Disability Allowance Payment

Fraud and Error Survey Report

Department of Social Protection
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APPENDIX

2011 Disability Allowance Fraud and Error Survey

1. Introduction

Purpose of survey

The Department undertakes fraud and error surveys to establish baseline fraud and error levels for social welfare schemes. The purpose of such surveys is to identify the level of risk associated with particular schemes and areas with a view to designing processes and control measures specifically targeted to minimise the level of future risk.

The purpose of this survey was to establish baseline levels of fraud and error in the Disability Allowance (DA) scheme. The survey took place in Q4 2010. The last fraud and error survey on DA was undertaken in 2005.

A review of medical eligibility was undertaken for the first time in parallel with this survey. While this is a significant element of the review process of the scheme, it cannot be considered to be an element of the fraud and error survey itself.

Agreed criteria

The Department agreed the following criteria with the Comptroller & Auditor General for the successful implementation of baseline fraud and error surveys:

- All cases for inclusion in the survey must be selected randomly from the population of cases in payment at a specific time;
- The sample size must be sufficiently large to yield reasonably reliable estimates;
- The reviews should be carried out as promptly as possible;
- Cases should be tested fully for all possible breaches of regulations;
- The monetary values of any changes as a result of the review together with the monetary value of the sample should be captured so that the results can be extrapolated to draw conclusions about the estimated value of the loss; and
- The results of the survey should be capable of being audited.

Methodology

The Department's statistician is involved in the surveys at design and reporting stage. At design stage, the best sample structure is identified to fit the scheme's profile of recipients. This could involve selecting a larger or smaller than normal sample depending on the profile of clients and claim duration. It could also involve over-sampling certain groups to ensure that they can be reported in the final results.

Results are re-weighted in line with the overall scheme profile and risk groups are identified, where possible. The survey also looks at what types of cases were giving rise to the changes in payment levels as a result of fraud/ error.

In terms of the DA survey sample, the following approach was adopted:

- A random sample of 1,011 DA claims in payment was selected.
- The sample of 1,011 was examined by the statistician and found to be representative as required by reference to age, location, gender etc.
- 1,007 claims were returned by medical assessors and social welfare inspectors following investigation and details were entered onto a database. Three cases are complex and are still under investigation by the inspectors in question – the customers continue to satisfy the medical conditions and the three cases remain in payment. The 4th case was reviewed by an inspector in August 2010 and no irregularity was found, however, the medical questionnaire was not returned. The file is with the inspector to visit the customer and enquire about the medical. In 1999, he was medically reviewed and the medical assessor recommended that it was not necessary to refer him again i.e. very low medical risk.
- The sample of DA cases were all examined and decided by deciding officers in the Control Unit of Social Welfare Services, Longford.

Net rate of fraud and error

The net rate of fraud and error is calculated based on the decision of the deciding officer (DO). Fraud or suspected fraud mainly arises where it appears to the DO that the customer knowingly gave false or misleading information or wilfully concealed relevant information. Error cases are primarily due to inadvertent customer, third party or departmental error.

The net rate refers to the position after account is taken of decreases in weekly rate, increases in weekly rate, terminations of payment, transfer to other payments and the position post appeals of any cases affected.

Figures are presented in terms of the level of expenditure and the number of cases affected.

2. Survey Results

Net Cost of Fraud and Error: 2.1% of expenditure

Fraud figure: **1.2% of expenditure equivalent to 1.6% of claims**

Error figure: **0.9% of expenditure equivalent to 7.0% of claims**

Medical Status Change: **2.0% of expenditure equivalent to 2% of claims**

3. Risk Categories

The data was analysed in greater depth where sample size allowed to establish risk categories, as follows:

Means: Customers with means are a higher risk grouping, compared to those customers assessed with nil means.

Age: The survey indicates a significantly higher than average risk in the 25-35 age group.

Payment Method: Cases paid via Electronic Fund Transfer (EFT) are a slightly higher than average risk of fraud/error.

Claim Duration (All Changes): The survey indicates that risk of medical status change reduces very significantly for claims with a duration >10 years. This outcome is significant in the context of assessing the cost effectiveness of any accelerated programme of control reviews of cases still in payment which were taken over from the (then Health Boards) and which have not been reviewed since. Forty five cases in the survey were DPMA (Disabled Persons Maintenance Allowance) legacy cases, which is too small from which to draw a firm conclusion. However, the indications are that these cases are significantly lower risk.

For factors other than medical status, the group of claims with a duration of 2-3 years appear to represent an increased risk of change.

