SSI Application Fraud Detection Efforts Should Be Improved

OCTOBER 2003

The Auditor Of Public Accounts Ensures That Public Resources Are Protected, Accurately Valued, Properly Accounted For, And Effectively Employed To Raise The Quality Of Life Of Kentuckians.

EDWARD B. HATCHETT, JR.
AUDITOR OF PUBLIC ACCOUNTS

October 16, 2003

To the Legislative Research Commission and the Honorable Paul E. Patton, Governor

Re: Performance Assessment: The Relationship Between Medicaid and SSI Eligibility

Ladies and Gentlemen:

We have assessed Kentucky's ability to ascertain the eligibility for Medicaid of Supplemental Security Income recipients, and present our findings for your consideration.

We are distributing this report in accordance with the mandates of Kentucky Revised Statute (KRS) 43.090. In addition, we are distributing copies to members of the Appropriations and Revenue Committees of the General Assembly, other germane committees, and interested parties.

Our Division of Performance Audit evaluates the effectiveness and efficiency of government programs. The Division also conducts performance audits, completes risk assessments, and benchmarks government operations. We will be happy to discuss with you at any time this performance assessment or the services offered by our office. If you have any questions, please call Gerald W. Hoppmann, director of our Division of Performance Audit, or myself.

We appreciate the courtesies and cooperation extended to our staff during the performance assessment.

Respectfully submitted,

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Summary and Background

Summary

Kentucky has the second highest percentage of residents receiving federal Supplemental Security Income (SSI) among the states in the nation. Since SSI recipients are automatically eligible for Medicaid, SSI eligibility fraud can balloon Medicaid costs if left unaddressed. Yet our research reveals few initiatives to curb fraud among applicants. We found that Kentucky's Department for Disability Determination Services (DDS) has not referred any cases of suspected fraud or abuse to the federal Social Security Administration (SSA), Attorney General, or any other law enforcement authority since before 1997.

Kentucky's DDS and the SSA have not made detecting fraud and abuse a priority. Even with Kentucky's high number of SSI recipients and annual applications, Kentucky has no in-state Cooperative Disability Investigations (CDI) unit dedicated to countering the high risk of waste, fraud, and abuse within the SSI program. Additionally, Kentucky's DDS Quality Assurance Unit failed to produce evidence that sufficient quality reviews were performed of the disability determination process.

Kentucky is one of 13 states that allow non-medical personnel to determine SSI eligibility. For FY 2002, an estimated 3,178 SSI applications in Kentucky were evaluated and approved by non-medical staff and without direct supervisory review.

The large number of SSI recipients could be the result of environmental factors, removal from welfare, poor access to health care, and lack of education. The absence of private health insurance could also exacerbate an individual's disability and cause long-term impairments. According to the Institute for Research on Poverty located at the University of Wisconsin-Madison, as much as one-third of the increase in SSI caseload growth may be due to increases in the value of Medicaid for those who might otherwise go without medical coverage.

In FY 2002, there were a total of 183,802 SSI recipients in Kentucky who received over $1.4 billion in Medicaid services. When compared to other states, Kentucky has the highest percentage (27%) of Medicaid recipients receiving SSI.

Eligibility data for SSI recipients contained insufficient address information to determine whether Kentucky residency requirements were met. Cabinet for Families and Children data indicates that 9,940 SSI recipients had a P.O. Box or general delivery address. An additional 554 SSI recipients had an out-of-state address. These data should be reviewed to ensure compliance with state and federal regulations governing residency requirements for Medicaid enrollment.

The budget crisis has short-changed Kentucky's obligation to those who are truly disabled and economically disadvantaged. The failure to diligently root out fraudulent SSI applications seems especially heartless.

Summary and Background

Background

SSI is a nationwide federal assistance program administered by SSA that guarantees a minimum level of income for needy, aged, blind, or disabled persons. Nationally, the average monthly payment per recipient is $407. The federal government is responsible for determining eligibility and making payments. Once enrolled in the SSI program, recipients become eligible for the state Medicaid program. Each state is responsible for paying the recipient's medical expenditures once he/she is declared disabled by SSA.

SSI Medical Eligibility is Determined by the Cabinet for Families and Children

Under Kentucky's agreement with the SSA, DDS within the Cabinet for Families and Children determines medical disability for the SSI program. This occurs after SSA determines that a person meets the nonmedical eligibility requirements to receive SSI.

Federal SSA field offices receive SSI applications and review applicable nonmedical eligibility requirements including income and assets levels. Once SSA confirms technical eligibility, the case is forwarded to DDS to determine whether the disability meets medical eligibility requirements.

SSA defines "disability" as an inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment. The impairment must be expected to result in death or last for a continuous period of not less than twelve months.

DDS gathers medical, educational, vocational, and other necessary evidence to determine whether applicants are medically disabled under Social Security law. DDS application processors determine whether the applicant has an impairment or combination of impairments severe enough to be expected to last at least 12 months. DDS collects necessary medical evidence from those who have treated the applicant, or if the information is not sufficient, independent examinations are undertaken and paid for by the federal government.

DDS compares the applicant's condition to a listing of medical impairments developed by SSA. The conditions describe situations that are ordinarily expected to prevent an individual from engaging in substantial, gainful activity. An applicant whose impairment is listed as equally severe or more severe is found to be disabled and awarded benefits. Those not meeting the impairment guidelines are evaluated further to determine whether they have vocational limitations that, when combined with medical impairment(s), prevent work.

DDS then uses assessments of the applicant's functional capacity to determine whether the applicant is able to work. If DDS finds that a claimant can be gainfully employed, benefits are denied. At any point in the application process, claims may be denied for lack of information and/or failure to follow prescribed treatments.

Summary and Background

Medicaid Enrollment is Automatic for SSI Recipients

Disabled persons enrolled in the SSI program are categorically eligible for Medicaid. Mandatory Medicaid eligibility groups are:

- elderly persons and the disabled; and certain other low-income Medicare beneficiaries;
- families that would have qualified for cash assistance for families with dependent children using guidelines in place on July 16, 1996;
- families receiving transitional medical assistance; and
- low-income pregnant women and children under 19 years of age.

Medicaid coverage is not available for low-income, nondisabled, working-age adults without children.

Medicaid program expenditures have doubled since 1992 and Kentucky budgets have consistently failed to accurately estimate enrollment and expenditure needs. Kentucky's annual growth in spending is 12%, over the national average of 11%. The following table illustrates Medicaid budgeted and actual expenditures and eligibles from 1997 through 2002.

Table 1
Budgeted Versus Projected Medicaid Expenditures and Eligibles

Year	Medicaid Budged Expenditures	Medicaid Actual Expenditures	Medicaid Budgeted Eligibles	Medicaid Actual Eligibles
1997	$2,489,771,200	$2,570,035,000	560,997	531,868
1998	2,717,815,200	2,636,764,127	578,297	520,074
1999	2,904,090,300	2,822,917,440	520,000	517,748
2000	2,862,274,600	3,215,400,565	546,000	557,067
2001	3,254,140,100	3,484,174,398	591,500	607,571
2002	3,398,523,200	3,788,895,201	599,400	626,729
Total	$17,626,614,600	$18,518,186,731	3,396,194	3,361,057

Source: Auditor of Public Accounts using information from the Commonwealth's Executive Budgets and Cabinet for Health Services' internal reports.

Findings and Recommendations

Kentucky Has a Significantly Large Number of SSI Recipients and Disability Applications

Kentucky's SSI participation is significantly higher than that in other states. For the past two years, Kentucky ranked second only to Mississippi in its percentage of population receiving SSI. Based on SSA's state statistical reports, 175,958 Kentuckians received SSI benefits in 2001. By December 2002, the number of Kentuckians receiving SSI grew to 176,779, which is 4.3% of the entire state population. This is more than double the national average of 2.1%.

Kentucky ranks second among regional states in disability applications as a percentage of overall state population. That places Kentucky significantly higher than regional averages and nearly twice the national averages for FY 2001 and FY 2002.

During FY 2002, Kentucky's DDS received more than 109,000 applications for disability assistance. This amounts to over 700 applications per year for each application processor. The following table provides additional information.

Table 2
Disability Applications for Atlanta SSA Regional States

State	FY 2001 Applications	Percentage of States' Population	FY 2002 Applications	Percentage of States' Population
Alabama	81,372	1.82	90,725	2.03
Florida	240,604	1.47	253,283	1.54
Georgia	120,370	1.44	135,861	1.62
Mississippi	81,815	2.86	88,514	3.10
Kentucky	**108,943**	**2.68**	**109,066**	**2.68**
N. Carolina	142,899	1.75	160,387	1.96
S. Carolina	72,389	1.78	78,043	1.92
Tennessee	116,995	2.04	119,736	2.09
Region	965,387	1.78	1,035,615	1.91
Nation	3,786,449	1.33	4,041,035	1.42

Source: United States Social Security Administration and United States Census Bureau.
*SSA reports did not break out SSI (no prior work experience) versus SSDI (prior work experience).

As of January 2003, DDS employed 155 full-time disability application examiners and various ancillary staffs totaling 407 persons responsible for the SSI enrollment process. This is a 13% increase from 360 employees in 1998.

As of May 2, 2003, there were 21,893 pending disability applications for which DDS had not reached a disposition. Table 3 illustrates the breakdown in age of the pending applications.

Table 3
Kentucky DDS' Pending Applications
Week Ending May 5, 2003

Type of Review	< 60 Days Old	60 – 89 Days Old	90-119 Days Old	>120 Days Old	% Less Than 120 Days Old	% Greater Than 120 Days Old
Initial Applications	9,018	2,120	1,122	563	96%	4%
Reconsiderations	2,394	372	113	101	97%	3%
Continuing Disability Reviews	4,557	839	419	275	95%	5%
Totals	**15,969**	**3,331**	**1,654**	**939**	**96%**	**4%**

Source: Auditor of Public Accounts using information provided by Kentucky's DDS.

The large number of applications could be the result of environmental factors, removal from welfare, poor access to health care, and a lack of education. The absence of private health insurance could also exacerbate an individual's disability and cause long-term impairments. According to the Institute for Research on Poverty located at the University of Wisconsin-Madison, as much as one-third the increase in SSI caseload growth may be due to increases in the value of Medicaid for those who might otherwise go without medical coverage.

While the vast majority of SSI claimants have legitimate disabilities and needs, there may be fraudulent reasons that contribute to the large number of recipients. Recent media accounts have painted a severe portrait of SSI enrollment abuse in Kentucky by reporting that there are doctors and attorneys actively marketing services and soliciting clients. According to a August 26, 2002 *Lexington Herald Leader* article, "residents are urged to apply for SSI by relatives and friends, sympathetic social workers and lawyers who offer to win their clients a disability check, for a fee." The article goes on to say "some lawyers recruit clients in impoverished counties through advertising that practically promises a monthly SSI check."

