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Report to the Honorable Henry A. Waxman, Ranking Minority Member, Committee on Government Reform, House of Representatives

September 1999

SUPPLEMENTAL SECURITY INCOME

Additional Actions Needed to Reduce Program Vulnerability to Fraud and Abuse

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Health, Education, and
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September 15, 1999

The Honorable Henry A. Waxman
Ranking Minority Member
Committee on Government Reform
House of Representatives

Dear Mr. Waxman:

The Supplemental Security Income (SSI) program, administered by the Social Security Administration (SSA), is the nation's largest cash assistance program. At the end of 1998, the SSI program was paying benefits to about 5.2 million needy blind and disabled recipients and 1.3 million needy aged recipients. Program expenditures for the year totaled about $29 billion ($25 billion and $4 billion, respectively). Over the next 10 years, the combined federal cost alone for SSI and related Medicaid benefits is estimated at $122,000 per recipient.

In the early 1990s, media reports and congressional hearings alleged that some SSI recipients may have improperly gained access to program benefits by feigning or exaggerating disabilities with the help of middlemen and medical providers. In 1995, we reported that some ineligible non-English-speaking applicants had obtained SSI benefits illegally by using middlemen, particularly interpreters, who had provided inaccurate translations or had coached applicants on how to appear disabled.[1] As a result, we recommended that SSA develop a more aggressive and programwide strategy to obtain and share data about interpreters and middlemen. Similarly, some providers have submitted misleading diagnoses for SSI applicants, claiming mental impairments and other conditions that are difficult to verify, to help applicants obtain medical eligibility for SSI benefits.

In light of these long-standing concerns, you asked us to (1) determine the extent to which SSI is vulnerable to individuals who obtain eligibility by feigning disabilities with the help of middlemen and medical providers; (2) describe SSA's methods for preventing, detecting, and responding to this type of program fraud and abuse; and (3) identify additional strategies SSA could use to more effectively address this problem. Some of SSA's actions discussed in this report were partially responsive to the recommendation in our earlier report.

[1]Supplemental Security Income: Disability Program Vulnerable to Applicant Fraud When Middlemen Are Used (GAO/HEHS-95-116, Aug. 31, 1995).

To conduct our work, we met with a variety of personnel involved in the administration of the SSI program, including claims representatives, claims adjudicators, fraud investigators, administrative law judges (ALJ), and SSA administrators. We also obtained and analyzed several databases to assess program vulnerability and consider the value of potential changes in administrative controls. We focused on six states with large SSI populations (together, these states comprise about 40 percent of all SSI recipients) or where SSA has experienced serious problems with disability fraud and abuse.

To identify program vulnerability to fraud and abuse and possible ways to enhance SSA prevention strategies, we enlisted the assistance of several investigative organizations. To protect the confidentiality of their records, these organizations provided information under special arrangements. This information identified medical providers who had been investigated or who were being investigated for fraudulent activities involving Medicaid, Medicare, and the payment of private health insurance benefits. We did not solicit information on the results of these investigations for several reasons. In some cases, the outcome of the investigation was not readily available because the case was still open, the organization lacked the resources to provide a complete listing of the outcomes, or the charges could not be substantiated. In the majority of cases, investigations do not result in an admission of guilt or a conviction of fraud. An investigation may be closed, for example, because a settlement is reached or the subject agrees to make restitution in exchange for nonprosecution. However, since investigations are not initiated on the basis of a simple complaint, we included all investigated providers in our analysis.[2] We use the term "suspicious" to characterize medical providers or middlemen who had been or were being investigated by these organizations at the time of our study.

Our work was done between October 1997 and May 1999 in accordance with generally accepted government auditing standards. See appendix I for additional information on our scope and methodology.

Results in Brief

Although the number of people who have feigned injuries or illnesses to obtain SSI benefits is unknown, the SSI program is vulnerable to this type of fraud and abuse. First, many SSI beneficiaries' impairments are difficult to objectively verify. From a sample file of beneficiaries—developed by SSA to

[2]For example, one organization told us that before starting an investigation, it had to have a written statement of facts supporting the position that false claims had been filed and the false claims did not appear to be the result of an honest billing error or misinterpretation of requirements.

research characteristics of the SSI population—we found that more than 60 percent had such impairments, including psychoses, schizophrenia, and other mental disorders, as well as a range of physical disorders. In addition, providers who have been investigated for defrauding Medicaid, Medicare, or private insurance companies furnished at least some portion of the supporting medical evidence for more than 12,000 (6 percent) of the 208,000 SSI disabled recipients in the six states we examined. Finally, over 96 percent of the 158 officials and staff we interviewed said they believed that the practice of middlemen helping people improperly qualify for SSI benefits has continued.

SSA has taken several actions, both on its own and in response to legislation, to reduce the program's vulnerability to this and other forms of fraud. SSA has

- established pilot fraud investigation teams in five states during 1998 to examine individual cases where significant fraud and abuse is suspected,
- developed new policies and procedures to make it easier to deny claims or terminate benefits when program fraud or abuse is detected, and
- strengthened its ability to handle its non-English-speaking clients.

These steps have achieved positive results. For example, as of March 31, 1999—just 6 to 14 months after they began their work—the pilot teams in five locations have provided information that contributed to cessations and denials of SSI benefits worth about $11 million. The overall effectiveness of SSA's actions, however, has been limited by several factors. First, front-line staff largely rely on their experience and perceptions to identify suspicious claims; they lack other valuable information, such as the names of middlemen and medical providers suspected of fraudulent or abusive practices by other employees or organizations, that could help them judge a claim's validity. In addition, SSA and Disability Determination Services (DDS) staff said that they do not always follow the new procedures because they believe the procedures conflict with agency work incentives that stress speed in processing claims and because they believe they are not adequately protected from legal liability that could arise if they were to follow claims denial procedures. They also question the agency's commitment to fighting fraud, since they repeatedly see the same suspicious middlemen and medical providers involved in SSI cases, despite previous referrals for investigation.

In our view, several additional types of actions could reduce SSI's vulnerability to fraud and abuse by middlemen and medical providers. SSA

could establish a national information system that identifies suspicious middlemen and medical providers. These type of data would help front-line staff, on whom SSA relies to fight program fraud and abuse, to better identify cases that warrant closer scrutiny. Further, SSA needs to (1) implement our recommendation from a previous report to reevaluate its work credit and incentive structure to encourage greater attention to fraud detection and (2) reexamine its policy regarding SSA-provided interpreters. The Congress may also wish to protect staff from legal liabilities that might arise from following new claims denial procedures.

Background

The SSI program, authorized under title XVI of the Social Security Act in 1972, provides cash benefits to blind, disabled, and aged individuals whose income and resources are below certain specified levels. To qualify for benefits, blind and disabled individuals must meet medical and functional disability criteria as well as financial eligibility requirements.

The benefit application process begins with initial interviews of applicants at any of SSA's 1,298 field offices. During these interviews, SSA staff solicit information on applicants' financial situation and the disability being claimed. Applicants can work directly with SSA staff or use middlemen who provide services, often for a fee, such as help in completing forms, interpreting for non-English-speaking individuals, and offering advice on how to navigate the application process. Interpreters supplied by SSA are also available to help non-English-speaking applicants through this process.