High-Risks Categories Identified in the Survey:

- Medical eligibility of those claims which are in payment for between 3 and 9 years.
- Duration of claim – Claims that are in payment for 2 years or less and for 10 years or more

are significantly lower risk that claims of a duration between 3 and 9 years.

- Means – those claims with means assessed against them are slightly higher risk of error than claims that are originally assessed with nil means.

- Payment Method – EFT is slightly higher than average risk but not significantly so.

4. Details of outcomes of survey cases

Fraud Cases

There were 26 cases identified as falling into the fraud category which resulted in a decrease/ termination of payment. Of these:

- 19 cases were closed because their whereabouts were not known;
- there was 1 case where means could not be established;
- 3 cases who failed to engage with the inspector/submit medical evidence; and
- 3 cases where the applicants were in prison.

Error Cases

There were 72 cases of error:

- 56 were classified as customer error; and
- 16 were classified as departmental error

There were 23 cases where the rate in payment increased as a result of the survey. These were mainly cases where the customer's or spouse's earnings had been reduced or where there were reduced levels of capital etc.

Terminations

Initial results show that there were 175 claims terminated, 149 (85%) on the grounds of medical eligibility no longer being satisfied. Forty five of these cases were subsequently reinstated on DA, following an appeal.

Appeals/Re-qualified for payment

Cases terminated were examined to determine whether they had since claimed/been awarded another social welfare payment. Cases were examined on 5th April 2012 for their current position.

- 104 of the 130 terminations (80%) are back on DA or another social welfare payment (including being paid as a qualified adult on their partner's social welfare payment). Ten are being paid as a qualified adult allowance on their spouse/partners claim, 94 are back on DA or are on another social welfare payment in their own right. The small number of claimants (11) that are once again in receipt of DA were claimants who could not be contacted during the DA review but who were subsequently re-instated upon making satisfactory contact or who chose not to appeal the termination of claim on medical grounds but instead submitted a new claim.

- 53 of these claims are at a lower rate than what the person received while on DA. These results have been incorporated into analysis.

- 110 cases were appealed (108 medical terminations and 2 cases where the rate was reduced due to increased means):

    - ✓ 85 of the appeal cases are finalised. Of these, 40 were disallowed (DO decision upheld by Appeals Officer) and 45 cases were allowed (applicant reinstated on DA without loss of payment).
    - ✓ The remaining 25 cases are with the Social Welfare Appeals Office for decision.

- In 26 cases, where the customers' claims remain terminated, the customer has not claimed a payment in their own right or transferred to their partner's claim as a qualified adult dependant.

Medical eligibility

Medical eligibility for the DA scheme is described in legislation (Chapter 10 (PART 3) of the Social Welfare Consolidation Act 2005 as amended, and Chapter 5 (PART 3) of the Social Welfare (Consolidated Claims, Payments and Control) Regulations 2007 S. I. No. 142 of 2007, as amended). It is determined by a DO based upon expert opinion from the Department's professional medical assessors.

The DO is supported by medical assessors in his/ her role in deciding medical eligibility. Supporting evidence provided by the applicant, such as GP and consultant medical reports and an applicant's self-assessment of the ways in which his/her life is impacted by their disability, are forwarded to the Department's medical assessors. The claimant's doctor may give medical opinion and facts regarding a claimant's diagnosis, history of illness, impact on the claimant's physical and mental well-being. The medical assessor is not making a diagnosis or disputing the opinion of claimant's medical team - rather s/he is determining the claimant's suitability for the scheme in terms of meeting the medical eligibility criteria. The medical assessor does this by reviewing all medical information supplied and applying his/ her experience in the field of occupational medicine with reference to protocols that are independently and internationally approved.

Termination of a DA payment on medical grounds (and refusal to award a new claim on medical grounds) typically results in a high appeal rate. The Appeals Officer (AO) is charged with adjudicating between the position of the Department and the position of the claimant. Upon appeal of a medical disallowance, it is normal for a different medical assessor to examine all the available evidence and provide a second opinion to the DO/AO. Where the opinion of the second medical assessor is that the person is medically eligible, the decision to terminate will normally be revised by the DO and the person reinstated on DA without the need for an AO determination.

Where the second opinion concurs with the first, an AO will make a determination in the case. All evidence is taken into account, including medical evidence from the persons treating physician(s), the opinion of the Department's medical assessor(s), additional evidence supplied since original decision/ review and evidence supplied in an oral hearing if one is held.