Kentucky's Processing Accuracy Rate Meets Federal Requirements

According to federal application processing requirements, Kentucky's DDS accuracy rates are at or above regional statistics based on SSA sampling reviews. SSA conducts routine sampling of processed applications (claims) to determine whether state DDS offices are accurately processing initial applications and redeterminations. The SSA annually reviews for accuracy 50 percent of allowed claims and 10 percent of denied claims, using the same documentation that Kentucky processors used. Table 4 documents the results of these reviews for the past five years for the Atlanta region states.

Table 4
Five Year Ranking of Regional States Accuracy Rates Per the SSA

State	1998	1999	2000	2001	2002
Alabama	94.3	91.8	91.6	96.1	96.1
Florida	92.2	96.7	95.1	94.0	93.8
Georgia	94.1	92.6	94.3	93.9	93.7
Kentucky	**94.5**	**94.0**	**93.3**	**94.0**	**92.8**
Mississippi	93.1	91.9	94.0	93.3	91.2
North Carolina	92.8	94.0	93.3	93.8	93.4
South Carolina	95.5	93.9	95.1	94.0	93.3
Tennessee	93.9	93.6	93.3	93.0	93.9
Region	**93.5**	**94.1**	**94.0**	**94.0**	**93.7**
Nation	**93.7**	**94.3**	**94.2**	**93.9**	**94.2**

Source: Auditor of Public Accounts using information from the Social Security Administration.

For FY 2002, Kentucky denied 59.9% of all applications received, which was the tenth lowest approval rate in the nation and third lowest in the region. This ranking indicates that Kentucky's approval rates are not unusually high, but it does have a high number of persons applying for disability.

Kentucky Does Not Have a Cooperative Disability Investigation (CDI) Unit

Despite having the second-highest percentage of SSI recipients in the nation, Kentucky has no in-state Cooperative Disability Investigations (CDI) unit. Also, DDS could not document any referrals to the SSA or state law enforcement agencies for fraud and abuse.

The United States General Accounting Office (GAO) downgraded its classification of the SSI program nationwide from "high risk for waste, fraud, abuse and mismanagement," due in large part, to the development of CDI units. The SSA has reported many successes of CDI units that include:

- Providing investigative evidence for use in making timely and accurate disability eligibility determinations;
- Pursuing criminal and civil prosecution of applicants and beneficiaries; and
- Identifying, investigating, and pursuing prosecution of doctors, lawyers, and others who facilitate and promote disability fraud.

SSA CDI units confirmed 1,065 cases of fraud and identified $62,907,926 in SSA savings and $38,324,690 in projected savings in other government program benefits, including Medicaid. Some examples of fraud include SSI recipients diverting checks, concealing assets, and feigning physical and mental impairments.

According to DDS, it would not be opposed to such a program but the decision to establish one is at the discretion of SSA. In addition, DDS staff assert that, because SSA has a branch of its Inspector General in Lexington, with two agents assigned to investigate suspected fraud in SSI and other SSA programs, the absence of a CDI program is not essential. Still, the absence of documented referrals is troubling.

Findings and Recommendations

DDS Has Not Referred Any Cases of SSI Fraud or Abuse Since at Least 1997

Fraud referrals may be made via an SSA fraud hotline, the SSA field office, or by contacting local SSA investigators. DDS did not provide any documentation that suspected fraud or abuse had been referred to the SSA or any state authorities since at least 1997.

While the vast majority of SSI claimants have legitimate disabilities and needs for Medicaid, some obtain coverage fraudulently. Last year alone, the SSA received over 26,000 allegations of SSI disability fraud nationwide.

Internal Review by DDS' Quality Assurance Unit Is Weak

The DDS Quality Assurance Unit failed to produce evidence that sufficient quality reviews are being performed of the disability determination process. The only substantial report issued in the past five years focused on administrative accuracy following processing of the applications. The report did not include an examination of front-end checks (prior to making final decisions) or of Kentucky's high concentrations of SSI enrollment.

According to federal requirements, Quality Assurance should:

- perform an on-going review of a random sample of cases processed by DDS;
- review high-risk cases;
- undertake special studies to provide information to management about any aspects of DDS operations;
- record data regarding the quality and characteristics of the cases reviewed;
- analyze all available data on DDS performance; and
- furnish recommendations for improvements.

The information provided for Quality Assurance for five years did not reach the level or quality of work demanded by federal requirements. There was one report provided by DDS, dated March 26,2001, that documents a special sample selection for a quality review and a conclusion. The other documents provided were mainly memoranda analyzing and reporting on SSA-developed statistics. These documents were lacking in details and recommendations for improvement. The Quality Assurance Unit Supervisor stated that some reports may have been prepared about 3 ½ years ago but have been destroyed, lost, or are archived and not readily available.

Due to the fact that SSA has not noted any unusual problems with Kentucky's application process, it does not find that the quality assurance unit is in conflict with SSA guidelines. According to Kentucky's SSA Disability Program Administrator, "SSA provides considerable flexibility to states in designing the quality assurance function, as long as outcomes are acceptable as measured by our federal quality review process."

In February 2003, after the APA's inquiry began, DDS started to sample mental impairment cases for further review. They reviewed 190 cases where a denial of benefits was proposed. Fifty-one of those cases (47%) were found to have decision or documentation errors. No other proactive sampling or reporting appears to have been conducted.

We observed other Quality Assurance Unit internal control weaknesses, which question the reasonable assurance of quality determinations.

- DDS Quality Assurance Unit has no substantive guidelines for internal performance, procedures, or benchmarking except for SSA broad guidelines for all states.

- DDS Quality Assurance Unit employees lack direct oversight and review by qualified medical professionals.

- DDS appears to lack a commitment to Quality Assurance Unit staffing. From 1997 through 2003, no more than seven persons worked for the Unit. In 2002, only one person was employed by the unit. Recent lulls in staffing indicate an insufficient level of commitment to fraud and abuse oversight.

Over 3,000 SSI Approvals Made Without Medical or Routine Supervisory Review

Kentucky is one of 13 "Single Decision Maker" states that allows non-medical personnel to determine SSI eligibility. For FY 2002, an estimated 3,178 SSI applications in Kentucky were evaluated and approved without medical or routine supervisory reviews.

The Single Decision Maker concept was developed by SSA to streamline the disability application process by avoiding the use of highly-qualified medical consultants. Other Single Decision Maker states include Alabama, Florida, North Carolina, Alaska, California, Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, and Pennsylvania.

Kentucky Limits the Use of Medical Consultants in SSI Determinations

In Single Decision Maker states, disability determination does not require the opinion of doctors, psychologists, or other medical professionals with advanced education and skills.

It was impossible to determine the number of Kentucky applications reviewed by medical consultants based on information provided by DDS. DDS estimates that 25% of all initial applications for adult physical disability are processed without the assistance of its 36 contracted medical consultants. DDS employees make these complex medical decisions with as little as one year of in-house training and without education germane to their job responsibilities.

DDS Application Processors Not Required to Have Degrees in Medical or Vocational Rehabilitation Areas

Application processors in Kentucky are not required to have degrees in medical or vocational rehabilitation areas and do not receive ongoing professional training in fraud and abuse detection. According to the class specifications maintained by the Personnel Cabinet, a Disability Adjudicator I should have a bachelor's degree, but the type of degree is not specified. Also, experience in adjudicating SSA disability claims or clerical experience with an organization that adjudicates SSA disability claims will substitute for the required bachelor's degree up to a maximum of two years.

Approximately 65% of DDS processors have educational backgrounds in disciplines far removed from their duties and some have no college degrees; only a few carry professional certification designations through the National Association of Disability Examiners. In addition, ten of the 27 (37%) section supervisors have only high school educations. The remaining section supervisors possess either a bachelor's or master's degree.

All disability determination personnel, no matter what the level of education and experience, would benefit from continuing professional education highlighting current trends and developments in fraud detection. This lack of ongoing professional training may be why DDS could not produce documentation of a single fraud investigation referral to the SSA or appropriate authorities over the five-year scope of our performance assessment.

Nearly Half of 2002 Medicaid Costs Are Related to SSI Recipients

For fiscal year 2002, the Commonwealth spent $3,050,771,087[1] to provide Medicaid services to 626,117 Medicaid eligible recipients. Almost half of the total cost, or $1,422,592,864, was for services provided to 183,802 SSI recipients. These persons constitute 30% of the total number of Medicaid recipients, but account for 47% of total Medicaid costs.

When compared to other states, Kentucky has the highest percentage of Medicaid recipients receiving SSI. The following table represents Kentucky's ranking among the Atlanta region states.

Table 5
SSI Recipients for Atlanta SSA Regional States
2001

State	Number of Persons Receiving SSI	Percentage of Population Receiving SSI	Number of Persons Receiving Medicaid	*Percentage and Number of Medicaid Recipients Receiving SSI
Kentucky	175,958	4.3	632,800	27% (168,920)
Alabama	161,584	3.6	598,400	26% (155,121)
Mississippi	128,568	4.5	566,900	22% (123,425)
Florida	386,931	2.4	1,831,700	20% (371,454)
N. Carolina	191,792	2.3	991,500	19% (184,120)
Georgia	198,229	2.4	1,063,100	18% (190,300)
S. Carolina	107,022	2.6	652,100	16% (102,741)
Tennessee	162,993	2.8	1,393,600	11% (185,273)
Region	1,513,077	2.8	7,730,100	20% (1,452,554)

Source: United States Social Security Administration (SSA), the Census Bureau, and the Kaiser Commission on Medicaid and the Uninsured.

* Auditor of Public Accounts calculation based on SSA's estimate that 96% of SSI recipients receive Medicaid nationwide.

More Than 10% of the Population Receive SSI in Twenty-One Kentucky Counties

More than 4% of all Kentuckians received SSI and Medicaid benefits during 2001. Many Kentucky counties had 10% or more of their populations receiving SSI and Medicaid benefits during fiscal year 2002, as illustrated in Table 6. See Appendix II and III for additional information.

[1] The $3,050,771,087 represents claim specific costs associated with individuals that were eligible for Medicaid as of June 30, 2002. This number does not include FY 2002 costs for recipients who were not eligible on June 30, 2002. Also, it does not include additional Medicaid costs that are paid cumulatively, i.e., transportation, disproportionate share hospital payments (DSH), and managed care. The amount used in Table 1, $3,788,895,201, is the FY 2002 expenditure total reported to the Legislative Research Commission.

Table 6
Kentucky Counties With 10% or More Population Receiving SSI and Medicaid Services During FY 2002

County	# of SSI Recipients Receiving Medicaid Services	*Population	Percentage of Population
Owsley	1,049	4,858	22.0
Wolfe	1,292	7,065	18.0
Breathitt	2,502	16,100	16.0
Clay	3,815	24,556	16.0
McCreary	2,189	17,080	13.0
Knox	3,891	31,795	12.0
Magoffin	1,592	13,332	12.0
Lee	942	7,916	12.0
Bell	3,554	30,060	12.0
Leslie	1,440	12,401	12.0
Martin	1,438	12,578	11.0
Clinton	1,092	9,634	11.0
Perry	3,295	29,390	11.0
Jackson	1,510	13,495	11.0
Knott	1,881	17,649	11.0
Whitley	3,601	35,865	10.0
Wayne	1,989	19,923	10.0
Harlan	3,246	33,202	10.0
Floyd	4,094	42,441	10.0
Letcher	2,412	25,277	10.0
Cumberland	679	7,147	10.0
Total	**47,503**	**411,764**	**11.5**

Source: Auditor of Public Accounts using Medicaid information provided by UNISYS for FY 2002.
*Based on FY 2000 Census.