The field offices forward the disability information gathered during the initial interviews to one of 54 state DDS offices, which are responsible for deciding if applicants meet the program's criteria for disability. These offices develop evidence related to a claim by obtaining reports from the medical sources that an applicant has used to treat or diagnose the impairment. If necessary, the DDS office may require an applicant to have an SSA-paid medical (consultative) examination to evaluate and document the impairment further. At this stage, non-English-speaking applicants again may rely on either their own or SSA-supplied interpreters to help them answer questions raised by DDS staff during the adjudication process and by medical providers during required SSA medical exams.

Individuals who are found eligible to receive SSI benefits are subject to periodic reevaluations of their financial status, known as redeterminations, and of their medical status, known as continuing

disability reviews (CDR). During a redetermination, the financial factors related to the recipient's eligibility—essentially earnings, assets, and current living arrangements—are reviewed. A CDR is conducted to determine whether a person is still medically and functionally unable to work. Situations that can trigger a CDR include medical evidence concluding that a condition is expected to improve, substantial earnings reported to SSA that indicate a recipient is working, and medical improvement reported to SSA by a vocational rehabilitation agency.

Individuals dissatisfied with SSA decisions to deny or terminate benefits (whether for financial or medical reasons) can use SSA's administrative review process. First, a dissatisfied person may request a reconsideration of the adverse decision. The reconsideration is an independent examination, by a specially trained DDS staff member, of all evidence on record plus any further evidence and information submitted by the claimant or the claimant's representative. If there is disagreement with the reconsidered determination, a hearing before an ALJ from SSA's Office of Hearings and Appeals (OHA) may be requested. At the hearing level, OHA personnel examine the evidence of record; the client or the client's representative may also introduce new evidence and new impairments. Finally, if a disagreement remains with the OHA decision, persons may request a review by SSA's Appeals Council.

At each of these levels, the input of middlemen and medical providers can be a factor. Middlemen and medical providers can have different motives for assisting persons in obtaining SSI benefits. Some middlemen and medical providers help individuals obtain SSI benefits because they want to help persons who have backgrounds similar to their own or who need financial assistance. Others are motivated by financial gain. Middlemen often charge fees for their services contingent upon applicants becoming eligible for program benefits. In most states, medical providers can bill Medicaid for treating SSI recipients, and improper Medicaid billings have been a long-standing problem.

Investigating possible fraudulent activity is the responsibility of SSA's Office of the Inspector General (OIG). In the past, SSA's OIG has cooperated in and reported on the results of investigations involving middlemen and medical providers. For example, in December 1997, the OIG reported on an extended family in Georgia that consisted of 181 members receiving SSI benefits. DDS personnel performed CDRs on 151 of them and terminated benefits to 88. The investigation disclosed that a psychiatrist who was responsible for helping many of these individuals qualify for SSI benefits

then billed Medicaid for their treatment after they were awarded SSI benefits.

SSI Is Inherently Vulnerable to Individuals Feigning Disabilities With the Help of Providers and Middlemen

Our analysis of the SSI program indicates that SSI is inherently vulnerable to people who, with the help of others, feign their impairments to obtain benefits. Over 60 percent of SSI disability cases from an SSA statistical sample involved impairments that are difficult to objectively verify, and thousands of SSI recipients in the six states we studied used suspicious medical providers to gain access to the program. Middlemen also play a significant role in SSI fraud and abuse, according to SSA officials and front-line staff.

SSI Program Recipients' Impairments Are Often Difficult to Objectively Verify

OIG fraud investigators, SSA officials, and DDS staff told us that certain types of impairments that can be feigned are difficult to objectively verify. Some specific impairments that they identified as falling into this category include mental retardation, post-traumatic stress syndrome, and depression. Back impairments, unrelenting severe pain, and vision problems that lack objective evidence, such as clearly documented pathology or treatment history, are also potentially exaggerated or feigned disorders.

Our analysis of a sample file of SSI beneficiaries—which SSA developed to research characteristics of the SSI population—shows that the majority of disabled recipients had the types of impairments that SSA and DDS staff considered susceptible to feigning.[3] Specifically, we found that 64 percent of disabled recipients in the April 1998 version of the sample file had impairments susceptible to feigning. Table 1 shows the estimated number of adults and children with impairments that SSA and DDS staff believe are difficult to objectively verify within broad categories of impairments.

[3]About 400,000 records (77.2 percent of the file) had information on SSI recipients' disabilities, representing over 4 million disabled SSI recipients.

Table 1: Estimated Number of SSI Child and Adult Recipients in April 1998 Sampling by Category of Impairments Considered by SSA and DDS Staff to Be Vulnerable to Feigning

	Child	Adult	Total	Percent of total
All SSI disabled recipients with identifiable impairments	799,730	3,251,580	4,051,310	100.0
Recipients with mental impairments susceptible to feigning				
Psychoses and neuroses	190,940	707,180	898,120	22.2
Schizophrenia	3,890	339,170	343,060	8.5
Mental retardation	302,870	738,570	1,041,440	25.7
Recipients with physical impairments susceptible to feigning				
Back disorders	•	136,490	136,490	3.4
Muscle, ligament, fascia disorders, sprains, and strains	•	21,170	21,170	0.5
Epilepsy	11,950	30,870	42,820	1.1
Vision problems	•	44,930	44,930	1.1
Chronic pulmonary insufficiency	•	59,490	59,490	1.5
Total recipients with impairments susceptible to feigning	**509,650**	**2,077,870**	**2,587,520**	**64.0**

Note: The data in the table represent persons who have impairments that are difficult to objectively verify. They do not suggest that individuals with these impairments are feigning them. Percentages have been rounded to the nearest 10th of a percentage point. The sampling errors for all but one of the numerical estimates in this table do not exceed plus or minus 6 percent of the estimate at the 95-percent confidence level.

Suspicious Medical Providers Are Assisting SSI Applicants and Recipients

From records maintained by SSA and other entities, we found that suspicious medical providers have helped individuals obtain or maintain SSI benefits and roughly estimated the program's vulnerability to these types of activities. Using SSA records for SSI beneficiaries in the six states we studied, we identified 208,085 SSI recipients who—through a determination or a redetermination conducted between January 1, 1997, and June 30, 1998—were found eligible for SSI benefits on the basis of an impairment that was difficult to objectively verify. From government agencies that pay Medicare and Medicaid benefits and a private organization that supports health insurance companies, we obtained lists of suspicious medical providers and compared them with lists of providers used by these SSI recipients.

Of the 208,085 SSI recipients who had impairments difficult to objectively verify, we found that 12,565 (about 6 percent) had used doctors identified as suspicious.[4] (See table 2.)

Table 2: SSI Recipients With Impairments Difficult to Objectively Verify Who Used Suspicious Medical Providers to Support Their Disability Claim, by State

State	SSI recipients with impairments difficult to objectively verify	SSI recipients who used medical providers suspected of fraud or abuse	Percentage
California	112,240	7,028	6.3
Florida	28,764	1,759	6.1
Georgia	12,969	711	5.5
Louisiana	8,162	551	6.8
Massachusetts	15,668	1,074	6.9
New York	30,282	1,442	4.8
Total	**208,085**	**12,565**	**6.0**

Of the suspicious providers identified by benefit-paying entities, we found that 1,447 assisted these SSI recipients in obtaining or maintaining benefits. Many assisted numerous SSI clients. For example, in California, 11 providers had assisted from 100 to 300 SSI recipients with impairments difficult to objectively verify. We also found that one medical practice had submitted evidence for 632 recipients with such impairments. (See table 3.)

