2013); SSA OIG, *Fiscal Year 2013 Inspector General Statement on the Social Security Administration's Major Management and Performance Challenges*. A-02-14-14056 (Baltimore, MD: Dec. 6, 2013).

[39] GAO-13-459.

[40] GAO-13-104.

Table 3: Key Practices for Agencies to Consider When Implementing Fraud Analytics Systems

Key practice	Description
Utilizing a variety of data sources	Using a number of sources for analytics, such as criminal, death, and corporate records, can improve results.
Social network analysis	This is emerging as an important tool to combat organized fraud since it can be used to demonstrate linkages among individuals involved in fraud schemes.[a]
Close and continuing collaboration	Feedback from the end users of analytics systems (such as investigators) can improve analysis, help refine predictive models, and limit false positives.
Collaboration with external stakeholders	Working with outside organizations, including other insurers and government health programs, can aid in the detection of fraudulent providers and leverage resources.
Publicizing the use of predictive analytics	Advertising analytic technologies may deter providers from committing fraud.
Mining text data	Using systems to search through the text in claims and related medical reports to detect instances of suspicious language or unwarranted similarities between claims.

Source: GAO analysis of our prior work on key practices to detect and prevent fraud. | GAO-15-19

[a]Social network analysis may or may not include the use of information from social media sites. Any use of such sites, including the use of information obtained from such sites, must be consistent with applicable federal laws and regulations.

The Effectiveness of Recent Fraud Detection Initiatives Could Be Hindered by SSA's Management Approach

In addition to predictive analytics, other SSA components are implementing several efforts that may have the potential to detect and prevent potential physician-assisted fraud.

SSA OIG Disability Fraud Pilot: The SSA OIG is piloting an effort to augment its CDI units and target organized fraud schemes, such as those that allegedly occurred in New York and Puerto Rico. OIG officials told us that this effort will differ from existing CDI efforts, which generally investigate potential fraud before SSA makes a disability determination and are focused on claimants. The fraud pilot will instead focus on third-party facilitators—including physicians and attorneys—and their involvement in systematic efforts to defraud SSA's disability programs. OIG officials noted that the pilot incorporates new performance measures that allow for prolonged investigations as opposed to the quicker investigations normally conducted by CDI units. The OIG began the pilot in the summer of 2013 in four locations and will consider expanding the effort in fiscal year 2015 after evaluating the success of the pilot and the effect it has had on SSA disability programs.

- **Disability Fraud Prevention Units:** SSA established a centralized fraud prevention unit based in New York City to identify instances of potential fraud and look for trends nationwide. Initially, this unit will utilize 20 disability examiners with experience in investigating claims associated with the New York City and Puerto Rico fraud cases. SSA recently established additional units in Kansas City and San Francisco. SSA expects that these units will provide ongoing investigative support to the OIG as well as analytical and programmatic support to federal and local prosecutors pursuing cases of potential fraud.

- **Office of Disability Adjudication Review (ODAR) data analysis efforts:** ODAR—which is responsible for overseeing the claims appeals process—has an ongoing effort analyzing data from claims decided at the appeals level. ODAR officials told us that this effort was intended to provide better oversight of administrative law judges, as well as to identify errors in decisions to be better able to target training resources. ODAR is also using these data to look for irregularities—such as repeated instances of similar language from a physician—and identify potential fraud, referring those cases to the OIG. Additionally, ODAR is working with the OIG disability fraud pilot to provide data in support of their efforts.

Although SSA officials indicated that several of these efforts will be under the purview of the recently reinstituted National Anti-Fraud Committee,[41] the agency lacks detailed plans describing how these various efforts will be implemented or how they will relate to each other. In prior work, we have reported that clearly delineating activities and timelines, and defining problems and goals, are key elements of sound planning. Specifically, agencies should identify activities needed to complete projects and be able to describe how these activities are related to each other.[42] However, SSA has yet to articulate how these efforts will relate to each other. For example, while the fraud analytics pilot, the OIG disability fraud pilot, the disability fraud prevention units, and ODAR's efforts all involve some

[41] According to SSA, the committee is co-chaired by the Deputy Commissioner for Budget, Finance, Quality, and Management, and the Inspector General. The committee will serve as a forum for senior executives to collaborate on anti-fraud efforts across the agency. The committee was originally formed in 1996, but met on an ad-hoc basis after 2003. It was reinstated in January 2014 and held its first meeting in March 2014.

