Wisconsin
Counties
Association

WCHSA
Wisconsin County Human Services Association

INCOME MAINTENANCE FRAUD FUNDING

The Income Maintenance Administration Allocation (IMAA) is a combination of state and federal funds provided to county income maintenance consortia to perform the eligibility determination and management functions associated with several federal and state programs, including Medical Assistance and FoodShare. Ten multi-county consortia administer income maintenance programs. Administration of IM is a shared cost between local county levy, federal revenue, and GPR, with typically a 50-50 split between federal revenue and the state's share of cost (funded through GPR and county tax levy).

County income maintenance consortia are required to operate a Fraud Prevention and Investigation Program (FPIP). The FPIP model "focuses on fraud prevention, using investigative staff dedicated to provide all investigation activities under a single funding source, utilizing local agency and/or private contracted investigators."

In the 2015-17 state biennial budget, the Joint Committee on Finance (JCF) doubled the FPIP appropriation - from $500,000 annually statewide to $1,000,000 annually statewide. This funding amount is well below the $1.8 million counties received in 2009. The increased funding provided in the 2015-17 state biennial budget has enabled local agencies to increase the number of investigations completed, as well as identify an increased number of cases in which overpayments were made and intentional program violations (IPV) occurred.

According to the Department of Health Services, in 2016, future savings based on the work of the IM consortia were over $18 million and overpayments were established at an all-time high of almost $22 million, for a total cost savings of $39,992,454. Approximately 1,263 intentional program violations were also established statewide. The return on investment in the FPIP program was 23:1 in 2016, a significant increase over prior years.

In some ways, efforts to identify and eliminate fraud, waste, and abuse has been a victim of its own success because the better counties are at it, the more work that is generated. The nature of the work has shifted as well. Over the last two years, the workload associated with potential fraud referrals consisted of more fraud investigations than overpayment referrals. As increased funding was provided, investigations increased, as did discrepancy evaluations, resulting in high numbers of overpayment referrals.

CURRENT STATUS: The Governor's budget maintains fraud funding at $1 million annually.

REQUESTED ACTION: Provide an additional $1.5 million annually in FPIP funding. Fifty percent of the funding request is GPR, 50% is federal funding.

TALKING POINTS:

- With the increased funding provided in the 2015-17 state biennial budget, counties successfully identified an increased number of IPV and overpayment cases, as well as increased the state's return on investment.
- Increased funding is essential to reducing the backlog in both fraud referral and overpayment referral cases – as of 2016, there were 9,012 backlogged referral cases and 37,034 backlogged overpayment referrals.
- Local IM staff has forged relationships at the local level that have helped in identifying and investigating suspected fraud within the program.
- Fraud funding is below historical funding levels, while workloads/caseloads have continued to increase.
- The state receives incentive funding as a direct result of claims established by the FPIP consortia and the resulting collection of overpayments. If incentive dollars are used to fund the increased FPIP payments to IM consortia, the proposal will be cost neutral to the state.
- The estimated value of the backlogged cases is $58,332,848.
- In 2016, each $1 spent on FPIP resulted in a savings of $23.

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Income Maintenance Fraud Funding

Introduction

Income maintenance (IM) refers to the eligibility determination and management functions associated with several federal and state programs, including BadgerCare, Medicaid, FoodShare and Foodshare Employment and Training (FSET). The Department of Health Services (DHS) contracts with ten multi-county consortia to administer income maintenance programs. Administration of IM is a shared cost between local county levy, federal revenue and GPR, with typically about a 50/50 split between the federal revenues and GPR for the state's share.

All consortia and tribal agencies are required to operate a Fraud Prevention and Investigation Program (FPIP). Fraud prevention and detection have always been an integral part of locally run income maintenance (IM) programs. Historically, local IM fraud staff have developed relationships with community stakeholders, including local sheriffs. The knowledge and affiliations gained through this local presence help support and enhance local fraud efforts.

On January 10, 2011, Governor Walker signed Executive Order #2, creating the Governor's Commission on Waste, Fraud and Abuse. This order tasked the Commission with identifying strategies to increase fraud prevention and detection in public assistance programs. Additionally, in September 2013, Governor Walker issued direction to the Wisconsin Department of Health Services to evaluate and implement six strategies that will strengthen fraud prevention in the state's public assistance programs. Since that time, system changes have been made, additional funding has been allocated to local agencies, and the collaboration of local and State staff have resulted in a significant rise in the number of investigations completed, overpayments calculated, and recoupments initiated. This paper serves two purposes: to provide an update on the success of and remaining challenges of these efforts, and to request additional resources to continue our efforts in eliminating waste, fraud and abuse.