[4]The lists provided to us contained the names of hospitals, group practices, and individual medical providers suspected or convicted of fraudulent or abusive activity. In our analysis, we excluded hospitals as a suspect source of medical information because hospitals have many providers and we could not identify which providers were under investigation. If we had included the hospitals, the number of recipients with questionable medical sources would have risen from 12,565 to 34,153 (16.4 percent of the recipients with impairments difficult to verify in the six states we analyzed).

Table 3: Suspicious Medical Providers and SSI Recipients They Assisted Whose Impairments Were Difficult to Objectively Verify, by State

	Number of suspicious medical providers									
Number of SSI recipients assisted	**1**	**2-5**	**6-10**	**11-25**	**26-50**	**51-100**	**100-300**	**301-500**	**500+**	**Total**
California	279	314	85	83	22	10	11	1	•	805
Florida	120	88	26	14	8	1	•	•	1	258
Georgia	12	15	10	3	3	2	2	•	•	47
Louisiana	16	11	7	12	6	1	•	•	•	53
Massachusetts	8	12	4	12	7	1	3	•	•	47
New York	116	74	23	12	7	3	2	•	•	237
Total	**551**	**514**	**155**	**136**	**53**	**18**	**18**	**1**	**1**	**1,447**

Although our analysis does not prove that any fraud or program abuse was committed in any of these cases, it shows that SSI recipients with impairments that are difficult to objectively verify have used evidence from medical providers who had been or were being investigated for fraudulent activities by other benefit-paying entities.

Front-Line Staff Believe Middlemen Continue to Help Persons Feign Disabilities

We could not determine the extent to which middlemen participate in cases involving feignable impairments or identify which middlemen were involved in a large number of cases because SSA does not routinely record the names and addresses of middlemen when a claim is filed. Therefore, to find out whether middlemen remain a significant source of potential fraud and abuse, we contacted 158 SSA, OIG, and DDS staff and managers in SSA's Baltimore headquarters and in field offices in California, New York, Massachusetts, and Washington and asked them if they believed problems with middlemen continued. Of these, 96 percent (152) indicated that SSA remains vulnerable to middleman fraud.

The following are examples of cases these staff cited.

- SSA and DDS staff in New York told us about a middleman whose clients are typically diagnosed as having severe mental conditions but continue to live at home and receive no treatment. The clients almost always have very low reported intelligence quotient scores and almost never have any historical medical records.
- In California, field office staff said some applicants are coached by middlemen on what to say and how to respond to questions before they come to the office. Staff in other offices told us that middlemen will use

various aliases to mask their true identity or go to offices where they are less known.

- Field office staff in California said that middlemen are still active in SSI cases, but are trying to hide their involvement. They said that when district offices in Southern California hired bilingual staff to address concerns about interpreter fraud, middlemen began taking their clients to other district offices. Because SSA does not maintain a centralized database on suspicious middlemen, its field staff cannot check whether a middleman accompanying a claimant should be considered suspicious.
- OIG investigators believe middlemen remain active because they have observed middlemen waiting in cars while an applicant pursues a claim or has a medical exam. OIG investigators further suspect that the middlemen continue to prepare claims applications and to coach applicants on how to act and respond to interview questions. In this regard, field staff pointed out that suspicious claims applications are prepared using language that mimics SSA policy manuals. They also said that suspicious applicants always seem to know the "right" answer to SSA employee questions.

SSA's Antifraud Initiatives Are Valuable but Limitations Undermine Effectiveness

To reduce SSI's vulnerability to fraud and abuse, SSA has undertaken several initiatives, some of which were required by legislation. SSA has established pilot investigation teams in five states dedicated to examining cases where fraud or abuse is suspected. It also has developed new procedures that DDS staff handling claims must use when they encounter suspicious disability claims and instituted new approaches for handling claims of non-English-speaking individuals. While these initiatives are useful steps in addressing potentially fraudulent cases, their effectiveness is limited by staff reluctance to routinely implement them. Staff perceive that these actions conflict with other agency goals or are not convinced of their effectiveness. Other staff believe that certain procedures expose them to potential legal liability.

SSA Is Piloting Fraud Investigation Teams

In 1998, SSA created as a pilot project five Cooperative Disability Investigation (CDI) teams to investigate suspected cases of disability fraud or abuse. The CDI teams are patterned after a fraud investigation unit established in 1994 to respond to a large number of disability fraud and abuse cases being identified in the Southern California area. Each CDI team investigates cases referred through SSA's OIG fraud hotline and by DDS and SSA field office staff who have been instructed to refer all cases—both applicants and recipients—in which they suspect disability fraud or abuse.

The referrals can cover questionable situations, such as a recipient's failing to report work activity or feigning disabilities.

Each CDI team consists of four or five members and is headed by an agent from SSA's OIG. Other CDI team members typically include DDS examiners and state law enforcement personnel, such as Medicaid fraud investigators. SSA has placed these units in five cities that it believes have serious disability fraud and abuse problems: Oakland, California; Chicago, Illinois; Baton Rouge, Louisiana; Atlanta, Georgia; and Brooklyn, New York. In cities that do not have a CDI team, SSA OIG offices continue to have the responsibility to investigate fraud cases.

In conducting their investigations, CDI teams obtain information that helps SSA decide whether applicants or recipients are truly qualified to receive benefits. Although teams do not typically develop evidence for the prosecution of criminal fraud, CDI investigations of individual applicants and recipients may provide a basis for the OIG to conduct broader investigations into the practices of medical providers and middlemen.

DDS staff continue processing the case even after referring it to the CDI team. While the DDS office assesses the medical information, the CDI team begins gathering evidence that either substantiates or contradicts statements that applicants or recipients have made regarding matters such as their income and how their disabilities limit their daily lives. The teams typically do this by conducting undercover surveillance of the individual's daily activities and interviewing the individual's neighbors, family, and friends. Although the disability determination can be made before the CDI team completes its investigation, if evidence is developed that affects the determination, the DDS office may reopen the case.

The effectiveness of the CDI teams has been demonstrated. For example, in 1998, a state DDS office referred a case to a CDI team because the applicant's treating physician had a history of providing similar information on multiple patients. The applicant alleged that headaches, memory loss, weakness, asthma, and depression severely limited her ability to carry out activities such as shopping and prevented her from obtaining a driver's license and learning English. The CDI investigation disclosed that the applicant had a valid driver's license, and during surveillance, CDI staff observed the applicant grocery shopping. Staff also approached the applicant with a question and discovered that she spoke English. This information led to a denial of benefits in the case.

As of March 31, 1999, SSA's OIG reported that the five CDI teams—which had been operating for 6 to 14 months—had conducted 624 investigations that contributed to the denial of benefits to 119 applicants and the cessation of benefits to 58 recipients, according to SSA's OIG. The OIG estimates total SSI program savings from these claims denials and cessations of benefits amounted to about $11 million.[5] The original investigative team established by SSA and DDS in Southern California has also had an effect on the program. From November 1995 through March 1999, this team's investigations have resulted in the cessation of benefits in 42 cases and the denial of benefits in 27 cases. According to the team, these investigations have saved the SSI program an estimated $5.5 million. SSA is pleased with these results and anticipates that similar teams will be placed in 12 additional locations by fiscal year 2003.

SSA Has Revised Procedures for Handling Suspicious Claims

In 1994, the Social Security Act was amended to require that evidence in eligibility determinations be disregarded "if there is reason to believe that fraud or similar fault was involved in the providing of such evidence." SSA issued implementing fraud or similar fault (FSF) procedures to the DDS offices in April 1998. FSF implementing procedures for SSA field offices and appellate adjudicators are still under development.