[42] GAO, *VA Disability Compensation: Actions Needed to Address Hurdles Facing Program Modernization,* GAO-12-846 (Washington, D.C.: Sept. 10, 2012).

analysis of disability claims data, SSA's plans do not address how these efforts will support each other or how it will avoid duplication across efforts. Additionally, SSA was unable to provide us with detailed information regarding the development of these initiatives or describe how they differed from each other.

Competing priorities may compromise SSA's ability to follow through on plans to enhance fraud detection and maintain this focus. As stated earlier, SSA has not sufficiently balanced the need to quickly process claims and pay benefits with the need to ensure program integrity. Moreover, SSA officials told us that the role of the agency and DDSs is to help claimants navigate a complex application process and that searching out fraud—while a concern—does not align with SSA's core mission. In addition, employees at two of the DDSs we visited told us that SSA only began to emphasize the need to look for potential fraud after the announcement of alleged schemes; and they were concerned about the agency's ability to maintain a sustained focus in this area. One DDS director added that SSA needs to build fraud detection into its regular business operations in order to sustain it. The director added that SSA currently budgets only enough resources to its DDSs to maintain their current business practices.

Conclusions

While the full extent and nature of physician-assisted fraud is difficult to measure, any occurrence has the potential to undermine confidence in SSA's ability to award benefits only to deserving individuals. The agency relies on front-line workers, including those who collect and assess claimants' medical records at DDS offices, to be the first line of defense against potential fraud. They are also expected to make timely and accurate disability determinations. In some instances, the agency's focus on making determinations quickly has been a disincentive to reporting suspicious physicians or potential fraud. Unless SSA and the DDSs work to remedy performance measures that primarily focus on and reward timeliness, possibly at the expense of delving into potentially problematic claims, the agency will remain vulnerable to potential fraud. Further, absent enhanced and consistent training, front-line staff may lack the expertise to identify and report potential fraud.

SSA has some controls in place to help ensure that sanctioned physicians do not perform exams on behalf of the agency. However, the agency could be exposing itself to risk by using medical evidence from physicians who are sanctioned by either federal or state governments. While there are numerous reasons a physician can be sanctioned, without knowing whether such physicians have provided medical

evidence and why they were sanctioned, SSA could be missing information needed to identify and flag for additional scrutiny potentially falsified medical evidence.

Lastly, as the agency begins to shift its focus to better detection and prevention of potential fraud through analytics, it will be important to balance these new efforts with the existing workload demands on front-line staff. Furthermore, even though substantial resources and collaboration will be needed to fully implement a successful analytics system and follow up on resulting leads, SSA has not systematically identified the data and actions needed to implement and make them successful. Given the lack of details that the agency was able to provide on its plans, we have concerns about their potential success. Absent a coordinated and cohesive effort, SSA could undermine the success of its new initiatives and remain vulnerable to physician-assisted fraud in the future.

Recommendations for Executive Action

We recommend that the Commissioner of the Social Security Administration take the following actions to improve the ability of the agency to detect and prevent potential physician-assisted fraud:

1. To address potential disincentives for staff to detect and prevent physician-assisted fraud, SSA should review the standards used to assess DDS performance; and develop and distribute promising practices to incentivize staff to better balance the goal of processing claims promptly with the equally important goal of identifying and reporting evidence of potential fraud.
2. To ensure that the agency captures complete information on suspicious claims, SSA should issue guidance to remind DDSs of its existing policy to report all claims with potentially fraudulent medical evidence to the SSA OIG, even if sufficient evidence exists to deny a claim.
3. To help front-line staff identify potentially fraudulent activity, SSA should enhance its training efforts by ensuring it provides fraud-related refresher training to all DDS employees on a regular basis. Such training should include the identification of suspicious medical evidence and providers, as well as the processes and procedures for reporting such information. To facilitate its efforts, the agency could coordinate with the SSA OIG and draw on the type of training provided by CDI units.
4. To address the potential risks associated with medical evidence submitted by sanctioned physicians, SSA should evaluate the threat

posed by this information and, if warranted, consider changes to its policies and procedures.