Kentucky's average total Medicaid benefits for an SSI recipient in FY 2002 was $7,740. Thirty-one counties exceeded this average amount. Of these 31 counties, two (Union and Pulaski) had an average Medicaid benefit paid per SSI recipient of over $12,000. The following table provides additional information.

Table 7
Average Medicaid Amounts Per County
FY 2002

Average Medicaid Amount Paid Per SSI Recipient	Number of Counties within the Average Medicaid Amount Range Paid Per SSI Recipient	Number of SSI Recipients Receiving Medicaid Benefits
$5,000 - $5,499	3	2,524
$5,500 - $5,999	5	3,625
$6,000 - $6,499	22	31,151
$6,500 - $6,999	25	31,512
$7,000 - $7,499	21	22,770
$7,500 - $7,999	20	32,104
$8,000 - $8,499	9	12,448
$8,500 - $8,999	5	8,182
$9,000 - $9,499	1	6,094
$9,500 - $9,999	3	23,268
$10,000 - $10,499	4	5,352
$10,500 - $10,999	0	0
$11,000 - $11,499	0	0
$11,500 - $11,999	0	0
$12,000 - $12,499	2	4,727
Total	**120**	**183,757**

Source: Auditor of Public Accounts using Medicaid information provided by UNISYS for FY 2002.

Questionable Claims Information May Indicate Fraud and Abuse

Eligibility data for SSI recipients contained address information that was insufficient to establish Kentucky residency. After confirmation with the Cabinet for Families and Children, 9,940 SSI recipients had a P.O. Box or general delivery address. An additional 554 SSI recipients had an out-of-state address listed. These recipients should be reviewed to ensure compliance with State and federal regulations on state residency requirements for Medicaid enrollment.

An initial review of Medicaid's FY 2002 eligibility and paid claims data contained nonspecific and out-of-state addresses for 47,754 SSI/Medicaid enrollees. Medicaid indicated its information system only maintains the eligible person's mailing address. Medicaid relies on the Cabinet for Families and Children's eligibility system to collect and track the person's complete address.

The list of 47,754 SSI/Medicaid enrollees was then sent to the Cabinet for Families and Children to verify each person's complete address. This review revealed that 10,494 recipients (22%) still had questionable or even blank addresses. These cases merit further review because it appears that neither party is tracking or confirming the recipient's residency adequately.

State and federal regulations require state residency as a condition of Medicaid enrollment. The regulations define residency as, "where the individual is living with the intention to remain there permanently or for an indefinite period, or where the individual is living and which he/she entered with a job commitment, or seeking employment whether or not currently employed."

The lack of detailed address information makes it easier for ineligible persons to receive SSI and Medicaid benefits. For example, a person could be living and working in Indiana, but apply for Kentucky Medicaid using a P.O. Box address in Louisville, Kentucky. In addition, the lack of a street address makes it more difficult to investigate a possible case of fraud.

The SSA's Office of Inspector General has identified numerous cases of fraudulent claims made with assumed identities and aliases in other states. This seems likely also to be occurring in Kentucky. In one state, investigations revealed an SSI 'representative payee' who purported to act on behalf of an incapacitated claimant and received undue benefits on behalf of 12 claimants. Detection and investigation will be hampered by Kentucky's incomplete address data, and similar frauds could go undetected.

Conclusion

The potential for fraud and abuse is high within Kentucky's SSI disability determination process as evidenced by:

- High numbers of SSI recipients in the Commonwealth
- Lack of aggressive fraud detection
- Absence of fraud referrals
- SSI is an impetus for receiving Medicaid services

State and federal administrators should collaborate to ensure that SSI fraud and abuse are minimized so that scarce SSI and Medicaid resources can be maximized.

Recommendations

The Auditor of Public Accounts recommends that DDS:

1. Work with the SSA to develop and activate an in-state CDI Unit.

2. Develop policies and procedures on fraud identification during the application process.

3. Strengthen the Quality Assurance Unit to ensure that routine sampling, reports, and reviews are conducted during the SSI determination process. DDS should also work with SSA to determine what other states are doing on quality assurance and adopt best practices.

4. Provide ongoing fraud and abuse detection training.

5. Accurately track the number of approved applications assisted by medical consultants to determine if these medical professionals should be more involved with the decisions of non-medical personnel.

6. Conduct routine sampling of applications to determine whether appropriate decisions were made. Medical consultants or supervisory staff could be used to review these cases.

7. Work with the Department of Medicaid Services to develop criteria to determine when the use of nonspecific and out-of-state addresses is allowable and track these situations in the eligibility database. The 10,494 recipients discussed in the report should be reviewed to determine whether they are in compliance with Medicaid's residency requirements.

Scope and Methodology

Appendix I

Scope and Methodology

Our performance assessment examined particular functions of CHS and CFC related to disability determination for SSI and Medicaid enrollment. Unless otherwise noted, all statistics and other information mentioned in this assessment consist of data available for FY 2002. Our performance assessment generally encompassed events occurring within the past five years with emphasis on more recent developments.

The data and information we received was obtained primarily through requests to the Cabinets for various source documents. CFC provided some data through access and retrieval of SSA files; at times we relied on interviews, email requests and telephone conversations when source documentation was not available. CHS provided us with Medicaid cost data for FY 2002 from the Commonwealth's fiscal agent for processing Medicaid claims (UNISYS).

We relied on management assertion from both cabinets to be complete and accurate. We did not assess the reliability of computer-based data or management controls since these areas were not significant to our performance assessment objective. Our assessment does not include an attestation of completeness and accuracy of data and information or methodologies employed by the Cabinets in accommodating our requests.

We also relied on interviews and requests made of Medicaid authorities in other states concerning practices and procedures. Background research included the review and assessment of related reports and studies from various independent assessment agencies including the General Accounting Office (GAO), National Association of State Medicaid Directors, National Governors Association, Kaiser Family Foundation, and various Kentucky media outlets.

In conducting this performance assessment, we performed the following noteworthy procedures:

- Requested and analyzed specialized data set from CHS concerning Medicaid enrollment, costs, and eligibility categories for FY 2002
- Interviewed CFC and CHS officials
- Interviewed SSA officials and obtained related data
- Reviewed APA Statewide Single Audit of the Commonwealth for related matters and findings
- Reviewed SSA Annual Reports and statistical data
- Reviewed applicable state and federal laws and regulations and publications pertaining to enrollment in SSI and Medicaid and oversight of the process
- Reviewed Kentucky Medicaid quality assurance reports for Medicaid negative enrollment
- Reviewed DDS Medical Consultant contracts
- Assessed national trends in Medicaid and SSI enrollment through examination of reports and data compiled by outside stakeholders
- Analyzed budgeted and expended funding for Kentucky Medicaid and Administrative costs

This performance assessment, including its findings, recommendations, and conclusions while not a full performance audit, did however follow applicable government auditing standards.

Medicaid Expenditures for SSI Recipients by County

Appendix II

County	Total Balance Paid for Medicaid Services for SSI Recipients	Number of SSI Recipients Receiving Medicaid Benefits	Average Medicaid Amount Paid Per SSI Recipient	2000 Population	Percentage of County Receiving SSI Benefits	*County Rank by the Percentage of County Receiving SSI Benefits
ADAIR	$12,909,941.06	1,256	$10,278.62	17244	7.28%	38
ALLEN	$5,785,618.20	879	$6,582.05	17800	4.94%	52
ANDERSON	$2,519,101.68	357	$7,056.31	19111	1.87%	107
BALLARD	$1,857,132.56	249	$7,458.36	8286	3.01%	88
BARREN	$12,204,183.43	1,825	$6,687.22	38033	4.80%	54
BATH	$6,367,162.41	986	$6,457.57	11085	8.89%	25
BELL	$23,564,237.10	3,554	$6,630.34	30060	11.82%	8
BOONE	$10,742,481.72	1,278	$8,405.70	85991	1.49%	110
BOURBON	$4,836,974.81	674	$7,176.52	19360	3.48%	79
BOYD	$19,817,553.34	2,633	$7,526.61	49752	5.29%	49
BOYLE	$8,658,485.89	1,194	$7,251.66	27697	4.31%	62
BRACKEN	$2,125,586.11	341	$6,233.39	8279	4.12%	66
BREATHITT	$16,181,595.53	2,502	$6,467.46	16100	15.54%	3
BRECKINRIDGE	$5,601,263.39	884	$6,336.27	18648	4.74%	56
BULLITT	$8,157,156.74	961	$8,488.20	61236	1.57%	108
BUTLER	$4,644,141.86	601	$7,727.36	13010	4.62%	59
CALDWELL	$3,518,616.70	560	$6,283.24	13060	4.29%	64
CALLOWAY	$5,567,337.60	739	$7,533.61	34177	2.16%	103
CAMPBELL	$14,883,577.58	1,932	$7,703.72	88616	2.18%	101
CARLISLE	$1,087,738.06	183	$5,943.92	5351	3.42%	80
CARROLL	$3,512,419.74	485	$7,242.10	10155	4.78%	55
CARTER	$12,995,310.74	1,883	$6,901.39	26889	7.00%	39
CASEY	$10,976,374.60	1,379	$7,959.66	15447	8.93%	24
CHRISTIAN	$18,247,013.14	2,399	$7,606.09	72265	3.32%	83
CLARK	$8,394,625.08	1,217	$6,897.80	33144	3.67%	76
CLAY	$23,000,550.17	3,815	$6,028.98	24556	15.54%	3
CLINTON	$8,739,332.74	1,092	$8,003.05	9634	11.33%	11
CRITTENDON	$2,766,720.60	350	$7,904.92	9384	3.73%	74
CUMBERLAND	$6,941,044.16	679	$10,222.45	7147	9.50%	20
DAVIES	$31,733,164.11	3,064	$10,356.78	91545	3.35%	81
EDMONSON	$4,018,991.04	547	$7,347.33	11644	4.70%	58
ELLIOTT	$3,257,760.59	544	$5,988.53	6748	8.06%	30
ESTILL	$7,962,583.65	1,288	$6,182.13	15307	8.41%	27