Under its implemented FSF procedures, DDS adjudicators must consider all evidence in the case record before determining whether any specific evidence should be disregarded. Supporting evidence should be disregarded only if a preponderance of other evidence establishes a reason to believe that fraud or similar fault was involved. Fraud or similar fault involves knowingly making an incorrect or incomplete statement or knowingly concealing material information. As is the case with the CDI teams, the goal of the FSF procedures is to prevent individuals who are not truly disabled from receiving benefits—not to develop sufficient evidence to prosecute a person for fraud.

To help DDS staff identify high-risk cases, the FSF procedures first list characteristics that have been commonly associated with fraudulent or abusive cases in the past. The FSF procedures then recommend special ways that high-risk cases should be handled and developed to determine whether there is reason to believe fraud or similar fault was involved. The special handling includes gathering additional evidence to determine whether statements about the disabilities and functional limitations of

[5]Because of the way CDI results were reported, it is probable that the actual number of cases investigated, terminated, and denied is higher.

clients are correct and complete and checking with appropriate staff to see if there are any known problems with the person's medical evidence sources or any middlemen involved in the cases.

These new procedures require DDS staff to document a fraud or similar fault finding and cite any evidence that is disregarded. After disregarding any evidence, DDS staff should make the disability determination based on the remaining evidence in the file. The procedures require that staff notify SSA's OIG of all cases where similar fault is suspected, alerting OIG to suspicious middlemen or medical providers who may have been involved in providing incomplete or incorrect statements. The OIG then has the option of investigating these cases further to establish whether fraud occurred.

SSA Has Made Changes in the Use of Agency-Supplied Interpreters

Program policy on the use of interpreters varies among the different components involved in making disability decisions. SSA has a general policy at its field offices of allowing non-English-speaking SSI applicants to choose whether they want to use their own interpreters or an SSA-supplied interpreter at the time a claim is filed. Interpreters provided by applicants must now sign a form stating that they will accurately translate applicant responses during the interview. However, if field staff suspect that an applicant-supplied interpreter is not providing accurate information during an SSA interview, they can stop the interview and reschedule it for a time when an SSA-supplied interpreter is available. Failure to sign the form is also grounds for SSA to stop and reschedule an interview with an SSA-supplied interpreter.

During required consultative medical examinations, the DDS offices in most states follow SSA's field office policy of generally allowing applicants to decide whether to use their own interpreter or one supplied by the DDS office. Staff can also insist that the applicant or recipient use an agency-supplied interpreter if they have suspicions about a case. One state, however, requires all non-English-speaking applicants and recipients to use DDS-supplied interpreters.

For cases denied by a DDS and then appealed, OHA requires that its ALJs use a qualified interpreter. Interpreters have to be able to read, write, and demonstrate fluency in the language of the claimant and in English. They should have a basic familiarity with SSA terminology, agree to act in the best interest of the claimant and the public at large, provide exact translations, and comply with SSA disclosure and confidentiality

requirements. Sources considered as qualified include SSA and state employees, consultative examination providers, family members, or persons affiliated with churches and advocacy groups.

Because of both an increase in the number of non-English-speaking clients and a heightened awareness of the problems associated with unscrupulous interpreters, SSA has hired over 2,300 additional staff with bilingual capabilities since 1993.[6] However, SSA does not know how many bilingual staff it has in total, nor has it determined how many it needs. SSA officials told us that the agency has begun tracking claimant language preferences so that it can target interpreter services more effectively. It is also placing more emphasis on ensuring that adequate funds are available to pay for non-English-speaking interpreter services where bilingual staff are not available and providing specialized training for bilingual employees.

Staff Concerns Limit the Effectiveness of Antifraud Initiatives

Each SSA initiative depends on its field and DDS staff first recognizing suspicious cases (which can be difficult) and then following the new procedures to refer the case for investigation by a CDI team, or use the new FSF procedures, or arrange for an agency-supplied interpreter. However, many of the staff whom we interviewed said they are reluctant to routinely take these actions for several reasons. Some staff believe the new procedures conflict with other agency goals, and some staff do not perceive the procedures as being effective in preventing fraud and abuse. In addition, some staff have concerns about their legal liability from following the FSF procedures.

Concerns About Conflicting Agency Goals

Many DDS staff told us that they do not refer all suspicious cases to CDI teams because such referrals require extra processing time. Specifically, in cases where fraud or similar fault is suspected, staff must develop evidence to support their suspicions; prepare referral forms that explain the basis for their concern; and, to the extent possible, provide evidence that supports their concern. Proposed referrals are then discussed with DDS management, which decides whether to refer the case to a CDI team.

According to DDS staff, this extended processing time is inconsistent with SSA's goal to quickly and accurately process claims and post-entitlement decisions, and SSA has not made allowances in its performance goals and measures (work credits) for the additional time needed to identify and handle suspicious cases. SSA continues to monitor processing times, and

[6]The changes in SSA interpreter policy and the hiring of additional bilingual staff partially respond to the recommendations that we made in our 1995 report.

staff believe that any delays in DDS decisions are viewed as negatively affecting performance. For example, one DDS examiner told us that when a case is held up, it has an adverse affect on an employee's mean case-processing time. At another DDS office, staff said that case examiners do not always refer suspicious cases because they do not want their processing times to suffer.

We heard similar comments about processing time concerns from staff in SSA field offices. For example, we were told that staff lack the time and resources to properly check claims. When they detect a possible problem during the interview and would like to follow up on those suspicions, they sometimes do not because they do not receive credit for the additional work. At another field office, a staff member said she believes the investigative teams are understaffed and she hates to let her processing time suffer by making referrals to them. At a third field office, we were told that the referrals were not an effective use of staff time.

When we discussed processing times and the new FSF and agency interpreter procedures with front-line staff, concerns such as the following were raised:

- DDS staff said that the new FSF procedures are more labor-intensive than those required for other claims. They can also require additional development of evidence. Further, they said that the guidelines on how to identify claims that might warrant special handling are so general that they could apply to most SSI claims.
- SSA field office staff echoed these views. They told us that stopping interviews because of concerns over interpreters just extends the time needed to handle and close a claim. It takes time to establish another date when SSA can arrange for its own interpreter and for the applicant to appear at another interview. Consequently, the new policy can result in field staff missing processing time goals.

According to an SSA official, the agency has developed a "culture" that values helping needy people and, within this culture, the prompt payment of benefits takes precedence over all other activities, including efforts to uncover fraud and abuse.

Concerns About Effectiveness of New Initiatives

Both DDS and SSA field office staff perceive that SSA's antifraud initiatives will have a limited effect on fraud and abuse, which adds to their reluctance to invest the time and effort required by these new initiatives.

Basically, staff believe that even if they deny a claim, applicants will ultimately be awarded benefits at the appeals level.

One basis for this perception stems from the differences in procedures for ALJs and DDS offices. Because FSF procedures have not yet been issued for ALJs, they operate under adjudicative rules, which may cause them to reach a decision different from other SSA decision levels. According to OHA officials, by law ALJs must give controlling weight to the medical opinion provided by an applicant's or recipient's treating physician, provided the medical opinion is well supported by acceptable clinical and laboratory diagnostic techniques and is not inconsistent with other evidence. Under FSF procedures issued for DDS-level adjudicators, DDS staff may decide not to give controlling weight to the medical evidence from a treating physician when the DDS office has evidence that the physician has repeatedly provided identical diagnoses in other cases. Consequently, a denial determination under FSF procedures by DDS adjudicators may well be overturned by the ALJ when the judge does not have the necessary documentation about the reasons the DDS did not give controlling weight to the treating physician's opinion.