5. To help ensure new initiatives that use analytics to identify potential fraud schemes are successful, SSA should develop an implementation plan that identifies both short- and long-term actions, including:
   - timeframes for implementation;
   - resources and staffing needs;
   - data requirements, e.g., the collection of unique medical provider information;
   - how technology improvement will be integrated into existing technology improvements such as the Disability Case Processing System and National Vendor File; and
   - how different initiatives will interact and support each other.

Agency Comments and Our Evaluation

We provided a draft of this product to the Social Security Administration for comment. In its written comments, reproduced in appendix II, SSA agreed with 4 of our 5 recommendations and partially agreed with one of them. SSA partially agreed with our recommendation to review its standards used to assess DDS performance; and develop and distribute promising practices to incentivize staff to better balance the goal of processing claims promptly with the equally important goal of identifying and reporting evidence of potential fraud. SSA did not specify why it did not agree fully, but did outline the critical role that field and DDS office staff play in identifying and detecting potential fraud. In our report, we acknowledge that these employees are the first line of defense against fraud. We also noted that based on our interviews, and review of agency and DDS performance standards, that there is a potential disincentive to report suspicious claims. If properly designed and managed, performance standards that include identifying and reporting suspicious claims could provide incentives to encourage staff to devote more time to program integrity issues while maintaining their ability to process claims in a timely manner. Such standards would also further demonstrate to DDS staff SSA management's commitment to preventing potential physician-assisted fraud in its disability programs.

SSA agreed with the remainder of our recommendations and provided additional information about the actions it has taken in the past year to enhance its fraud detection and prevention efforts and steps they will take going forward.

SSA also provided technical comments on our report, which we incorporated as appropriate. In these comments, the agency noted that our report implies that fraud schemes are more commonplace than they actually are. Our report states that the full extent and nature of physician-assisted fraud is difficult to measure and that even one instance of this type of fraud could result in a large number of beneficiaries improperly receiving benefits, as well as substantial costs to the government. SSA also commented that our report overemphasized the potential utility of the List of Excluded Individuals and Entities for identifying potential physician-assisted fraud. In our report, we noted key limitations and challenges to using this list. Nonetheless, we maintain that some physicians—an important component of the disability determination process—have been at least suspected of fraudulent activities by others and this is important information for SSA to consider. We believe SSA can improve staffs' ability to identify cases that deserve closer scrutiny by more fully assessing the potential threat posed by sanctioned physicians. Such an assessment would also help the agency identify actions that DDS offices could take to better track and screen for evidence from these providers. In the long-term it could also assist with the agency's new fraud analytics efforts.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Commissioner of Social Security and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7215 or bertonid@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

Daniel Bertoni
Director, Education, Workforce,
and Income Security

Appendix I: Objectives, Scope, and Methodology

In conducting our review of potential physician-assisted fraud in the Social Security Administration's (SSA) disability programs, our objectives were to examine (1) SSA's policies and procedures for detecting and deterring physician assisted fraud, and (2) the steps SSA is taking to improve its ability to detect physician-assisted fraud. We reviewed relevant federal laws and regulations, as well as SSA program documentation including policies, procedures, training manuals, and performance plans, as well as reports and testimonies from SSA and the Office of the Inspector General (OIG) on fraud detection and prevention efforts. We evaluated SSA's efforts against its own policies and procedures, federal internal control standards, and other key fraud analytics practices to detect and prevent potential fraud. We also interviewed key officials in SSA and conducted site visits to five states where we interviewed Disability Determination Services (DDS) and SSA regional office staff. Additionally, we interviewed organizations that represent DDS management and front-line SSA employees, in addition to meeting with private disability insurers and other organizations involved in preventing fraud. We compared the medical provider vendor lists in two states to a list of federally sanctioned doctors.