Medicaid Expenditures for SSI Recipients by County

Appendix II

County	Total Balance Paid for Medicaid Services for SSI Recipients	Number of SSI Recipients Receiving Medicaid Benefits	Average Medicaid Amount Paid Per SSI Recipient	2000 Population	Percentage of County Receiving SSI Benefits	*County Rank by the Percentage of County Receiving SSI Benefits
FAYETTE	$54,897,295.77	6,094	$9,008.42	260512	2.34%	99
FLEMING	$5,049,920.65	768	$6,575.42	13792	5.57%	48
FLOYD	$29,951,707.53	4,094	$7,316.00	42441	9.65%	18
FRANKLIN	$12,484,012.00	1,415	$8,822.62	47687	2.97%	90
FULTON	$3,113,403.43	593	$5,250.26	7752	7.65%	33
GALLATIN	$2,202,960.54	246	$8,955.12	7870	3.13%	86
GARRARD	$4,203,539.58	602	$6,982.62	14792	4.07%	67
GRANT	$4,710,021.33	674	$6,988.16	22384	3.01%	88
GRAVES	$14,931,558.13	1,549	$9,639.48	37028	4.18%	65
GRAYSON	$8,605,718.31	1,339	$6,426.97	24053	5.57%	48
GREEN	$5,692,377.17	747	$7,620.32	11518	6.49%	43
GREENUP	$11,119,571.12	1,590	$6,993.44	36891	4.31%	62
HANCOCK	$1,625,344.67	245	$6,634.06	8392	2.92%	93
HARDIN	$25,004,848.03	2,923	$8,554.52	94174	3.10%	87
HARLAN	$21,000,052.80	3,246	$6,469.52	33202	9.78%	17
HARRISON	$4,099,435.40	683	$6,002.10	17983	3.80%	71
HART	$7,515,151.80	1,148	$6,546.30	17445	6.58%	42
HENDERSON	$10,901,965.41	1,496	$7,287.41	44829	3.34%	82
HENRY	$3,780,414.53	568	$6,655.66	15060	3.77%	73
HICKMAN	$1,158,988.19	176	$6,585.16	5262	3.34%	82
HOPKINS	$12,693,182.38	1,998	$6,352.94	46519	4.30%	63
JACKSON	$8,292,040.91	1,510	$5,491.42	13495	11.19%	13
JEFFERSON	$195,087,192.67	20,470	$9,530.40	693604	2.95%	91
JESSAMINE	$6,395,144.72	957	$6,682.49	39041	2.45%	98
JOHNSON	$13,987,074.82	1,938	$7,217.27	23445	8.27%	28
KENTON	$26,750,076.88	3,511	$7,618.93	151464	2.32%	100
KNOTT	$14,038,123.99	1,881	$7,463.12	17649	10.66%	14
KNOX	$24,434,332.81	3,891	$6,279.71	31795	12.24%	5
LARUE	$3,581,588.86	506	$7,078.24	13373	3.78%	72
LAUREL	$27,228,387.25	3,410	$7,984.86	52715	6.47%	44
LAWRENCE	$9,574,649.25	1,435	$6,672.23	15569	9.22%	22
LEE	$6,396,684.26	942	$6,790.54	7916	11.90%	7
LESLIE	$11,305,827.85	1,440	$7,851.27	12401	11.61%	9
LETCHER	$20,105,380.50	2,412	$8,335.56	25277	9.54%	19
LEWIS	$6,717,863.03	1,039	$6,465.70	14092	7.37%	37

Medicaid Expenditures for SSI Recipients by County

Appendix II

County	Total Balance Paid for Medicaid Services for SSI Recipients	Number of SSI Recipients Receiving Medicaid Benefits	Average Medicaid Amount Paid Per SSI Recipient	2000 Population	Percentage of County Receiving SSI Benefits	*County Rank by the Percentage of County Receiving SSI Benefits
LINCOLN	$9,906,249.74	1,577	$6,281.71	23361	6.75%	40
LIVINGSTON	$2,318,772.96	309	$7,504.12	9804	3.15%	85
LOGAN	$7,988,686.85	1,110	$7,197.02	26573	4.18%	65
LYON	$1,483,802.43	207	$7,168.13	8080	2.56%	96
MADISON	$20,859,143.94	2,763	$7,549.45	70872	3.90%	69
MAGOFFIN	$11,692,698.78	1,592	$7,344.66	13332	11.94%	6
MARION	$7,743,765.77	1,154	$6,710.37	18212	6.34%	45
MARSHALL	$5,429,593.55	646	$8,404.94	30125	2.14%	104
MARTIN	$8,998,079.51	1,438	$6,257.36	12578	11.43%	10
MASON	$4,766,376.84	752	$6,338.27	16800	4.48%	61
MCCRACKEN	$19,149,761.69	2,325	$8,236.46	65514	3.55%	78
MCCREARY	$16,816,964.33	2,189	$7,682.49	17080	12.82%	4
MCLEAN	$2,577,298.76	322	$8,004.03	9938	3.24%	84
MEADE	$3,490,871.64	527	$6,624.04	26349	2.00%	105
MENIFEE	$3,387,127.26	573	$5,911.22	6556	8.74%	26
MERCER	$4,463,065.27	724	$6,164.45	20817	3.48%	79
METCALFE	$5,551,220.21	759	$7,313.86	10037	7.56%	34
MONROE	$7,713,799.24	1,099	$7,018.93	11756	9.35%	21
MONTGOMERY	$6,953,334.85	1,179	$5,897.65	22554	5.23%	50
MORGAN	$6,686,600.63	1,146	$5,834.73	13948	8.22%	29
MUHLENBERG	$10,097,401.04	1,506	$6,704.78	31839	4.73%	57
NELSON	$7,763,260.87	1,097	$7,076.81	37477	2.93%	92
NICHOLAS	$2,974,136.10	414	$7,183.90	6813	6.08%	46
OHIO	$7,590,166.08	1,048	$7,242.52	22916	4.57%	60
OLDHAM	$3,651,507.05	353	$10,344.21	46178	0.76%	111
OWEN	$2,645,482.21	406	$6,515.97	10547	3.85%	70
OWSLEY	$6,955,148.29	1,049	$6,630.27	4858	21.59%	1
PENDLETON	$2,858,331.26	446	$6,408.81	14390	3.10%	87
PERRY	$26,917,574.62	3,295	$8,169.22	29390	11.21%	12
PIKE	$36,628,673.13	5,534	$6,618.84	68736	8.05%	31
POWELL	$6,465,587.42	995	$6,498.08	13237	7.52%	36
PULASKI	$53,690,013.37	4,316	$12,439.76	56217	7.68%	32
ROBERTSON	$942,185.73	117	$8,052.87	2266	5.16%	51
ROCKCASTLE	$9,784,630.98	1,251	$7,821.45	16582	7.54%	35
ROWAN	$12,106,819.66	1,249	$9,693.21	22094	5.65%	47
RUSSELL	$11,108,795.40	1,498	$7,415.75	16315	9.18%	23

Medicaid Expenditures for SSI Recipients by County

Appendix II

County	Total Balance Paid for Medicaid Services for SSI Recipients	Number of SSI Recipients Receiving Medicaid Benefits	Average Medicaid Amount Paid Per SSI Recipient	2000 Population	Percentage of County Receiving SSI Benefits	*County Rank by the Percentage of County Receiving SSI Benefits
SCOTT	$5,363,233.00	827	$6,485.17	33061	2.50%	97
SHELBY	$4,539,058.36	657	$6,908.76	33337	1.97%	106
SIMPSON	$3,792,880.51	490	$7,740.57	16405	2.99%	89
SPENCER	$2,219,167.60	255	$8,702.62	11766	2.17%	102
TAYLOR	$11,722,577.72	1,535	$7,636.86	22927	6.70%	41
TODD	$3,572,862.27	470	$7,601.83	11971	3.93%	68
TRIGG	$2,287,661.84	421	$5,433.88	12597	3.34%	82
TRIMBLE	$1,501,804.95	227	$6,615.88	8125	2.79%	94
UNION	$4,954,407.50	411	$12,054.52	15637	2.63%	95
WARREN	$28,838,617.31	3,343	$8,626.57	92522	3.61%	77
WASHINGTON	$3,427,706.94	528	$6,491.87	10916	4.84%	53
WAYNE	$13,365,010.59	1,989	$6,719.46	19923	9.98%	16
WEBSTER	$3,777,872.74	525	$7,195.95	14120	3.72%	75
WHITLEY	$27,579,156.07	3,601	$7,658.75	35865	10.04%	15
WOLFE	$8,391,116.58	1,292	$6,494.67	7065	18.29%	2
WOODFORD	$2,835,911.17	355	$7,988.48	23208	1.53%	109
Total	$1,420,537,585.31	183,757	$7,730.52	4,041,769		
* Counties may have the same rank as another county because their SSI percentages are identical						
Other	$6.94	1	$6.94			
Guardianship	$2,048,735.84	44	$46,562.18			
Out-of-state	$6,543.00	1	$6,543.00			
Total	$1,422,592,871.09	183,803	$7,739.77			

Kentucky Counties with High and Low Populations Receiving SSI Benefits

Appendix III

Kentucky Counties with the 10 Highest and 10 Lowest Percentages of Their Population Receiving SSI Benefits

County	Percentage of County Receiving SSI Benefits	High School Graduates	Bachelor's Degree or Higher	Persons with a Disability	Median Household Money Income	Per Capita Money Income	Persons Below Poverty	2000 Unemployment Rate
Owsley	21.59%	49.2%	7.7%	1,676	$15,805	$10,742	45.4%	3.90%
Wolfe	18.29%	53.6%	10.6%	2,291	$19,310	$10,321	35.9%	8.90%
Breathitt	15.54%	57.5%	10.0%	5,463	$19,155	$11,044	33.2%	8.70%
Clay	15.54%	49.4%	8.0%	7,471	$16,271	$9,716	39.7%	6.10%
McCreary	12.82%	52.6%	6.7%	5,536	$19,348	$9,896	32.2%	7.40%
Knox	12.24%	54.1%	8.8%	10,089	$18,294	$10,660	34.8%	5.80%
Magoffin	11.94%	50.1%	6.3%	3,891	$19,421	$10,685	36.6%	14.00%
Lee	11.90%	50.9%	6.3%	2,275	$18,544	$13,325	30.4%	5.10%
Bell	11.82%	56.6%	9.0%	10,009	$19,057	$11,526	31.1%	6.30%
Leslie	11.61%	52.5%	6.3%	4,273	$18,546	$10,429	32.7%	4.80%
Spencer	2.17%	75.4%	11.1%	2,192	$47,042	$19,848	8.8%	3.00%
Calloway	2.16%	77.9%	24.0%	6,882	$30,134	$16,566	16.6%	3.20%
Marshall	2.14%	76.9%	13.7%	6,544	$35,573	$18,069	9.5%	5.60%
Meade	2.00%	77.9%	11.3%	4,679	$36,966	$16,000	11.3%	4.30%
Shelby	1.97%	79.1%	18.7%	5,204	$45,534	$20,195	9.9%	2.40%
Anderson	1.87%	80.4%	12.0%	3,612	$45,433	$18,621	7.5%	2.90%
Bullitt	1.57%	76.0%	9.2%	11,299	$45,106	$18,339	7.9%	3.00%
Woodford	1.53%	82.6%	25.9%	4,308	$49,491	$22,839	7.3%	1.60%
Boone	1.49%	85.1%	22.8%	12,690	$53,593	$23,535	5.6%	2.80%
Oldham	0.76%	86.5%	30.6%	5,106	$63,229	$25,374	4.1%	2.20%
Kentucky		74.1%	17.1%	874,156	$33,672	$18,093	15.8%	4.10%
National		80.4%	24.4%	49,746,248	$41,994	$21,587	12.4%	4.00%