In addition, SSA and DDS staff told us that they are reluctant to refer all fraud or similar fault cases to SSA's OIG for possible prosecution—although FSF procedures require them to do so—because they perceive that the OIG is not willing to investigate such cases. In the past, the OIG has devoted its limited resources to investigating fraud cases where large dollar amounts were involved or a conviction was likely. Furthermore, when fraud cases were referred to the OIG, there was no feedback on the outcome of the referrals. When staff continued to see the same middlemen and providers involved in other cases, they concluded that the OIG referrals were not a productive use of their time.

The OIG is aware of these views and is developing systems to better inform field staff about the status of cases they have referred. There have also been staffing increases to improve its investigative capacity and efforts have been made to publish information about the outcome of fraud cases.

Concerns About Staff Liability

Finally, staff are concerned that they can be held liable for actions they take under the new procedures, which require them to place written statements in the files whenever they believe material information provided by applicants, medical providers, middlemen, or other third parties is misleading, inaccurate, or incomplete. Staff fear that if this type of statement becomes known, they could be sued and held liable for

damages claimed by medical providers and interpreters alleging that DDS staff impugned their reputations.

One state DDS has not yet implemented the new FSF procedures because of these concerns. Although the principle of sovereign immunity generally exempts states from liability suits based on actions taken by employees performing their official duties, state laws and court decisions have created some exceptions to that immunity. Officials in the state pointed out that there is nothing to prevent providers, middlemen, or organizations representing them from seeking to hold the state or its employees liable under one of the exceptions. The state does not want to incur the time or expense involved in defending itself and its employees or risk an adverse outcome.

SSA officials stated that the agency cannot guarantee that DDS employees would be held harmless by a court. Such a guarantee would mean that the government would have to defend any DDS employee, even if the employee were negligent in making adverse statements about a medical provider or other third party in a claims file. SSA officials also believe it is clear that the guidelines for identifying suspicious claims are just that—guidelines—and not mandates to apply the FSF procedures to each case meeting these criteria.

Opportunities Exist to Better Identify and Track Suspicious Middlemen and Medical Providers

In our view, there are several additional actions SSA could take to help reduce the SSI program's vulnerability to fraud and abuse. Because SSA relies heavily on its front-line staff to detect suspicious claims and the involvement of suspicious middlemen and medical providers, it is important that resources and processes assist staff in their identification efforts and encourage them to use SSA's new initiatives.

Better Information Needed for Front-Line Staff

Approaches that focus on obtaining and sharing information about suspicious middlemen and medical providers programwide would likely enhance SSA's ability to identify cases where individuals may be obtaining benefits by feigning disabilities. With this type of information, DDS personnel and SSA's field staff could better determine which claims should receive increased scrutiny and target their investigations of current beneficiaries to evaluate whether they should be removed from the program. Such information could also help staff more readily identify cases that meet certain profiles (suspicious middlemen and medical providers), which should result in more effective referrals from DDS

examiners and better use of CDI and OIG resources. The information could also be used to identify those middlemen and providers who are involved in multiple claims.

SSA could use information it has to begin developing comprehensive databases on suspicious middlemen. SSA and DDS staff could annotate the database with the reasons for their suspicions about each identified middleman. Because data on practicing middlemen are not readily available, SSA would need to require that all third parties involved in claims document their identity (for example, name, address, and social security or driver's license number). With these data, SSA could identify the cases in which each middleman was involved, and SSA field and DDS staff could check the database when handling claims and add new names to this database as they became known. Thus, SSA, with its own data on suspicious middlemen, could centralize and share this information agencywide, as we suggested in our 1995 report. While SSA plans to centralize information on suspicious middlemen within each DDS through its new FSF procedures, this step may not be sufficient to address the problem of middlemen operating among offices in more than one location. Limiting the databases to specific geographic areas would likely reduce their effectiveness as a tool to identify the involvement of suspicious middlemen in SSI cases.

With databases that could be shared agencywide, the agency would be better able to identify potential problem cases and unscrupulous middlemen, regardless of the office being used. SSA could also require that its own interpreters be used when an applicant uses a suspicious middleman listed in the database, instead of requiring staff to rely on their suspicions that an interpreter is providing inaccurate translations. To facilitate the use of agency-supplied interpreters in these situations, SSA could require that non-English-speaking claimants schedule an interview at a field office where staff have the appropriate language capability. If this is inconvenient for the client, SSA could schedule an interview at an office of the applicant's choosing and send an agency-supplied interpreter to that office on the established appointment date.

SSA could supplement the middleman database with information on suspicious medical providers identified by other entities (for example, the Medicaid and Medicare programs and private insurance companies) to identify cases for scrutiny. SSA's past experience with investigating disability fraud and abuse has shown that medical providers suspected or convicted of Medicaid fraud have provided many SSI recipients with

misleading medical evidence that helped them improperly obtain benefits. Moreover, fraud investigators have told us that medical providers who try to take advantage of one program often try to abuse or defraud other programs as well.

Benefit-paying agencies typically maintain databases of suspicious providers they have investigated for alleged fraudulent and abusive activities. If SSA gathered and maintained this information, it could determine through computer matching whether any SSI applicants or recipients had used or were using these same providers. A match would not prove that the applicant or recipient was actually feigning his or her disability. However, it would alert DDS staff to the possibility of fraud or abuse and highlight the case for more careful review either by them or by a CDI team, if one is present at the DDS office. Establishing such a database would require some changes in SSA recordkeeping practices. For example, the agency would have to include in its electronic records the names of the medical providers used by applicants and recipients to supply medical evidence. Currently, only state DDS offices maintain provider names to facilitate payment for medical evidence submitted on the behalf of claimants.

To ensure such comprehensive databases would be secure and the information therein confidential, SSA would need to address widespread weaknesses in controls over access to its systems, which we recently reported on.[7] These control weaknesses expose its computer systems to external and internal intrusion, subjecting sensitive SSA information to potential unauthorized access, modification, and disclosure. Although SSA has developed and continues to pursue corrective actions to address these problems, some organizations may not want to disclose data they maintain on providers, fearing that improper handling would adversely affect their own operations.

In addition, medical providers and middlemen may be concerned that their reputations could be damaged if it becomes known that they had been suspected of fraud or abuse and the suspicions may not have been substantiated. There are ways to address these concerns. For example, insurance laws in most states allow regulators to maintain databases of suspicious medical providers and others suspected of defrauding insurance companies. To encourage these companies to report the names of suspicious providers and other parties in the claims they are evaluating,

[7]Information Security: Serious Weaknesses Place Critical Federal Operations and Assets at Risk (GAO/AIMD-98-92, Sept. 23, 1998).

the laws guarantee that the companies cannot be sued by a suspicious provider or other third party for maintaining or referring such data, as long as the referral was made without malice or intent to harm. In addition to these state-level databases, insurance companies provide the names of suspicious individuals to the National Insurance Crime Bureau, a national not-for-profit organization that maintains a central database for member insurance companies to consult in their efforts to deter and prevent insurance crimes. It is also used by law enforcement agencies in their efforts to combat fraud.

Further, SSA is required by law to take certain steps to ensure the privacy and security of data, whether that information was internally generated by SSA or obtained from other agencies. These steps include traditional safeguards such as developing a security plan, audit trails, automated alerts to prevent inappropriate requests for personal information, personal identification numbers and passwords, training, and periodic internal and external evaluations of all privacy and security measures.