Interviews and Site Visits

To understand SSA's policies and efforts to improve fraud detection, we interviewed officials in a number of SSA components. These included:

- The Office of the Deputy Commissioner, Operations, which is responsible for overseeing the initial disability determination process and state DDS offices;
- The Office of Disability Adjudication and Review (ODAR), which is responsible for overseeing the disability appeals process;
- The Office of the Chief Strategic Officer;
- The Office of Information Security; and
- The Office of the Inspector General (OIG).

To gain additional perspectives on how SSA policies are implemented and challenges regarding detecting physician-assisted fraud, we conducted site visits to a non-generalizable sample of five states. We chose these states in order to provide diversity in terms of their geographic location, whether the state had a single or multiple DDS locations, the presence of an OIG Cooperative Disability Investigations (CDI) unit, and the data system used by a state. During our site visits, we interviewed DDS management, medical relations professionals, disability examiners and supervisors, and medical consultants. When possible, we

randomly selected examiners and consultants, who worked with the DDS for at least 1 year, to interview based on rosters provided by DDS management. In three of the states, we met with examiners individually. In the other two states, we met with examiners in a group setting because of challenges with scheduling individual interviews. In addition to providing information on SSA's policies and procedures, DDS officials and staff provided insights on SSA's newer fraud detection initiatives. Additionally, we spoke with regional SSA officials in each of the regions that correspond with our site selection. We also spoke with OIG CDI staff in each location where they were present. The information we obtained at our site visits is illustrative and not intended to reflect the experiences of DDSs in other states. See table 4 for key characteristics of our site visit locations.

Table 4: Key Characteristics of GAO Site Visit Locations

DDS	SSA regional office	CDI unit	DDS structure[b]
Alabama	Atlanta, GA	No[a]	Decentralized
California	San Francisco, CA	Yes	Decentralized
Illinois	Chicago, IL	Yes	Centralized
Maryland	Philadelphia, PA	No[a]	Centralized
West Virginia	Philadelphia, PA	No[a]	Decentralized

Source: GAO review of SSA and OIG information. | GAO-15-19

[a]SSA plans to start-up a CDI unit in this state.

[b]Decentralized DDS structures are those that process claims through more than one office in a state.

We also interviewed officials from SSA's New York regional office to better understand how recent alleged fraud cases in New York and Puerto Rico—both within that SSA region—were uncovered, as well as changes made in response to these incidents. In addition, we interviewed officials at the Michigan DDS because it has a dedicated fraud unit.

To supplement our site visits, we interviewed national organizations that represent DDS examiners, managers, and Administrative Law Judges, including:

- Association of Administrative Law Judges
- National Council of Social Security Management Associations
- National Association of Disability Examiners
- National Council of Disability Determination Directors

To provide additional context, we interviewed a number of other federal agencies, private insurers, and other organizations that are familiar with the disability determination process, detecting fraud, or with implementing predictive analytics. These organizations included:

- American Academy of Disability Evaluating Physicians (a professional organization serving physicians involved in disability management and evaluations)
- Coalition Against Insurance Fraud (an anti-fraud alliance that includes public and private insurers)
- Centers for Medicare and Medicaid Services
- Department of Health and Human Services, Office of Inspector General
- Elder Research Inc. (a consulting company focused on predictive analytics and data mining)
- The Recovery Accountability and Transparency Board
- Unum (a private insurer that uses predictive analytics to identify potential fraud)

Analysis of Medical Provider Data

We conducted data matching using information from California and Illinois to help determine the extent to which sanctioned medical providers submitted evidence in disability decisions. We attempted to find providers who appeared in both of these two data sources:

1. *The List of Excluded Individuals and Entities (LEIE):* The list is maintained by the Department of Health and Human Services OIG, and lists individuals who are excluded from federal health care programs for a number of reasons, including health care fraud.