	Range for the counties within Kentucky with the 10 highest percentages of their population receiving SSI benefits	Range for the counties within Kentucky with the 10 lowest percentages of their population receiving SSI benefits
High school graduates	49.2%-57.5%	75.4%-86.5%
Bachelor's degree or higher	6.3%-10.6%	9.2%-30.6%
Persons with a disability	1,676-10,089	2,192-12,690
Median household money income	$15,805-$19,421	$30,134-$63,229
Per capita money income	$9,716-$13,325	$16,000-$25,374
Persons below poverty	30.4%-45.4%	4.1%-16.6%
Unemployment rate	3.9%-14%	1.6%-5.6%

PAUL E. PATTON
GOVERNOR

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VIOLA P. MILLER, ED.D.
SECRETARY

September 26, 2003

The Honorable Edward B. Hatchett, Jr.
Auditor of Public Accounts
144 Capitol Annex
Frankfort, KY 40601

Re: Cabinet for Families and Children, Department for Disability Determination Services' Response to SSI Application Fraud Detection Efforts Report

Dear Mr. Hatchett:

Thank you again for the opportunity to respond to what is represented to be the final draft of the above-referenced report. The Cabinet assures you that it wholeheartedly agrees with the statement contained in the conclusion of your report that "(s)tate and federal administrators should collaborate to ensure that SSI fraud and abuse are minimized so that scarce SSI and Medicaid resources can be maximized." In these days of budget constraints, it is incumbent on all governmental agencies to clearly identify measures, within the scope of their respective authority, to effectively and efficiently administer their programs.

The Cabinet believes, as your report shows, that it is effectively and efficiently evaluating conflicting medical information to determine whether an applicant or recipient is entitled to SSI benefits, including Medicaid coverage. Thus, the Cabinet's role in fraud detection activity focuses on ferreting out cases in which medical information that is grossly inconsistent with reported or expected behaviors, given the medical findings. In such cases, DDS can require the applicant or recipient to appear in person for an examination by a physician or psychologist.

On the other hand, the Social Security Administration is responsible for non-medical eligibility determination, i.e., evaluating non-medical criteria, including the applicant's or recipient's residence. Thus, your report's focus on mailing and residence addresses is misplaced in evaluating the performance of

DDS. Nonetheless, DDS is committed to collaborating with SSA, DMS or any other appropriate agency to assist, within the bounds of the Cabinet's authority, to root out fraud. In fact, the data files supplied by your office have been forwarded to SSA to evaluate the findings and resolve any issues.

The Cabinet shares your concern about ever escalating health care costs. In fact, your data support the fact that Kentucky has been able to curtail the rate of health care cost inflation far better than its sister states. In addition, Kentucky's rate of growth of SSI enrollment is significantly lower than that in other states in the region. Most surprisingly, the average total Medicaid benefits for an SSI recipient were astonishingly low given the existence of the severe medical conditions that afflict disabled recipients. These data demonstrate that Kentucky has performed its role well in effectively and efficiently managing this program.

The report's list of duties of DDS's QA unit is a list of potential tasks, not mandatory tasks. States are free to select those techniques and tactics that best advance the agency's goals. In Kentucky, DDS has focused its QA activities on training disability examiners; training physicians and psychologists in the medical evaluation process requirements; and assisting the medical staff in working through a backlog of claims awaiting medical review. Moreover, your report ignored the fact that DDS's QA performed three studies that evaluated over 2,000 claims in the past year. Thus, the QA function focused on delivering a quality product prospectively as well as retrospectively.

Finally, media accounts of alleged rampant SSI fraud have been long on innuendo and suggestion but lack any fact or substance. Likewise, unscrupulous lawyers or physicians or psychologists can conspire to defraud the SSA and DDS—this may be an unfortunate fact of life, not unique to Kentucky. However, your report provides no evidence that Kentucky suffers disproportionately from such efforts. In fact, in light of the low rate of program growth, fraud does not appear to be a major problem in Kentucky.

A more detailed response to the report is attached in an easy to read, side-by-side format. In this way, the Cabinet is able to comprehensively respond to the report. In addition, a letter from Eleanor Barrineau, SSA's Disability Program Administrator for Kentucky, is attached for your consideration. Her comments on DDS's performance should be given great weight since SSA is the federal agency that partners with Kentucky for processing disability claims and sets policy, performance criteria, and funding for DDS.

Again, thank you for sharing your report with the Cabinet and for your willingness to consider DDS's position on the issues. The Cabinet will continue to work collaboratively with SSA and any other appropriate law enforcement agency to safeguard the integrity of the disability program.

Sincerely,

Viola P. Miller

Viola P. Miller
Secretary

VPM/NKM/cag

cc: Marcia R. Morgan
Stephen Jones
Eleanor Barrineau

SOCIAL SECURITY

Atlanta Region
Social Security Administration
61 Forsyth St., SW
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September 26, 2003

Ms. Viola P. Miller, Ed.D.
Secretary
Cabinet for Families and Children
275 East Main Street
Fourth Floor West
Frankfort, Kentucky 40621

Dear Ms. Miller:

The DDS shared with me a copy of the draft report by the State Auditor of Public Accounts (APA) on Medicaid and SSI Eligibility. I am concerned because the report contains a number of errors of fact and does not accurately reflect the nature and quality of the SSI disability determination process in Kentucky.

The overall conclusion of the report seems to be that there must be significant fraud since Kentucky and some of its counties have a relatively large proportion of their populations on SSI. As you know, the economic, demographic, and health status of various state and county populations have a great impact on the proportion of their citizens who meet the disability and need requirements for SSI. The health of Kentucky citizens may be a major factor. According to the state Department for Public Health, Kentucky has:

- the third-highest heart disease rate in the nation
- the third-highest cancer rate in the nation
- the highest lung cancer death rate in the nation
- an occupational death rate that is nearly double the U.S. rate
- the highest percentage of adult smokers in the nation
- the second highest percentage of obesity in the nation

These health factors, combined with the economic and demographic factors listed in Appendix III of the report, are the most logical explanation for the higher-than-average disability rates in Kentucky as a whole and in some of its counties.

However, we are very aware of the need to address any potential fraud in the disability program. SSA takes very seriously its obligations as a steward of public funds, and the disability claims process is designed to prevent fraud. Because it requires multiple and independent sources of evidence, our program is designed to prevent fraud. We do have specific anti-fraud instructions, and all KY DDS adjudicative/QA staff were trained on them at the time they were last revised. New employees are also trained on these procedures.

I want to assure you that the APA's statement that SSA and the DDS do not make fraud-fighting a priority is incorrect. Specifically, our two full-time fraud investigators (Special Agents of our Office of the Inspector General) located in Kentucky have handled 408 fraud referrals since 1999. These referrals have come from the DDS, SSA Field Office, members of the public, and other law enforcement agencies. Specific DDS referral numbers are not reported because DDS fraud referrals flow (following SSA instructions) first to the local Field Office, which conveys the information to our Office of Inspector General. Any member of the public, DDS employee, or SSA employee can also call our national toll-free fraud hotline. These 408 referrals led to 281 investigations, which were resolved with a number of measures including prosecution, restitution, and penalties, in addition to denial or termination of benefits where appropriate.

Another important stewardship activity is the Continuing Disability Review (CDR) process, in which all those receiving disability receive a regular review (usually every three years) of their medical eligibility. This process, combined with the review of non-medical factors conducted by our SSA field offices, helps ensure the integrity of the disability rolls. Due to its excellent management of its overall caseload and the cooperation of SSA field offices in Kentucky in initiating the reviews, the Kentucky DDS was the most current of any state in the region in conducting CDRs.

We are continually reviewing our fraud-fighting efforts and welcome the input from the Auditor of Public Accounts. Since the draft report did not provide any specific information supporting the presence of fraud, we would appreciate any information the APA may have regarding specific potential fraud situations that may need investigation. We are currently considering new sites for Cooperative Disability Investigation units for Fiscal Year 2004 and will consider Kentucky's interest.

Regarding DDS quality reviews, I want to assure you that the statement, "Kentucky's DDS Quality Assurance Unit failed to produce evidence that sufficient quality reviews were performed of the disability determination process" is not accurate. The APA report is critical of the DDS's QA function, yet contradicts itself by noting that the DDS's quality has been consistently better than regional averages. SSA provides considerable flexibility to states in designing the DDS QA function, as long as outcomes are acceptable as measured by our federal quality review process. The fact that the DDS QA unit at times focused on training rather than end-of-line case review is not at all in conflict with SSA's guidelines. We expect the DDS's QA component to contribute to a high quality product by providing training, mentoring, and special case assistance rather than just conducting end-of-line reviews. The report ignores the significant contributions of supervisors and case consultants (who conduct both in-line and end-of-line reviews) to assuring a high quality product. In fact, the DDS was reorganized last year in order to enhance supervisory monitoring of examiner staff.

Also, our Area Director, located in Lexington, provides close local coordination and conducts joint initiatives aimed at improving the quality of the disability process from the initial application to final adjudication. An employee reporting to the Area Director is on site at the DDS four days a week working on front-end quality activities and resolving issues on nonmedical aspects of claims.

The draft report also objects to qualifications of Kentucky disability examiners in general, and to the Single Decision Maker (SDM) concept. The vast majority of disability examiners in Kentucky and in DDSs nationwide have a college degree, and those who do not typically have significant qualifying experience. Since disability examining is not specifically taught at universities, the exact degree held is less important than the analytical skills developed. Disability examiner training is extensive and constantly refreshed via in-service instruction. The Kentucky DDS has long had, and continues to have, one of the best training programs in the nation. Before, during, and after its implementation of the Single Decision Maker concept, the Kentucky DDS conducted extensive training to prepare examiners for their enhanced role. Much of the training was aimed at helping examiners determine the extent of medical consultant input needed on each case, and the majority of cases still have medical input. Our special federal QA reviews of SDM cases have shown them to have comparable or higher quality as compared to non-SDM cases.

While we disagree with much of the report as written, we welcome state scrutiny of its role in SSA's disability process. We also understand that increased Medicaid expenditures are a major budget concern for state government. We would be most willing to work with the staff of the Auditor of Public Accounts to enable him to develop an accurate picture of the disability determination process. We are also aware that any process as complex as that of making disability determinations is not perfect and are always looking for ways to improve at both state and federal levels.

Thank you for your continued strong support of the disability determination process in Kentucky, and we look forward to continuing to work with you to maintain the strong program in your state, and also to explain the process to other components in state government.