While the survey rate of termination on medical grounds is high - 149 cases (14.8% of cases), this is reduced to 104 cases (10.3% of cases) following the appeals process. While this level of success upon appeal is notable, it should be borne in mind that there is an element of subjectivity in the medical conditionality which is not mirrored in the other scheme conditions e.g. means, residency etc. and appeal outcomes tend to reflect this subjectivity.

5. Controls

A revised control review policy for the DA scheme was implemented in January 2009.

The control review policy for the DA scheme introduced a change from the 'review date' model which existed previously, whereby reviews were triggered by reference to review dates entered on the penlive system, to a 'risk-based' model that is based on a control risk rating assigned to the medical and means categories within each claim at award and review stage. The risk ratings take account of the 2005 fraud and error survey for the DA scheme and previous audits.

The review policy has been trialled for a period of 2 years to determine its effectiveness and is currently under review. With the completion of this fraud and error survey, an updated review policy will be finalised and put in place taking account of the survey and the experience of the previous review policy.

6. Conclusions and Recommendations

Key survey finding

The overall net cost of fraud and error for Disability Allowance is 2.1% of expenditure.

The main conclusions of the survey are:

- Excluding the results of the review of medical status and compared to previous fraud and error surveys (which excluded medical status), the overall fraud and error cost is 3.1%. This compares favourably to the 2005 survey results. It is to be noted in this survey that the net cost allows for the impact of claimant migration to other social welfare payments.

- Although DA is intended to provide a long-term income support for people with a significant disability, there is a still a high risk of change in medical eligibility, particularly in the 3 – 9 year period following claim award.

- Claim reviews, commencement of employment information, data matching, prison service data and anonymous reports provide a suite of control measures to safeguard the scheme and these must continue.

- The number of cases terminated for "whereabouts not known", 19 or 1.9% of cases, indicates the need to increase the number of continuing eligibility reviews via mailshot for the DA claim load, targeted as far as possible at high risk cases.

Key recommendations

In light of the survey conclusions, the following recommendations are made:

1. The DA review policy, which is currently under review, should be revised in light of the findings of this survey and appropriate changes implemented to DA control and review processes.

2. Pending the finalisation and implementation of any policy changes, such as time-limiting awards, there should be an increased number of medical assessments carried out on DA recipients, targeted primarily on those claims that are in payment for between 3 and 9 years.

3. In view of the fact that medical assessments of DA recipients are very costly, both in terms of the cost of paying GPs for medical reports and, administratively, at scheme level, medical review and assessment stage as well as in the Social Welfare Appeals Office, a more cost effective way of confirming medical eligibility of DA recipients

should be considered, including preliminary triage. Consideration should also be given to the feasibility and value for money of outsourcing medical assessments.

4. Given the relatively high rate of successful appeals against medical disallowance, it is recommended that:

    - The current processes, procedures and communications employed in medical reviewing DA customers should be reviewed to improve efficiency, effectiveness and fairness. Outcomes may be beneficial to other schemes with a medical conditionality e.g. domiciliary care allowance, invalidity pension etc.
    - The MR99, self-assessment of the impact of disability by a recipient/ applicant (issued in the case of in-payment reviews) should be reviewed to improve accessibility to persons with an intellectual disability or brain injury etc.

5. A circular to outline the report findings and issues that need to be addressed should issue to all relevant scheme staff, Longford SWS Control staff and the Regional Support Unit.

6. The forms issued to customers at the award stage and intermittently should be reviewed to ensure that the implications of providing false information or concealing information are appropriately stated and stressed.

7. There should be an increased level of systematic "continuing eligibility" reviews of DA customers, targeted at high risk customers. It is noted that resources to carry out an increased level of means reviews is limited. However, when the existing DA claim load is migrated onto the BOMi platform in Q4 12, enhanced and automated functionality will increase capacity in this regard.

Appendix 1 – Table of results

DA survey results	Initial Fraud and Error level	Reinstated claims/appeals	Net Fraud and Error level
Fraud value	2.1%	0.9%	1.2%
Error value	1.0%	0.1%	0.9%
Fraud and Error value	**3.1%**	**1.0%**	**2.1%**
2005 F and E survey results - value	*7.0%*		
Medical Value	15.3%	13.3%*	2.0%
Fraud cases	2.6%	1.0%	1.6%
Error cases	7.1%	0.1%	7.0%
Fraud and error change cases	**9.7%**	**1.1%**	**8.6%**
2005 F and E survey results - cases	*15.8%*		
Medical Cases	**14.8%**	**12.8%***	**2.0%**

* 4.7% of the values and 45/4.4% of the cases under this heading were reinstated on appeal