2. *State Vendor Files:* Vendor files are maintained by each DDS and list medical providers who were reimbursed for providing medical evidence in support of disability claims. These vendors include claimants' treating physicians who are reimbursed for providing copies of medical records, and consultative exam providers, who conduct medical exams for the DDS under contract, among others.

Table 5: Data Sources Used in GAO's Analysis

Data sources used	Entity responsible	Population covered	Timeframe of data analyzed
List of Excluded Individuals and Entities	HHS OIG	Federally sanctioned medical providers	As of the end of January 2014
California Vendor File	CA DDS	All individuals or entities paid for medical records by the CA DDS	As of February 2014
Illinois Vendor File	IL DDS	All individuals or entities paid for medical records by the IL DDS	As of April 2014

Source: GAO review of relevant data systems. | GAO-15-19

We conducted matching between each state vendor file and the LEIE on the basis of tax identification numbers—Social Security Numbers or Employee Identification Numbers. In instances when we found a match between both sources, we gave the DDSs (through SSA) summary information on the providers and obtained information on when they last submitted evidence or conducted exams in support of claims. The Illinois DDS provided us with additional information on our matches in June 2014 and the California DDS in August 2014. Providers can be sanctioned for a number of reasons not related to health care fraud; therefore, the results of our matching do not indicate that fraud occurred in either federal health care or disability programs. Additionally, the results of our data matching are not generalizable to other states or to the wider population of disability claims.

There were several limitations in both the state vendor files and the HHS LEIE that could have affected the results of our matching, including:

- DDS vendor data did not include all physicians who submitted medical evidence on behalf of claimants or individual physicians who performed consultative examinations on behalf of SSA. Since these files are used for payment purposes, DDSs only maintain tax identification numbers for vendors (e.g., physicians, clinics, or third-parties managing records on behalf of physicians) who they pay for records or services; not necessarily the individual physicians who see claimants.

- According to the HHS OIG, the LEIE may not reflect all sanctioned medical providers, given limitations on OIG's authorities, appeals of exclusions, and occasional delays in referrals to the OIG. The SSA OIG also noted that sanctioned physicians may move on and off the list depending on the outcome of appeals and reinstatements. Therefore, a doctor providing medical evidence to SSA on behalf of a

disability claimant may be on the exclusions list one quarter and off the next.

As a result of these limitations, any results in matching are likely to be a lower bound.

We conducted data reliability assessments on both states' vendor data and found these data sets to be sufficiently reliable for our analysis. We restricted these assessments to the specific variables and records that were pertinent to our analyses. We conducted interviews with SSA staff familiar with the data and requested additional information from the DDSs. We also assessed the completeness of the data, including frequency analysis of relevant fields, testing for population of variables, out of range values, and duplicate records. In both states, the data's unique identifiers that we used for matching were not populated for all records. We followed up with SSA and the DDSs to gain an understanding of why some fields were not populated. Because the vendor files are used for payment purposes, the DDSs only collect tax identification numbers for entities they pay for medical records or consultative examinations. We restricted our matching to vendor data that we determined had a legitimate tax identification number and eliminated duplicates in the data. We then asked the DDSs to verify the last date of payment for providers whom we matched to assess whether they were receiving payment while they were sanctioned.

We conducted similar data reliability steps for the HHS LEIE, including electronic testing and interviews with the HHS OIG officials responsible for maintaining the list. We found these data to be sufficiently reliable for our analysis.

Identification of Key Practices for Implementing Fraud Analytics Systems

We identified a number of key practices that organizations should consider when implementing analytics to uncover potential fraud in disability claims. These practices are based on our past work that examined the use of analytics to detect Medicare fraud.[1] To validate these practices and determine their relevance for disability programs, we shared the list of practices with private sector entities that have experience implementing analytics for disability programs. We also asked these entities whether there were additional practices that should be added to our list. These entities generally agreed with the practices from our prior work and suggested that we add mining text data to our list because this capability is critical to identifying similar medical language across claims.

We conducted this performance audit from July 2013 to November 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings based on our audit objectives.