Encouraging Staff to Pursue Suspicious Cases

Fighting fraud and abuse will require changes in management approaches. SSA needs to demonstrate to its front-line staff that it is serious about having them pursue questions about suspicious cases. Management systems that emphasize timely processing of claims without recognizing the additional time needed to develop evidence related to suspicious cases are hindering SSA's antifraud efforts.

Both the OIG and we have noted how staff perceive agency priorities. For example, we concluded in a recent report that long-standing problems in the SSI program are attributable to SSA's ingrained organizational culture that has historically placed a greater value on quickly processing and paying SSI claims than on controlling program costs.[8] We recommended that SSA reevaluate its field office work-credit and incentive structure at all levels of the agency and make appropriate revisions to encourage better verification of recipient information and greater staff attention to fraud prevention and detection. The OIG also noted that developing fraud cases for referrals can require significant amounts of time and concluded that SSA cannot simply measure claims processing by how many and how quickly cases are processed because this approach creates a disincentive to staff for developing fraud cases. It also suggested that incentives to

[8]Supplemental Security Income: Action Needed on Long-Standing Problems Affecting Program Integrity (GAO/HEHS-98-158, Sept. 14, 1998).

develop suspicious cases be provided and that adjustments to tracking processing times be made.[9]

SSA told us that giving special consideration when tracking staff claims processing times in suspicious cases remains under review.

Conclusions

SSI and other benefit programs may be losing millions of dollars each year because individuals improperly obtain benefits by feigning disabilities with the help of medical providers and middlemen. Every individual who obtains benefits in this manner will cost the federal government an estimated $122,000 in SSI and Medicaid benefits over the next 10 years. While SSA has made progress in addressing this problem since our 1995 report and its efforts have had positive results, detecting fraudulent and abusive SSI cases remains difficult.

Because SSA relies heavily on its front-line staff to identify potential fraud and abuse, it is important for staff to have the ability to detect suspicious cases. Their detection abilities would be strengthened if they had additional tools to meet this challenge. To the extent that information on problem middlemen and medical providers can be developed, maintained, and shared with staff, SSA's fraud detection and prevention efforts will be enhanced. In addition, by implementing our previous recommendation to reevaluate its work-credit and incentive structure to encourage better verification of recipient information and greater staff attention to fraud prevention and detection, staff will be encouraged to use the new procedures. Finally, we believe legislative action to address staff liability concerns could enhance the use of established procedures to fight fraud.

Recommendations

We recommend that the Commissioner of Social Security take the following actions:

- Study the feasibility of obtaining information on suspicious medical providers from federal, state, and private entities that face similar fraud and abuse issues as SSA does in managing the SSI program.
- Systematically track suspicious middlemen and medical providers identified by SSA staff and outside agencies, and routinely share this information throughout SSA. For example, SSA could electronically maintain information on such medical providers and middlemen and on the SSI applicants and recipients they serve. This information would help

[9]SSA, Proceedings of the 2nd Annual Fraud Conference, Sept. 8-12, 1997.

SSA (1) determine which claims should receive increased scrutiny to prevent these applicants from improperly receiving benefits and (2) target investigations of current beneficiaries to determine if they should be removed from the program.

- Reexamine SSA's policy regarding SSA-provided interpreters for SSI applicants with the aim of determining the extent to which it is followed by field and DDS staff and its effectiveness, and whether the use of SSA-provided interpreters should be required in situations which meet certain profiles.

Recommendation to the Congress

To address liability concerns related to maintaining lists of suspicious middlemen and medical providers and following FSF procedures, the Congress may wish to provide a limitation of the legal liability of state employees who follow SSA policies that require them to identify and document middlemen and medical providers suspected of providing misleading, inaccurate, and incomplete evidence in disability claims.

Agency Comments and Our Evaluation

We provided SSA a draft of this report for review and comment. In its written response, SSA agreed that more can be done to prevent fraud in the SSI program and endorsed our recommendation to reexamine its current policy on the use of interpreters. However, the agency indicated that while our other two recommendations have potential value, it wanted to explore them further before committing to developing implementation strategies for them. SSA also emphasized that its issuance of a plan to improve SSI program management was evidence of its commitment to fight fraud and noted that it has taken actions that can substantially reduce the potential for such fraud.

Our views about several specific concerns raised in SSA's letter follow. SSA's letter is reprinted as appendix III.

- Regarding the finding that SSI remains vulnerable to middleman fraud, SSA is concerned that our report relies almost exclusively on anecdotal evidence. SSA said that while the middleman problem has not been completely eradicated, it believes that it has taken actions that substantially reduce the potential for middleman fraud and remains committed to taking further action.

  As our report states, SSA does not routinely record the names and addresses of middlemen when a claim is filed. As a result, we could not

determine the extent of suspicious middleman involvement in SSI cases involving feignable impairments. As a substitute measure, we spoke with staff SSA relies on to identify potentially fraudulent cases (its field office employees and DDS staff) and SSA's fraud investigators. Both said middleman fraud is a continuing problem.

- SSA is also concerned that we may have overstated the extent of the problem with unscrupulous medical providers. It said that lists of suspicious providers may prove to be a valid indicator of the potential for fraud in a case. However, it also said that our inclusion of persons suspected of fraud rather than limiting the study to those convicted or otherwise sanctioned for fraud could overstate the problem. SSA noted that being investigated for fraud cannot and should not be equated with being convicted or sanctioned.

  Precisely measuring the SSI program's vulnerability to fraud and abuse is difficult. By its nature, fraud is surreptitious and perpetrators are not always identified and prosecuted. Even if the rate is half what we measured, there is a problem that SSA needs to address. Some medical providers—an important component of the disability adjudication process—have been at least suspected of fraudulent activities by others. We believe SSA can improve staff ability to identify cases that deserve closer scrutiny by developing and maintaining lists of medical providers and middlemen whose past actions make their involvement in SSI cases suspicious.

- SSA emphasized that its October 1998 plan to improve SSI management addresses employee views that workload priorities overshadow antifraud activities. It said the plan makes it clear that SSA is pursuing initiatives designed to balance its program stewardship responsibilities with its public service responsibilities. Over time, it believes the plan activities will achieve this balance.

  We believe SSA's issuance of a plan to improve SSI management is a positive step in its efforts to combat fraud and abuse in the program and that it has taken a number of actions to enhance program stewardship. However, the plan mentioned by SSA does not specify any initiatives that directly address employee perceptions that workload priorities overshadow antifraud activities. SSA needs to take some specific actions to overcome this widespread and deep-seated perception among its staff.

- SSA commented that the majority of the cost savings achieved by its five CDI teams are not necessarily related to fraud perpetuated against the program. It said that many if not most of the CDI team savings appear to involve instances of disability decisions being made incorrectly or without proper documentation rather than fraud.

  As our report notes, the purpose of the CDI teams was not to prove fraud; rather, it was to assist SSA and DDS staff in making benefit-related decisions. The report notes that the CDI teams believe that their investigative work contributed to denials and cessations of benefits—not that they contributed to prosecutions for fraudulent activity.