Sincerely,

Eleanor H. Barrineau

Eleanor H. Barrineau
Disability Program Administrator

Agency Response
Cabinet for Families and Children (CFC) Appendix IV

Summary and Background - Page 1

The Federal Disability program (SSI and SSDI) were designed with the intention to curb fraud:

- There is extensive separation of duties among staff. Multiple staff in different locations are required to put someone into benefit status.
- Specific medical findings to support a existence of a disabling condition are required, along with other supporting evidence that is consistent with the findings.
- Annual verification of address and income status.
- Frequent Continuing Disability Reviews (CDR) of medical condition, including current specific medical findings

The DDS has complied with federal requirements and conducted fraud prevention training for all adjudicators. Both federal and state quality reviews ensure that requirements are met. Since fraud referrals can be made via SSA's fraud hotline, the SSA field office, or by calling the local OIG agent, the conclusion that no cases have been referred is not supported. SSA has two Office of Inspector General agents in Kentucky who have investigated over 400 incidences of suspected fraud.

SSA's special quality studies have shown single decision maker decisions to be as accurate as or more accurate than other decisions. This is a procedure that has been studied and tested for several years and has been rolled out nationally because it was so successful. The last statement is incorrect as extensive supervisory reviews <u>are</u> conducted.

There is no question that the medical card and the access it gives to treatment is more valuable than the SSI check. It is reasonable to presume the costs are so high for the disabled population is more because they are chronically ill than because of fraud.

Economic and demographic factors and health status of state and county populations have a significant impact on the number of citizens who meet the disability and need requirements of SSI. The State Department of Public Health reports that Kentucky has:

- The third-highest heart disease rate in the nation
- The third-highest cancer rate in the nation
- The highest lung cancer death rate in the nation
- An occupational death rate that is nearly double the U.S. rate
- The highest percentage of adult smokers in the nation
- The second highest prevalence of obesity in the nation.
-

These significantly higher disease rates and disease risk factors in the state have a major impact on the disability rate and associated Medicaid spending.

SSA's claims process involves gathering and updating residence information for all SSI recipients. This information is updated on regular eligibility reviews, and independently verified on sample reviews. This information including both the residence and mailing addresses are sent to the State. For Disability claims themselves, the county of residence and not the mailing address determines the DDS jurisdiction. The KY DDS checks the residence of each disability claim against the Social Security records before accepting jurisdiction for it.

The APA has sent us two data files that contained his findings relating to the questionable addresses. We had insufficient time to resolve the issues raised but we agree that these two pools of names needed further examination. The DDS has neither the legal authority nor the field staff to investigate particular addresses. Nor does the Department have the systems access to evaluate these in any depth. We have referred these to the Social Security Administration for investigation.

APA's Reply: Fraud detection work by the SSA does not negate DDS' responsibility for fraud detection.

Finding #1 - Kentucky Has a Significantly Large Number of SSI Recipients and Disability Applications – Page 4

Economic and demographic factors and health status of state and county populations have a significant impact on the number of citizens who meet the disability and need requirements of SSI. This is as stated above. Note the growth in recipients for the two year period is less than 1%, 0.4%. The Kentucky DDS denies benefits to almost 70% of initial applications and about 60% of all claims seen. The typical criticism of the Department it is that it denies too many applications.

The professional staff who evaluate these claims are Disability Adjudicators (levels I, II, and III). They are also referred to as Disability Examiners.

We repeat our comments from above. Economic and demographic factors and health status of state and county populations have a significant impact on the number of citizens who meet the disability and need requirements of SSI. The State Department of Public Health reports that Kentucky has:

- The third-highest heart disease rate in the nation
- The third-highest cancer rate in the nation
- The highest lung cancer death rate in the nation
- An occupational death rate that is nearly double the U.S. rate
- The highest percentage of adult smokers in the nation
- The second highest prevalence of obesity in the nation.

These significantly higher disease and health risk factor rates in the state have a major impact on the disability rate and associated Medicaid spending.

Attorneys, who specialize in Disability claims, advertise aggressively nationwide. This is not unique to KY. The media articles referred to were long on innuendo and suggestion, but lacked any evidence or facts to support their claims.

With such a high percentage of Federal review plus extensive supervisory review and an accuracy rate at or above the Regional level, the APA is acknowledging a strong and accurate performance by the DDS.

Correction: 59.9% of all applications were not approvals but rather, denials.

Finding #2 - Kentucky Does Not Have a Cooperative Disability Investigation (CDI) Unit – Page 6

The CDI unit is but one aspect of the fraud prevention strategy used in the Federal disability program. There is a very extensive substantive review process.

- At application point, residency information is obtained and proof is required of income/asset information.
- SSA staff does a review of claims coming into the DDS from the different SSA Offices.
- DDS case consultants and supervisors review many claims of the individual adjudicators. Until the worker has a year of experience and has demonstrated skill, every claim action and decision are reviewed. After the year the case consultant and supervisor review a sample of decisions (end of line), of aged claims, and of examination purchase requests (in line) on a significant portion of every worker's claims.
- SSA has a sample taken every day that is random (FedQA) and a weighted sample (PER). The extent of this review was acknowledged by the APA above.
- SSA staff does a sample of onsite review/validations of claimant statements.

- Every allowed claim is reviewed at least every third year for continued medical eligibility and usually yearly for income eligibility.
- SSA's Office of the Inspector General (OIG) investigates allegations of fraud. There are two permanent agents assigned to Lexington who have investigated 408 alleged instances of fraud since 1999.

The CDI units focus on the entire Disability program and not just SSI/Medicaid. GAO's reduction of the SSI risk assessment was due to SSA's overall stewardship of the program including the items listed above. The CDI units which are scattered across the country are but one aspect of this stewardship.

Finding #3 - Internal Review by DDS' Quality Assurance Unit Is Weak – Page 7

The Quality Assurance process in the DDS is far more extensive than the work of the QA unit. For new adjudicators, supervisors conduct a 100% review of all completed claims for their first year or longer, until they demonstrate a high level of proficiency. As additional claim types are added over the second year of employment to the mix of what the new adjudicator will do, 100% of these claims will also be reviewed. In addition there are reviews of aged claims, claims in which an examination is requested, and claims sent for medical consultation.

Overlooked by the APA are QA studies, beginning in October 2002 and continuing through spring 2003, of over 2000 claim reviews and resulted in procedural changes in the Department.

The 2003 study was planned before the APA visit and was a result of issues raised throughout the Region concerning mental denials.

The standards of review are those outlined by SSA in its POMS manuals. An internally published "QA book" showing how to review samples is also used . The QA staff showed both to the Auditor.

In the QA Unit (and throughout the program) physicians and psychologists are used as consultants who provide assessments on request.

It is true that, for a short time in 2002, as a result of retirements and promotions in the DDS, there was only one person in QA. The staff of 7 that the APA mentions is a level consistent with other states throughout the Region.

Finding #4 - Over 3,000 SSI Approvals Made Without Medical or Routine Supervisory Review – Page 8

SSA's studies have shown that Single Decision Maker decisions are as accurate as other DDS decisions. Reports for the SSA prototype studies of SDM show accuracy rates virtually the same for prototype and non-prototype states. In some instances the prototype accuracy is higher than the regular pattern of medical consultant input. SDM claims are subject to the same sampling process that the APA mentioned above. This procedure has been "rolled out" nationwide.

Kentucky DDS does not limit the use of in house physicians, psychologists, and other medical professionals. If the adjudicator, supervisor or any of the Disability professionals working on a claim desire medical consultation, they are able to obtain it.
Any adjudicator with a year of experience will make an SDM decision **only** with the review and assent of his supervisor. The disability decision is not solely a medical decision. It is partly medical, partly legal, and partly administrative. When the medical portion of the decision is highly complex, the medical consultant will be asked for input. However, part of the reason for testing the SDM concept was that a number of conditions appear frequently and the findings lead to straight forward conclusions. SSA's testing found that the lay professional could handle these medical assessments with outcomes as accurate as if done by a medical professional.

The fact that the adjudicator must deal equally with medical, legal, and administrative matters complicates specification of a particular degree. Based on program experience, communication (both oral and written) and analytical skills are the key abilities that make a successful adjudicator. Ability to reason and synthesize facts to make an argument is far more consequential than the particular major earned. The factual areas and development of the skills to put them together comprise the heart of the intensive 4 month training program and the apprenticeship served for the next 8 months to a year.

The typical applicant for a disability professional position must have a bachelor's degree. The few who come in with 2 years of college and specific disability program experience are those who, in their prior support work in DDS, have demonstrated the communication and analytical skills necessary to be an adjudicator. Some who do not get the opportunity to complete college, have the ability to do professional work. The number of people hired without a degree are few, but have demonstrated their capability. Eight of the 10 supervisors without a degree have experience of 20 years or more with the program.

The DDS has complied with federal requirements and conducted fraud prevention training for all adjudicators. Both federal and state quality reviews ensure that requirements are met. Since fraud referrals can be made via a fraud hotline, the SSA field office, or by calling the local OIG agent, the conclusion that no cases have been referred is not supported. SSA has two Office of Inspector General agents in Kentucky who investigate suspected fraud. Over the period there have been 408 fraud investigations by OIG in Kentucky.

Finding #5 - The Majority of 2002 Medicaid Costs Are Related to SSI Recipients – Page 9

Medicaid is a true lifeline for the sickest of our citizens. Continued treatment for chronic conditions is far more cost effective than emergency indigent treatment for untreated chronic conditions. The link between SSI and Medicaid was established because people unable to work cannot get health coverage. People in such poverty cannot afford to purchase coverage. The combined effects of being disabled and poor was the reason that the programs were linked. People are found to be disabled because they have chronic or fatal illnesses. This is the reason for the "disproportionate" Medicaid costs for the disabled that the APA points out.

It is well known that Kentucky, other poor states in Appalachia and in the southeastern U.S. have very high application rates. This is part of the reason that the KY allowance rate is one of the lowest in the country.
The disability program's strict criteria require extensive medical and other documentation before claims are approved.

Finding #6 - Questionable Claims Information May Indicate Fraud and Abuse – Page 11

SSA's systems provide both mailing and residence address information on SSI recipients to the state. Where a P.O. Box is shown as the mailing address, SSA records, which are transmitted to the state, also contain a specific residence address. This information is updated on the regular eligibility reviews, and independently verified on sample reviews.

For Disability claims themselves, the county of residence, and not the mailing address, determines the DDS jurisdiction. The KY DDS checks the county of residence for each disability claimant before accepting jurisdiction for it. The SSA field office gives the DDS the county of residence and state.
The APA has sent us two data files that contained his findings relating to the questionable addresses. There was insufficient time to resolve the issues raised but these two pools of names needed further examination.
The DDS has neither the legal authority nor the field staff to investigate particular addresses. Nor does the Department have the systems access to evaluate these in any depth. The DDS referred these data files to the Social Security Administration for investigation

Conclusion – Page 12

It is correct that there are large numbers of SSI recipients in the Commonwealth. It is also correct that SSI recipients are eligible for Medicaid services. We disagree that attention to fraud detection is inadequate.