Background

In the last two biennial budgets, in partnership with WCHSA, Governor Walker and the Wisconsin Legislature have made significant investments in preventing and detecting waste, fraud and abuse – not only by rebuilding the Department's infrastructure for fighting fraud, but also by investing in building this capacity at the local level.

In 2015, the Legislature graciously approved an additional $500,000 per year in funding to be allocated to IM Consortia. These funds, in combination with original allocations, have been used effectively and efficiently to reduce fraud with a return on investment identified as being $15 saved for every $1 spent.

This funding has enabled local agencies to increase the number of investigations completed, overpayments identified, and intentional program violation sanctions imposed. Below are some examples of how the funding was used.

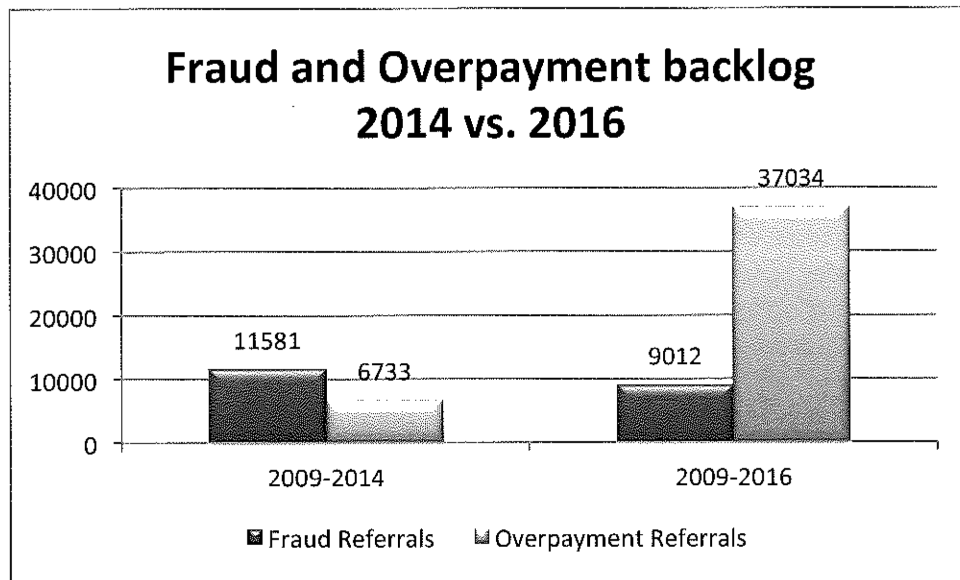
- The Capital Consortium used the additional funds to add another staff member dedicated to calculating overpayments and imposing Intentional Program Violations (IPV) sanctions. The 2016 sanctions imposed increased 70% through October compared to all of 2015, 53 to 31 sanctions respectively.

- Great Rivers Consortium hired an additional fraud investigator with the additional funding received in 2016. This Investigator to date has completed an additional 108 investigations and 29 IPV's.

- Bay Lake Consortium used the additional funds to hire an overpayment specialist. In 9 months, she completed 533 overpayments with claims totaling $719,771 resulting in potential incentives of $100,000+.

Successes and Challenges

Figure 1



In some ways, efforts to identify and eliminate fraud, waste and abuse has been a victim of its own success because the better we become at it, the more work we generate. As illustrated in Figure 1, a significant shift has occurred in recent years. To best understand the shift, it is useful to understand the basic flow of how fraud work is created and processed. Potential fraud and overpayment referrals come from a variety of sources. Local IM staff may have suspicions they want further investigated. Clients themselves may report new information that (although not fraudulent) creates a benefit overpayment that must be recouped for a prior benefit month. Others come from anonymous and sourced tips into local agencies. Many referrals are triggered through automated data exchanges that "flag" when there may be a discrepancy between what is on the clients file and what the data source is reporting. For each of these referrals, as assessment is done to determine the extent of an overpayment or if the case needs to be referred for further fraud investigation work. Whether fraudulent or not, when a client ends up owing benefits back to the state, this is called a "claim" and federal incentives exist to generate repayment on such claims.

Prior to the receipt of additional funding, the workload associated with potential fraud referrals consisted of more fraud investigations than overpayment referrals at a ratio of 1.72:1. As increased funding was provided, investigations increased as did discrepancy evaluation, resulting in high numbers of overpayment referrals.