- Finally, before pursuing two of our recommendations, SSA would like to have in-depth discussions about these approaches with its OIG staff and GAO. SSA said that implementing two of our three recommendations—tracking suspicious middlemen and medical providers SSA encounters and sharing this information with its staff; and studying the feasibility of obtaining information on suspicious medical providers from federal, state, and private entities to supplement this information—may be fruitful. However, SSA is concerned about the definition of suspicious medical providers or middlemen and the legal ramifications of tracking individuals who may not have been convicted or have not admitted guilt. Because the suspicious individuals in our study included people who had been or were being investigated as well as people who have been convicted or sanctioned, SSA states that this approach raises serious legal issues relative to the Privacy Act, the Freedom of Information Act, individual state and employee liability, and accessibility (security). Specifically, SSA notes that the Privacy Act requires that agencies maintain records that are accurate, complete, relevant, and timely as reasonably necessary to ensure fairness in any determinations made about the individual. Before establishing such a system of records, SSA would have to make the public aware of its plans by publishing a notice of its intended actions and allowing the public to comment. Once aware of the records system, the public could use the provisions of the Privacy Act to obtain records about themselves and the right to request correction of erroneous information in the records. If SSA inappropriately or incorrectly labels individuals as suspicious without the benefit of convictions or admissions of guilt, it could be vulnerable to legal challenges in civil actions brought by these individuals.

  We agree that SSA must comply with the Privacy Act and other relevant legislation and must act carefully and responsibly in characterizing

individuals as suspicious, particularly where that characterization could lead to criminal prosecution, denial of benefits, or other adverse consequences. Our definition of "suspicious" was reasonable for research purposes but may not be appropriate for law enforcement purposes. In our opinion, however, the Privacy Act is not an impediment to implementing our recommendation to systematically track suspicious middlemen and medical providers. SSA already maintains a system of records, the Program Integrity Case Files, that contains the same kind of information and complies with the Privacy Act. We believe this system of records—or a similar one designed for this purpose—could be used to carry out our recommendations as well. Information in the Program Integrity Case Files, according to SSA's published Privacy Act notice, includes the identity of "persons suspected of violating Federal statutes affecting the administration of programs under the responsibility of SSA." We see no reason why information about suspicious middlemen and providers in the SSI program could not be maintained in the same fashion. Since SSA already maintains such records, our recommendations create no new category of risk of civil liability for incorrectly labeling individuals as suspicious. Nevertheless, the intent of our recommendations is to provide SSA and DDS staff with information, such as the involvement of suspicious middlemen or providers in a case. This type of information will enable them to identify potentially fraudulent cases for closer review.

We are providing copies of this report to the Honorable Kenneth S. Apfel, Commissioner of Social Security. We will also send copies to other interested parties on request. If you or your staff have any questions about this report, please contact Barbara Bovbjerg, Associate Director, at (202) 512-5491, or Rod Miller, Assistant Director, at (202) 512-7246. Other major contributors to this report were Nancy Cosentino, Jill Yost, William Staab, and Kevin Craddock.

Sincerely yours,

Cynthia M. Fagnoni
Director, Education, Workforce,
and Income Security Issues

Contents

Letter 1

Appendix I Scope and Methodology 28
Interviews With SSA Managers and Staff 28
Analysis of SSI Recipients in Susceptible Diagnostic Categories 28
Analysis of Suspicious Medical Providers Involved in SSI Cases 29

Appendix II Impairments Considered by SSA to Be Vulnerable to Exaggeration 31

Appendix III Comments From the Social Security Administration 32

Tables
Table 1: Estimated Number of SSI Child and Adult Recipients in April 1998 Sampling by Category of Impairments Considered by SSA and DDS Staff to Be Vulnerable to Feigning 7
Table 2: SSI Recipients With Impairments Difficult to Objectively Verify Who Used Suspicious Medical Providers to Support Their Disability Claim, by State 8
Table 3: Suspicious Medical Providers and SSI Recipients They Assisted Whose Impairments Were Difficult to Objectively Verify, by State 9
Table I.1: Number of Interviews GAO Conducted With Individuals to Ask About the Continued Existence of Middleman Fraud in the SSI Program, by Organization 28
Table II.1: Impairments Considered Susceptible to Exaggeration in SSI Claims 31

Abbreviations

ALJ	administrative law judge
CDI	Cooperative Disability Investigation
CDR	continuing disability review
DDS	Disability Determination Services
FSF	fraud or similar fault
HCFA	Health Care Financing Administration
MFCU	Medicaid Fraud Control Unit
NICB	National Insurance Crime Bureau
OHA	Office of Hearings and Appeals
OIG	Office of Inspector General
SSA	Social Security Administration
SSI	Supplemental Security Income

Scope and Methodology

This appendix describes our approach for collecting and analyzing data and for interviewing officials in agencies coping with fraud and abuse in health insurance programs. Our work was directed at determining (1) the potential risk that recipients become eligible for SSI by feigning disabilities with the help of middlemen and medical providers; (2) how SSA prevents, detects, and responds to this type of program fraud and abuse; and (3) additional methods SSA could use to effectively address this problem. We did not, however, verify the accuracy of the automated data provided by SSA or the investigative organizations. We conducted our review from October 1997 to August 1999.

Interviews With SSA Managers and Staff

To determine the beliefs of SSA managers, front-line staff, and various fraud investigators about the continued existence of middleman fraud, we asked 158 individuals to discuss their opinions on and experiences with middleman fraud in the SSI program. These individuals were not randomly selected and were not in sufficient numbers to constitute a statistically valid sampling of the opinions of all individuals who work with the SSI program. Table I.1 shows the number of interviews we held, by organization.

Table I.1: Number of Interviews GAO Conducted With Individuals to Ask About the Continued Existence of Middleman Fraud in the SSI Program, by Organization

Organization	Number of interviews
SSA headquarters	17
OHA headquarters	5
SSA regional offices	10
DDS offices	43
SSA field offices	43
OHA regional offices	7
Investigators	33

Analysis of SSI Recipients in Susceptible Diagnostic Categories

To learn which mental and physical disabilities are considered susceptible to being feigned or exaggerated, we interviewed disability specialists at SSA headquarters in Baltimore, medical consultants and medical relations officers at DDS offices in seven states, and investigators who specialize in disability fraud. We also reviewed SSA's Program Operations Manual, which lists impairments prevalent in claims involving fraud or similar fault. The specific categories we identified as susceptible to feigning are identified in appendix II.

We then analyzed the distribution of diagnostic categories among recipients in SSA's Characteristic Extract Record, often referred to as the "10-percent file," to identify how many adults and children had mental or physical disabilities that fell into the susceptible diagnostic categories. Because over 20 percent of the records lack the diagnostic code which would indicate the disability that qualified the recipient for SSI benefits, our analysis reflects only those records in the 10-percent file that contained the diagnostic code.

Analysis of Suspicious Medical Providers Involved in SSI Cases

To determine the potential extent of SSI disability fraud and abuse by medical providers, we obtained records from SSA that identified SSI recipients whose disabilities were among those considered susceptible to being feigned or exaggerated. The records covered six states (California, Florida, Georgia, Louisiana, Massachusetts, and New York). SSI recipients in these states constitute about 40 percent of the total SSI population.

Using these recipient names and social security numbers, the DDS offices for these six states created files containing records that identified both the SSI recipients and the medical providers who had submitted evidence to support their disability claims. (In many cases, the DDS record contained only the name of a hospital, and it was not possible to identify the specific doctor at the hospital who had been involved in a claim.) The names of those medical providers were matched against lists of providers who had been or were currently under investigation by agencies tasked with investigating suspicious medical providers, the Health Care Financing Administration (HCFA), the National Insurance Crime Bureau (NICB), and the states' Medicaid Fraud Control Units (MFCU). We did not verify the accuracy of the data provided by these agencies.