We agree with this statement.

Recommendations – Page 12

The DDS has been interested for some time in starting a CDI unit and has indicated that interest to SSA. If offered the opportunity by SSA, DDS would establish a unit.

These procedures are already in place. SSA deals with these at the point of taking the claim. SSA reviews status annually. DDS scrutinizes claim data and is particularly aware of resolving inconsistencies in the medical findings.

With the retirements and staff losses of 2002, DDS is in process of rebuilding the QA unit. It is in the process of doing general review but also focused specific studies which reviewed over 2000 claims.

This is part of the training process. New staff receive fraud training as part of the basic training process.

DDS will track claims with no medical staff input more closely in the future.

This is the purpose of the PER and FedQA sampling in place now.

The DDS has seen that there are a number of instances in the data files from the APA in which the address data needs further scrutiny. We have presented these issues to the SSA staff for further investigation.

The Secretary for Health Services
COMMONWEALTH OF KENTUCKY
275 EAST MAIN STREET
FRANKFORT, KENTUCKY 40621-0001
(502) 564-7042

PAUL E. PATTON
GOVERNOR

MARCIA R. MORGAN
SECRETARY

October 3, 2003

Mr. Edward B. Hatchett, Jr.
Auditor of Public Accounts
Suite 144, Capitol Annex
Frankfort, KY 40601-3448

Dear Mr. Hatchett:

Attached is our response to your audit "SSI Application Fraud Detection Efforts Should Be Improved". We take very seriously the issues addressed in the report. The Cabinet for Health Services is dedicated to ensuring that needed services are available to meet the needs of the citizens of the Commonwealth and to effectively manage the resources that are available to us.

We do not agree with the conclusions reached in your report. We firmly believe that the number of SSI recipients in the Commonwealth is directly attributable to the economic, demographic and health status of Kentucky's citizenry.

The Cabinet for Health Services is actively and aggressively pursuing allegations of fraud and abuse. While your report speaks to the efforts of other Cabinets and Agencies, your report does not address the efforts that this Cabinet has made.

Finally, we have had several discussions with your staff regarding the use of the address fields in the many data systems utilized by the Department for Medicaid

Services. We strongly disagree with the conclusions drawn in the report regarding the address information for SSI recipients.

Thank you for the opportunity to respond to the audit.

Sincerely,

Marcia R. Morgan
Secretary

C: Secretary Miller
Commissioner Robinson

Attachment

Agency Response
Cabinet for Health Services (CHS) Appendix IV

Summary and Background - Page 1

Paragraph 1

Supplemental Security Income (SSI) is a program for individuals who have been determined to be disabled. According to information obtained from the U.S. Census Bureau, the Commonwealth of Kentucky has the second highest percentage of individuals, over the age of 5, who are disabled; therefore it is reasonable and logical that Kentucky has the second highest percentage of residents receiving SSI. While the auditor prefers to correlate the high number of individuals in Kentucky receiving SSI with fraud, we contend that it is, unfortunately, more of a statement of the overall poor health of the citizens of the Commonwealth.

We can not report on the activities of the Department for Disability Determination Services, since it is housed in the Cabinet for Families and Children; however we will report on the activities related to SSI fraud and abuse that have occurred with the Cabinet for Health Services.

The Cabinet for Health Services, Office of the Inspector General, operates a Medicaid/Welfare fraud hotline and information referral system. Prior to Calendar Year 2002, informants calling regarding SSI fraud were referred to the Social Security Administration. In the autumn of 2001, staff from the Cabinet for Health Services, Office of the Inspector General, met with staff from the Social Security Administration to formalize this process, which was refined during Calendar Year 2002. Currently, when information is received by the CHS OIG, correspondence is issued to the SSA OIG, and copied to the Department for Medicaid Services, which outlines the allegation.

The Social Security Administration has responsibility and jurisdiction for determining if fraud has occurred. In the event that the SSA finds an individual is ineligible for SSI, SSA notifies the CHS OIG who in turn notifies the Department for Medicaid Services. DMS then takes appropriate actions related to the individual's Medicaid eligibility and any overpayment that may have occurred.

Our records indicate that, in the first nine months of Calendar Year 2003 alone, over 130 referrals have been made from the CHS OIG to the SSA OIG.

In addition, during Fiscal Year 2002, the Cabinet for Health Services, Office of the Inspector General referred 566 Medicaid recipient investigations to either the Attorney General or to the Department for Medicaid Services and/or its Contractors. While this volume reflects all Medicaid referrals and not just SSI referrals, it demonstrates the Cabinet's commitment to identifying and pursuing fraudulent activities in Kentucky's Medicaid Program.

APA Reply: The focus of this report is the lack of proactive fraud identification by DDS. The type of fraud detection mentioned by CHS, while a good fraud tool, is reactive as opposed to proactive.

Paragraph 2

Again, we contend that Kentucky's high number of SSI recipients is consistent with and directly correlated to Kentucky's high number of individuals who are disabled. The Cabinet for Health Services has made detecting fraud and abuse a priority as demonstrated by the 130 referrals that have already been made this year.

According to the SSA: DDS has complied with federal requirements and conducted fraud prevention training for all adjudicators and both federal and state quality reviews ensure that requirements are met. Since fraud referrals can be made via their fraud hotline, the field office, or by calling their local OIG agent, the conclusion that no cases have been referred is not supported. SSA has two Office of Inspector General agents in Kentucky who investigate suspected fraud.

Paragraph 3

According to SSA: This is incorrect as extensive supervisory reviews are conducted. Also, our special quality studies have shown single decision-maker decisions to be as accurate as or more accurate than other decisions.

Paragraphs 4 and 5

Economic and demographic factors and health status of a population have a significant impact on the number of citizens who meet the disability and need requirements of SSI.

According to the Department for Public Health, Kentucky has:

- The third-highest heart disease rate in the nation;
- The third-highest cancer rate in the nation
- The highest lung cancer death rate in the nation;
- An occupational death rate that is nearly double the national rate;
- The highest percentage of adult smokers in the nations; and
- The second highest prevalence of obesity in the nation.

According to the U.S. Census Bureau, Kentucky has:

- The second highest rate of disabled individuals in the nation;
- A lower percentage of high school graduates than the national average;
- A lower percentage of individuals with bachelors degrees than the national average; and
- A larger percentage of individuals who are not in the work force than the national average.

These significantly higher disease rates, coupled with these unfavorable demographic factors, certainly have a major impact upon the number of SSI Medicaid recipients and their cost of care.

Paragraph 6

This information is incorrect. We requested the two files from the auditor: the one that purported to have 9,940 SSI recipients with a P.O. Box, general delivery, or blank address; and the file that had an additional 554 SSI recipients with an out-of state address.

The file with the addresses of 9,940 SSI recipients contained no blank addresses. All of the addresses were either P.O. Box or general delivery; both of which are valid forms of address. Federal law precludes excluding an individual from eligibility due to the lack of a permanent or fixed address. In addition, Post Office Boxes and General Delivery are valid addresses and typical of rural areas. According to the article, "The Census Was About Power", which appeared in the Appalachian Reader, …"individuals living in rural areas tend to use post office boxes, rural route number and/or general delivery addresses rather than street addresses…" These are valid addresses.

Next, we looked at the file with addresses of 554 SSI recipients. This file did contain blank addresses, however, we did locate a valid address in our system for each and every blank. In addition, we performed a sampling of the 554 out-of-state addresses and confirmed that the out-of-state address listed was for the individual's payee, not the individual. Again, we verified that we have a valid Kentucky address for the entire sample.

We have had numerous discussions with the auditors concerning the address fields: the differences between a mailing address and the address of residence, and the fact that there are several data bases that must be accessed to obtain the correct information.

In summary, the auditor's office did not access all of the eligibility databases prior to drawing their conclusions concerning insufficient address information; therefore, we requested that the auditor share with us the address files for our analysis. Of the 9,940 addresses that are cited, 9,940 are valid addresses since they are either P.O. Box, or general delivery addresses.

In the file with 554 addresses, we identified 25 that were blank, which we researched and were able to confirm a valid Kentucky address. We also did a sampling of the 554 out-of-state addresses and confirmed a valid Kentucky address for the entire sample.

APA Reply: Again, while a Post Office Box is a valid address it does not establish, identify, or confirm Kentucky residency.

Paragraph 7

Throughout this budget crisis, the Kentucky Cabinet for Health Services and its Department for Medicaid Services have taken extraordinary measures to reduce expenditures to ensure that individuals most in need of services continue to receive those services.
We have also improved our administrative processes to enhance revenues, and to pursue monies owed to the Department.

The Cabinet has also, as discussed above, worked collaboratively with the Social Security Administration, Cabinet for Families and Children, Office of the Inspector General, Office of Attorney General, U.S. Attorney's Office, to enhance fraud detection efforts.

While the auditors find fault with the fraud detection efforts of the Social Security Administration and the Cabinet for Families and Children's Disability Determination Services, they do not even discuss the efforts that the Cabinet for Health Services and its Department for Medicaid Services and Office of the Inspector General have taken to identify, report, and act upon allegations of fraud and abuse.

Finding #1 - Kentucky Has a Significantly Large Number of SSI Recipients and Disability Applications – Page 4

Note: Agency's response only contains information not provided previously.

Kentucky ranks first among regional states in the number of persons over the age of 5 with a disability; therefore it is reasonable that we have a high number of disability applications.

The regional states have the following disability rates:

Alabama - 21.27%
Florida - 20.49%
Georgia - 17.80%
Kentucky - 21.63%
Mississippi - 21.36%
North Carolina - 19.14%
South Carolina - 20.21%
Tennessee - 20.21%

According to SSA: The workload data cited is not for SSI applications, but is for the total disability workload under Social Security. Only about a third of the 109,000 claims are for SSI benefits. Twenty-five percent of the workload is a review for continued eligibility of recipients already receiving benefits. This continuing eligibility review is another important aspect of stewardship activities. About 3% is assistance given on claims under the jurisdiction of the U.S. Office of Hearings and Appeals for which the DDS makes no determination.

According to the SSA: There is a very substantive review.

- At application point, residency information is obtained and proof is required of income/asset information.
- SSA staff does a review of claims coming into the DDS from the different SSA Offices.
- DDS case consultants and supervisors review many claims of the individual adjudicators. Until the worker has a year of experience and has demonstrated skill, every claim action and decision are reviewed. After the year the case consultant and supervisor review a sample of decisions (end of line) aged claims and examination purchase requests (in line) on a significant portion of every worker's claims.
- SSA has a sample taken every day that is random (FedQA) and a weighted sample (PER).
- SSA staff does a sample of onsite review/validations of claimant statements.
- Every allowed claim is reviewed at least every third year for continued medical eligibility and usually yearly for income eligibility.