[1] GAO, *Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness*, GAO-13-104 (Washington, D.C.: Oct. 15, 2012).

Appendix II: Comments from the Social Security Administration

SOCIAL SECURITY
Office of the Commissioner

October 23, 2014

Mr. Dan Bertoni
Director, Education Workforce,
and Income Security Issues
United States Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Bertoni,

Thank you for the opportunity to review the draft report, "SSA DISABILITY BENEFITS: Enhanced Policies and Management Focus Needed to Address Potential Physician-Assisted Fraud" (GAO-15-19). Please see our attached comments.

If you have any questions, please contact me at (410) 966-9014. Your staff may contact Gary S. Hatcher, our Senior Advisor for Records Management and Audit Liaison Staff, at (410) 965-0680.

Sincerely,

Katherine Thornton
Deputy Chief of Staff

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE, MD 21235-0001

COMMENTS ON THE GOVERNMENT ACCOUNTABILITY OFFICE DRAFT REPORT, "SSA DISABILITY BENEFITS: ENHANCED POLICIES AND MANAGEMENT FOCUS NEEDED TO ADDRESS POTENTIAL PHYSICIAN-ASSISTED FRAUD" (GAO-15-19)

Recommendation 1

Review the standards used to assess DDS Performance; and develop and distribute promising practices to incentivize staff to better balance the goal to process claims promptly with the equally important goal of identifying and reporting evidence of potential fraud.

Response

We partially agree. Our field office and disability determination services (DDS) employees are our first and best line of defense against fraud. Our Office of the Inspector General (OIG) relies heavily on their expertise – the majority of fraud referrals come from our front-line employees. In FY 2013, we made over 22,500 disability fraud referrals to OIG, of which OIG opened about 5,300 cases and, of those, referred over 100 to the United States Attorney's Office for criminal prosecution.

Furthermore, OIG typically relies on Social Security and DDS employees to analyze and interpret disability case files. Following an OIG finding of fraud or similar fault, our employees coordinate with OIG to suspend or terminate benefits or impose administrative penalties.

Our employees take their stewardship responsibilities seriously and continue to show their vigilance in detecting, preventing, and combatting fraud. Our anti-fraud activities are a top priority for the agency, and we will continue to encourage our employees to report potential fraud and give them the tools that they need to be successful.

Recommendation 2

Issue guidance to remind DDSs of its existing policy to report all claims with potentially fraudulent medical evidence to the SSA OIG, even if sufficient evidence exists to deny a claim.

Response

We agree that information concerning potential fraud is important for identifying trends. Beginning the second quarter of FY 2015, we will research how to identify denial cases for this purpose.

Recommendation 3

Enhance its training efforts by ensuring it provides fraud-related refresher training to all DDS employees on a regular basis. Such training should include the identification of suspicious medical evidence and providers, as well as the processes and procedures for reporting such information. To facilitate its efforts, the agency could coordinate with the SSA OIG and draw on the type of training provided by CDI units.

Response

We agree. Social Security Administration (SSA) and DDS front-line employees remain our best line of defense against those seeking to cheat the system. In fact, we expanded our anti-fraud training to agency employees in FY 2014. In collaboration with the Office of the Inspector General (OIG), we developed a mandatory national anti-fraud interactive video teletraining (IVT)/video on demand (VOD) training program for all SSA and DDS employees. The training provided a general overview of our anti-fraud efforts for identifying and reporting fraud activity, and reminded employees of their stewardship responsibility to report suspected fraud, waste, and abuse. The IVT broadcast aired on September 17, and we released the VOD on September 22. Employees are required to complete the training by October 31.

In addition, we also conducted targeted, component training and education in FY 2014. In FY 2014, our Office of Operations (Operations) initiated its Think Twice First (TTF) Campaign that focuses on key fraud awareness topics each month, emphasizing the importance for all Operations employees to be actively engaged in the agency's process for fraud detection, investigation, and prosecution. The campaign touches each employee in Operations, knowing that they are the “front-line” defense against fraud and must understand the importance of developing a suspicious item or issue to determine if fraud exists.