Current data shows that overpayment referrals outnumber fraud investigations at a ratio of 4.12:1. In other words, a process bottleneck which once existed at the step of initial investigation has now migrated to the claims establishment step. The current backlog contains 37,034 referrals which are known to have recoverable overpayments in need of claims calculation and establishment. The receipt of additional funding would assist consortia in moving referrals through the *entire* benefit recovery process, including the crucial final steps of claims establishment and recoupment.

Another big factor that coincided with this timeframe is the impact of the Affordable Care Act (ACA). Various provisions of the Affordable Care Act now require eligibility workers to rely upon the use of automated data exchange processes in determining applicant and recipient financial eligibility for public assistance programs. The ACA also increased the number of data exchanges being used. Changes to policy and programming now allow some families to receive medical coverage benefits without worker involvement. The income verifications are received through data exchanges. Thus, we are unable to do up front screening on these cases. When the exchanges do not work as intended, inappropriate benefits can be issued. This new directive to rely on data exchanges for benefit issuance is another reason more discrepancies must be evaluated for fraud and overpayments..

Local agencies are positioned to continue to increase the number of fraud investigations completed, overpayments identified and Intentional Program Violation (IPV) sanctions imposed. Attachment 1 displays data on referrals requiring investigation and referrals requiring overpayment calculation and recovery.

Intentional program violations that disqualify fraudulent applicants and recipients from the program for 1 to 10 years have also increased after the funding was received. The more resources, the more IPV sanctions the consortia are able to impose.

All of the work listed above acts as a deterrent to future fraudulent activity. The indirect benefit is gained through these fraud prevention mechanisms. As customers are held accountable for fraudulent reporting through claims establishment and/or imposition of intentional program violation sanctions, a strong message that fraud does not pay in Wisconsin is sent. This signaling is important in guiding future actions of applicants and recipients.

Increased claims establishment results in increased revenue to DHS/DCF and IM Consortia. In many consortia, this increased revenue is channeled directly back to fraud prevention and detection activities, further enhancing fraud programs and helping to reduce fraud and waste in Wisconsin. Given that IM Consortia have demonstrated incredible cost-effectiveness with previous funding increases, it is believed that the ability to raise the cost-effectiveness ratio will increase further when more claims can be established.

Funding Request

We are requesting $1.5M in additional fraud funding for the FPIP consortia (an additional $750,000 GPR/year before being matched with federal funds). This request is based on backlog data plus current averages of investigations per year, see Attachment 1. The increased funding is essential to reducing the backlog and reversing that trend and ensuring adequate resources are available to eliminate waste and fight fraud and abuse. Fraud not only wastes taxpayer funds, but it also undercuts those truly in need.

The State realizes incentive funding as a direct result of the claims established by the FPIP consortia and the resulting recoupment of overpayments. We estimate that if this request is granted, the additional GPR could generate additional federal incentives to offset the investment.

Historical View for Balance of State

(Milwaukee and OIG excluded)

	2009	2010	2011	2012	2013	2014	2015	2016	2016 Extrapolated to 12 months
FUNDING									
Total Funding BOS (excluding Milw. and OIG)	$1.8M	$1.8M	$.5M	$.5M	$.5M	$.5M	$.75M	$1M	$1M
FRAUD EFFORTS									
Claims Established			$4.6M	$6M	$9M	$7.3M	$8.4M	$10.6M	14.13M
Cost Avoidance (Future Savings)			$6.8M	$8.5M	$11.4M	$8.8M	$9.8M	7.8M	10.4M
Total Program Savings			$11.4M	$14.5M	$20.4M	$16.1M	$18.2M	18.4M	24.53M
Individuals Suspended for IPV	126	82	106	203	549	1085	692	332	443M
IPV Savings					$.5M	$1M	$.7M	.3M	0.4M
FPIP Consortia Investigations			3759	4837	7032	8240	11394	10356	13808
STATE REVENUE FROM COLLECTIONS (SFY)									
Food Stamps		$138,072	$184,191	$335,263	$470,028	$533,726	$535,020		
Medicaid		$250,515	$200,133	$231,597	$297,415	$318,193	$247,046		
TOTALS		$388,587	$384,324	$566,860	$767,443	$851,919	$782,066		

	2009	2010	2011	2012	2013	2014	2015	2016	Total
BACKLOG – Updated as of 11-7-16									
BOS Fraud Referral Backlog		23	83	288	1,511	2,056	1,228	3,823	9,012
BOS Overpayment Backlog	6	19	49	243	1,164	6,001	15,504	14,048	37,034
Estimated Backlog Claims Amount	$8,160	$46,172	$140,012	$585,072	$2,918,764	$9,978,864	$22,170,992	$22,484,812	$58,332,848