HCFA and NICB Matches

We matched the name, address, and tax identification number of the service providers in the DDS file against providers listed in the HCFA and NICB files. These files contained identifying information for medical providers who had been either suspected or convicted of defrauding or abusing programs paying Medicare, Medicaid, and private health insurance benefits. For those providers who appeared in both lists, we created a file of the records for all SSI recipients who had obtained evidence from them.

MFCU Match

State regulations require state MFCUs to protect the privacy and confidentiality of service providers investigated for possible fraudulent

activity. For this reason, we developed a protocol for this data match that differed from those used with the HCFA and NICB data.

We created for each state MFCU a file in which we had assigned a control number to each service provider identified in the DDS records. MFCUs matched the name, address, and tax identification information in our file against their databases of investigated service providers, then provided us with a list of the control numbers associated with providers who appeared in both files. Using the control numbers, we generated a file of SSI recipients who had used medical evidence from these suspicious providers to prove their disability.

Impairments Considered by SSA to Be Vulnerable to Exaggeration

SSA uses a four-digit code to designate disabilities. The codes are based on the International Classification of Diseases, published by the Department of Health and Human Services. The diagnostic codes are divided into general areas, such as cardiovascular, musculoskeletal, and mental. To determine which of these disabilities were most likely to be feigned or exaggerated by a person applying for SSI disability benefits, we interviewed medical consultants and medical relations officers at DDS offices in seven states, disability specialists at SSA headquarters, and investigators who specialize in disability fraud. We also reviewed SSA's Program Operations Manual, which lists impairments prevalent in claims involving fraud or similar fault. From these sources, we developed the following list of disabilities that were considered susceptible to being feigned or exaggerated.

Table II.1: Impairments Considered Susceptible to Exaggeration in SSI Claims

SSA disability code	Description
Adult/childhood disabilities	
2900-2949	Organic mental disorders
2950-2959	Schizophrenic disorders
2960-2999	Affective disorders
3000-3009	Anxiety disorders
3010-3059	Personality disorders
3060-3169	Somatoform disorders
3170-3199	Mental retardation
3450-3459	Epilepsy
Adult-only disabilities	
3690-3699	Blindness and low vision
4960-4949	Chronic pulmonary insufficiency
7240-7249	Disorders of the back (discogenic and degenerative)
7280-7289	Disorders of the muscle, ligament, and fascia
8480-8489	Sprains and strains (all types)

Comments From the Social Security Administration

SOCIAL SECURITY
Office of the Commissioner

August 17, 1999

Ms. Cynthia M. Fagnoni
Director, Education, Workforce,
and Income Security Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Fagnoni:

We appreciate the opportunity to comment on this draft report, Supplemental Security Income: Additional Actions Needed to Reduce Program Vulnerability to Fraud and Abuse, and agree that more can be done to prevent fraud in the Supplemental Security Income (SSI) program. That is, in fact, one of the main reasons the Agency developed a plan to improve the overall management of the SSI program. That plan, "Management of the Supplemental Security Income Program: Today and in the Future" was issued in October 1998.

We also appreciate your recognition of recent actions we have undertaken to combat fraud in our SSI program, including establishment of Cooperative Disability Investigation (CDI) teams in some of the Disability Determination Services (DDS) and development of new policies and procedures to address claims handling when fraud or abuse is detected.

I would like to address some specific matters raised in your report. First, as evidence that the program remains vulnerable to "middleman" fraud, the report relies almost exclusively on opinion and anecdote. While we acknowledge that the middleman problem has not been completely eradicated, we believe we have taken actions that substantially reduce the potential for such fraud and remain committed to further actions to address this issue.

With regard to the issue of evidence submitted by "suspicious" medical providers, while this may prove to be a valid indicator of the potential for fraud, we are

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

2

concerned that you may have overstated the extent of the problem, and hence, the vulnerability to fraud. In addition, your definition of "suspicious" includes both those providers suspected of fraud and those for whom convictions have been obtained. Being investigated for fraud cannot, and should not, be equated with being convicted or otherwise sanctioned for fraud. Moreover, your report acknowledges that your analysis of suspicious medical providers "…does not prove that any fraud or program abuse was committed in any of these cases."

Your report also suggests that many employees view workload priorities as overshadowing antifraud activities. The plan that we issued last October makes it clear that we are pursuing initiatives designed to balance our program stewardship responsibilities with our public service responsibilities. I believe those activities will ensure that over time we achieve this balance.

Finally, while we appreciate your support for our CDI teams, we believe readers of your report might assume that the vast majority of the OIG's estimated savings associated with our CDI teams' efforts are related to issues of fraud. We cannot agree that these savings are necessarily attributable to fraud. Many, if not most, of our CDI teams' efforts, to date, appear to involve instances of disability decisions being made incorrectly or without proper documentation rather than instances of fraud perpetuated against the program.

Our comments with regard to your specific recommendations follow.

GAO Recommendation 1 and 2

Study the feasibility of obtaining information on suspicious medical providers from Federal, State and private entities that face similar fraud and abuse issues as SSA does in managing the SSI program.

and

Systematically track suspicious middlemen and medical providers identified by SSA staff and outside agencies and routinely share this information throughout SSA. For example, SSA could electronically maintain information on such medical providers and middlemen and on the SSI

applicants and recipients they serve. This would help SSA determine which claims should receive increased scrutiny to prevent these applicants from improperly receiving benefits and to target investigations of those currently on the rolls to determine if they should be removed from the program.

SSA Comment

We believe the approaches and indicators you are proposing in this report may be fruitful. However, before pursuing them, we would like to have some in-depth discussions around each of these approaches with GAO and our OIG prior to developing any implementation strategies. Of crucial importance in our discussions will be the definition of "suspicious" medical providers or middlemen and any legal ramifications of tracking such individuals.

While there may be value in obtaining information on suspicious middlemen and medical providers and electronically tracking such individuals, your recommendations to do so raise serious legal issues. We are currently working with our General Counsel on issues regarding the Privacy Act, Freedom of Information Act, individual State and employee liability, and accessibility (security). Your draft report indicates that the information regarding suspicious middlemen and medical providers was, in some instances, provided by several investigative organizations and was not necessarily based on convictions and/or admissions of guilt. The Privacy Act requires that agencies maintain records that are accurate, complete, relevant and timely as reasonably necessary to assure fairness in any determination made about the individuals. Before establishing any such system of records, SSA must publish in the Federal Register a notice describing the system of records and allow a period for public comment. With certain exceptions that do not apply here, the Privacy Act grants individuals access to records about themselves and the right to request the correction of erroneous information in such records. If SSA inappropriately or incorrectly labels individuals as suspicious without benefit of convictions or admissions of guilt, the Agency could be vulnerable to legal challenges in civil actions brought by these individuals under the Privacy Act. For these reasons, as well as the other legal matters noted above, we believe that there are fundamental

issues with these recommendations that require further consultation with GAO, OIG and our General Counsel.

GAO Recommendation 3

Re-examine SSA's policy regarding SSA-provided interpreters for SSA applicants with the aim of determining the extent to which it is followed by field and Disability Determination Services staff and its effectiveness, and whether the use of SSA-provided interpreters should be required in situations which meet certain profiles.

SSA Comment

We agree with this recommendation and will re-examine the Agency's current policy regarding SSA providing interpreters and whether the use of SSA interpreters should be required in situations which meet certain profiles.

Sincerely,

Kenneth S. Apfel

Kenneth S. Apfel
Commissioner
of Social Security

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