Additionally, Operations issued a DDS Administrator Letter to all DDSs providing an overview of fraud reporting, investigation, and prosecution to reinforce the importance of our anti-fraud efforts. The letter included an overview of fraud procedures, a reminder of anti-fraud responsibilities and policies, and links to available anti-fraud training tools.

Our Office of Quality Review also conducted fraud training for its employees in 2014, and plans to conduct three additional classes in FY 2015.

Beginning the second quarter of FY 2015, we will continue to enhance training for all DDS employees. The training will include the significance for reporting fraud, as well as business procedures. We will also develop an on-going training strategy that incorporates recent OIG findings and trends to stay aware of shifting schemes to defraud the disability program. We will work with the OIG, Continuing Disability Investigation Units, and other experts to develop and deliver this training. We will communicate efforts to reinforce and provide feedback on the effectiveness of these referrals.

Recommendation 4

To address the potential risks associated with medical evidence submitted by sanctioned physicians, SSA should evaluate the threat posed by this information and, if warranted, consider changes to its policies and procedures.

Response

We agree. While we remain watchful for additional prospects, currently we believe the best opportunity to further evaluate the possible review of the license statuses of medical evidence providers is in conjunction with the implementation of the National Vendor File—part of the national Disability Case Processing System (DCPS), which is under development. We anticipate limited data for exploration prior to FY 2017.

Recommendation 5

Develop an implementation plan that identifies both short-term and long-term actions, including: (1) timeframes for implementation; (2) resources and staffing needs; (3) data requirements, e.g., the collection of unique medical provider information; (4) how technology improvement will be integrated into existing technology improvements such as the Disability Case Processing System and National Vendor File; and (5) how different initiatives will interact and support each other.

Response

We agree. Success is predicated on a thoughtful strategic plan and establishing the tactical steps needed to achieve that strategy. In FY 2014, the Acting Commissioner of Social Security approved and signed a charter reinstituting our National Anti-Fraud Committee (NAFC), co-chaired by the Inspector General (IG) and our Deputy Commissioner for Budget, Finance, Quality, and Management. The NAFC's mission is to support national and regional strategies to combat fraud, waste, and abuse. Throughout FY 2014, the NAFC monitored 11 different anti-fraud initiatives, and will continue monitoring our anti-fraud activities in FY 2015.

In FY 2015, we will enhance our anti-fraud efforts and develop a comprehensive plan, which considers our resourcing and staffing levels, available technology, and the integration of all of our activities.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Daniel Bertoni, (202) 512-7215 or bertonid@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gretta L. Goodwin (Assistant Director), Nyree Ryder Tee (Analyst-in-Charge), Daniel Concepcion, Brian Schwartz, and Melinda Cordero made key contributions to this report. Additional contributors include: James Bennett, Sarah Cornetto, David Chrisinger, Alex Galuten, Sheila McCoy, Zachary Sivo, Almeta Spencer, Vanessa Taylor, and Walter Vance.

Related GAO Products

Highlights of a Forum: Data Analytics for Oversight and Law Enforcement. GAO-13-680SP. Washington, D.C.: July 15, 2013.

Social Security Administration: Long-Term Strategy Needed to Address Key Management Challenges. GAO-13-459. Washington, D.C.: May 29, 2013.

Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness. GAO-13-104. Washington, D.C.: October 15, 2012.

Social Security Disability: Collection of Medical Evidence Could Be Improved with Evaluations to Identify Promising Collection Practices. GAO-09-149. Washington, D.C.: December 17, 2008.

Results-Oriented Cultures: Insights for U.S. Agencies from Other Countries' Performance Management Initiatives. GAO-02-862. Washington, D.C.: August 2, 2002.

Supplemental Security Income: Additional Actions Needed to Reduce Program Vulnerability to Fraud and Abuse. GAO/HEHS-99-151. Washington, D.C.: September 15, 1999.

Supplemental Security Income: Action Needed on Long-Standing Problems Affecting Program Integrity. GAO/HEHS-98-158. Washington, D.C.: September 14, 1998.

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