According to SSA: There is no backlog of claims. There are many tasks that must be done to evaluate a claim for disability. These tasks take the DDS on average about 70 days to complete per claim. The nature of the work is to take an action and wait. Typically an examiner waits for medical reports from multiple sources. Some claims are completed in less than 70 days but some take longer. But the staff is taking actions on all of them. Claims are not waiting in a queue for their turn to be decided. The process takes weeks of preparation before a decision can be made because information must be evaluated from all sources.

There is, of course, a difference between applying for SSI and actually being approved. The programs strict criteria require extensive medical and other documentation before claims are approved.

Finding #2 - Kentucky Does Not Have a Cooperative Disability Investigation (CDI) Unit – Page 6

SSA Comments: SSA has a branch of its Office of the Inspector General in Lexington, and its agents investigate suspected fraud in SSI and other SSA programs. They do not need to rely on assistance from agents in other states. SSA has 10 regional offices throughout the U.S., not 17. SSA's good stewardship of the SSI program was cited by GAO in removing SSI from high risk status. Our continuing eligibility reviews were also cited along with our antifraud efforts. The DDS and SSA are committed to fraud prevention, detection, and where necessary, prosecution, as evidenced by our anti-fraud procedures and training and by the activities of our Office of Inspector General.

We can not report on the activities of the Department for Disability Determination Services, since it is housed in the Cabinet for Families and Children; however we will report on the activities related to SSI fraud and abuse that have occurred with the Cabinet for Health Services.

The Cabinet for Health Services, Office of the Inspector General, operates a Medicaid/Welfare fraud hotline and information referral system. Prior to Calendar Year 2002, informants calling regarding SSI fraud were referred to the Social Security Administration. In the autumn of 2001, staff from the Cabinet for Health Services, Office of the Inspector General, met with staff from the Social Security Administration to formalize this process, which was refined during Calendar Year 2002. Currently, when information is received by the CHS OIG, correspondence is issued to the SSA OIG, and copied to the Department for Medicaid Services, which outlines the allegation.

The Social Security Administration has responsibility and jurisdiction for determining if fraud has occurred. In the event that the SSA finds an individual is ineligible for SSI, SSA notifies the CHS OIG who in turn notifies the Department for Medicaid Services. DMS will then takes appropriate actions related to the individual's Medicaid eligibility and any overpayment that may have occurred.

Our records indicate that, in the first nine months of Calendar Year 2003 alone, over 130 referrals have been made from the CHS OIG to the SSA OIG.

In addition, during Fiscal Year 2002, the Cabinet for Health Services, Office of the Inspector General referred 566 Medicaid recipient investigations to either the Attorney General or to the Department for Medicaid Services and/or it Contractors. While this volume reflects all Medicaid referrals and not just SSI referrals, it demonstrates the commitment to fraud detection by the Cabinet for Health Services.

Finding #3 - Internal Review by DDS' Quality Assurance Unit Is Weak – Page 7

According to SSA: There are two simultaneous daily samples pulled for SSA, FedQA and PER. The SSA computer pulls them at the time of disposition with no foreknowledge in the DDS. In addition there is a review of the review by a third review component. The reviews examine every aspect of the claim, from jurisdiction, based on where the claimant resides, to the severity of the medical condition, adequacy of the documentation on which the decision was made and the correctness of the decision itself. SSA does do face to face validations with a sample of claimants. This information demonstrates that Kentucky takes appropriate action to address quality issues as they arise. Again, there is an ongoing supervisory review. The fact that Kentucky's performance is at or above regional averages would not support the notion that there are problems with Kentucky's decision process. The quality assurance unit is not specifically designed for fraud detection. It focuses on assuring that decisions are supported by objective and other evidence, which does assist in the prevention of fraud.

According to SSA: Quality Assurance is only one of a variety of internal DDS reviews. The highest volume review is within the individual unit and is done by the section supervisor and case consultant. In the sections the supervisors have extensive records.

According to SSA: The review cited was appropriately targeted to the most error-prone cases based on recent federal quality review results.

According to SSA: There are about 100,000 total cases processed each year, of which about 25% are continuing eligibility reviews to assure that those receiving benefits continue to meet our requirements. The QA unit operates in compliance with SSA standards. QA unit employees received anti-fraud training along with other DDS employees. Medical professionals assist the unit as needed. The staffing level of the Kentucky QA unit is consistent with that for other states.

Finding #4 - Over 3,000 SSI Approvals Made Without Medical or Routine Supervisory Review – Page 8

According to the SSA: The "Single Decision Maker" (SDM) is a process that has been in test for a number of years and has been closely monitored by SSA. In fact, it has been so successful that it was rolled out nationally this year. The quality of work for an SDM has been as good as any SSA has reviewed. Being a single decision maker does not reduce the documentary requirements nor does it change the standards for the decision. For many conditions SSA spells out the requirements for allowance. With experience the adjudicator can evaluate the condition because it matches listed conditions or because the aspects are straight forward. In any case, this has been extensively studied by SSA and deemed a success and implemented nationwide. Supervisors do review many/most of these cases. When the medical consultant participates it is usually a half-hour in addition to the time that the examiner spends. They spend less time because they do less. Plus they are responsible for the evaluation of medical information. The decision is an administrative decision that takes into account more than just the medical evidence.

Adjudicators in KY are required to have a degree, although no particular major is required. They receive extensive medical, administrative rules and program training. Part of their training concerns fraud and abuse. In 2000 there was a national SSA fraud training that the DDS participated in and this is included in training for new professional staff. In the past the requirement for examiners was not college (20 years ago). These supervisors have extensive experience and have demonstrated their skill level over a long period of time. The DDS has extensive ongoing training. Again, the DDS has conducted fraud prevention training for all adjudicative employees. Training often covers changes in medical practice and medical standards or relates to program changes.

APA Reply: **We understand that 100% of cases are reviewed for adjudicators with less than one year of experience. Our concern is that after only one year of experience, non-medical staff are making medical determinations and without direct supervision.**

Finding #5 - The Majority of 2002 Medicaid Costs Are Related to SSI Recipients – Page 9

Kentucky's significantly higher disease rates, coupled with unfavorable demographic factors, have a major impact upon the number of SSI Medicaid recipients and their cost of care.

The Kentucky counties that have been illustrated in Table 6 further exemplify this correlation.

The National Rate for percent of the population over the age of 5 that is disabled is 17.68%; Kentucky's rate is 21.63%. All of the counties listed exceed the national rate and the Kentucky rate. In fact, the disability range for these counties is a high of 34.98% and a low of 28.17%.

Nationally, 80.4% of the population has a high school degree. In Kentucky, this rate drops to 74.10%. All of the counties listed are below both the national rate and the Kentucky rate. The percentage of the population with a high school degree for these counties ranges from a high of 61.30% to a low of 49.2%.

The percentage of individuals in the United States with a Bachelor's degree is 24.40%; again this drops to 17.10% in Kentucky. All of the counties listed are below both the national rate and the Kentucky rate. The percentage of the population with a Bachelor's degree for these counties ranges from a high of 13.4% to a low of 6.3%.

In the United States, 36.1% of the population aged 16 and over is not in the workforce. This percentage increases to 39.1% in Kentucky. All of the counties listed are above the national average, and all but one are above the Kentucky average. The percentage of the population aged 16 and over for these counties ranges from a high of 62.6% to a low of 37.5%

Given the significance of these indicators, it is reasonable that these counties would have the highest percentage of SSI recipients.

Not only do the economic and demographic characteristics of a population impact upon the number of SSI recipients and the cost of their care; the geographic location of services will impact upon the cost of care in a particular county.

To reiterate the information that has already been given to the Auditor of Public Accounts regarding Union and Pulaski Counties, these two counties each contain an Intermediate Care Facility for individuals with Mental Retardation or a Developmental Disability. Oakwood is located in Pulaski County and has 338 residents. Higgins is located in Union County and has 53 residents. The location of these facilities in these counties greatly increases the expenditure per recipient in those areas.

Approximately one-third of the total expenditures in each of these counties is for the individuals residing in those facilities; statewide less than 3% of expenditures for SSI and state Supplementation Recipients are for Intermediate Care Facility services for individuals with Mental Retardation or a Developmental Disability.

APA Reply: **The high number of individuals receiving SSI should be of concern to policy makers. Therefore, routine sampling should occur to determine if fraudulent activity is prevalent.**

Finding #6 - Questionable Claims Information May Indicate Fraud and Abuse – Page 11

See Paragraph 6's response under Summary and Background.

Conclusion – Page 12

We do not agree that the high number of SSI recipients is an indicator of fraud. We feel that the number of SSI recipients is consistent with the economic and demographic indicators in the Commonwealth of Kentucky.

We do not agree that there is a lack of fraud detection and an absence of fraud referrals.

We agree that individuals who are disabled consider Medicaid a valuable resource in meeting their health care needs.

The Kentucky Cabinet for Health Services is actively working with the Federal Social Security Administration to identify and report fraud and abuse.

Recommendations – Page 12

While these recommendations are made to the Cabinet for Families and Children, Department for Disability Services, the Cabinet for Health Services would like to comment on Recommendation 7.

First, there are not 10,494 recipients with questionable addresses. In fact our analysis indicated that there are no recipients with questionable addresses. The specific information related to these addresses is in the body of the report.

Second, we actively work with our eligibility contractors to ensure that both federal and state eligibility requirements are met.

Finally, through our ongoing Quality Assurance process, we routinely monitor various aspects of the eligibility determination process to ensure compliance.

Auditor of Public Accounts Information

Appendix V

Contributors to This Report

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Obtaining Audit Reports

Copies of this report or other previously issued reports can be obtained for a nominal fee by faxing the APA office at 502-564-2912. Alternatively, you may

order by mail:	Report Request Auditor of Public Accounts 144 Capitol Annex Frankfort, Kentucky 40601
visit :	8 AM to 4:30 PM weekdays
email:	Hatchett@kyauditor.net
browse our web site:	http://www.kyauditor.net

Services Offered by Our Office

The staff of the APA office performs a host of services for governmental entities across the commonwealth. Our primary concern is the protection of taxpayer funds and furtherance of good government by elected officials and their staffs. Our services include:

Performance Audits: The Division of Performance Audit conducts performance audits, performance measurement reviews, benchmarking studies, and risk assessments of government entities and programs at the state and local level to identify opportunities for increased efficiency and effectiveness.

Financial Audits: The Division of Financial Audit conducts financial statement and other financial-related engagements for both state and local government entities. Annually the division releases its opinion on the Commonwealth of Kentucky's financial statements and use of federal funds.

Investigations: Our fraud hotline, 1-800-KY-ALERT (592-5378), and referrals from various agencies and citizens produce numerous cases of suspected fraud and misuse of public funds. Staff conducts investigations to determine whether referral of a case to prosecutorial offices is warranted.

Training and Consultation: We annually conduct training sessions and offer consultation for government officials across the commonwealth. These events are designed to assist officials in the accounting and compliance aspects of their positions.

General Questions

General questions should be directed to Matt Cantor, Intergovernmental Liaison, at (502) 564-5841 or the address above.