

**State of Wisconsin  
Department of Health Services**

**OFFICE OF THE INSPECTOR GENERAL**



**2011-2015 Comprehensive Report**

**P-01220 (02/2016)**

February 1, 2016

Kitty Rhoades, Secretary  
Wisconsin Department of Health Services  
One West Wilson Street  
Madison, WI 53703

Dear Secretary Rhoades:

Today, as Inspector General of the Department of Health Services, it is my pleasure to present to you the first of what I hope to be an Annual Report on the activities of the Department of Health Services Office of the Inspector General (OIG).

This report represents a culmination of the efforts that have been put forth to create and enhance the efforts of OIG since its creation by Governor Scott Walker in October 2011.

The report describes the reasons why the OIG was created and the staffing strategy for the office, as well as some of OIG's significant accomplishments from 2011 through 2015. I believe that through reading this report you will better understand how OIG has exceeded the goals that the Governor and the Legislature laid out, as well as how OIG is a leader in the prevention and detection of fraud, waste, and abuse in public assistance programs.

This report also demonstrates that the success of OIG is due primarily to the hard work and dedication that OIG employees have invested in building and maintaining effective fraud fighting tools.

Sincerely,

A handwritten signature in black ink, appearing to read "AS White", with a long horizontal flourish extending to the right.

Alan S. White, Inspector General  
Office of the Inspector General  
Wisconsin Department of Health Services

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## **Top Accomplishments of the Office of Inspector General 2011-2015**

1. Completed initial phases of OIG development, became fully staffed and operational.
2. Established fraud reporting hotline and web-based portal and received more than 13,000 complaints.
3. Increased the number of staff investigating and detecting recipient fraud from 1 to 24.
4. Increased recipient fraud cost avoidance and overpayments by 80%, including \$26.5 million in program savings for CY 2015 compared to \$14.6 million in CY 2012.
5. Increased monitoring and detecting of violations of FoodShare program rules and the number of individuals suspended for Food Share program violations increased from 200 in CY 2012 to more than 1,300 individuals in CY 2015.
6. Through the federal data matching completed by the PARIS Match Program, saved \$2.4 million through cost avoidance and identified overpayments of \$6.4 million since 2012.
7. Designed and piloted a FoodShare QUEST card replacement project that was enacted by legislation to permanently become a Department of Health Services FoodShare program integrity activity.
8. Identified nearly \$50 million in Medicaid provider overpayments
9. Recovered nearly \$40 million in overpayments to Medicaid providers.
10. Collected nearly \$90 million through drug settlements.
11. Increased monitoring of Medicaid providers to ensure compliance with Medicaid rules and regulations and increased the number of audits of Medicaid providers to more than 2,000 per year.
12. Began a personal care oversight improvement initiative, including home visits to verify needs.
13. Implemented new federally required program integrity activities, including:
  - Affordable Care Act (ACA) Program Integrity Provisions
  - Recovery Audit Contractor
  - Electronic Health Record Incentive Program Audits

## **Office of the Inspector General Activities and Accomplishments 2011-2015**

Governor Walker created the Department of Health Services Office of the Inspector General (OIG) in October 2011 to consolidate and improve the Department's public assistance program integrity and fraud prevention efforts. Prior to October 2011, the Department carried out program integrity activities related to public assistance programs; however, staff was dispersed among multiple divisions and there was no systematic process for communication among the units or with other Department staff or state agencies. As a result, there was also limited public visibility of existing program integrity efforts, creating uncertainty for individuals wanting to report suspected fraud and abuse.

Creating OIG consolidated existing audit and investigation staff and resources. Additional staffing resources for OIG were provided in the 2011-2013 biennial budget. These additional resources allowed the Department to build the necessary internal infrastructure to be able to better prevent and detect waste, fraud, and abuse in the Department's public assistance programs. For example, before OIG was created there was only one staff at the department whose job it was to investigate recipient fraud. Today, OIG has an entire section and 24 employees that work to investigate recipient fraud. Without the Governor's investments in preventing and detecting waste, fraud, and abuse at the Department of Health Services, this section would not exist.

OIG's main priority is to protect taxpayer dollars by tracking and preventing waste, fraud, and abuse in Wisconsin's public assistance programs. These programs are a safety net for individuals and families in need and to keep these programs viable and sustainable over the long term, program integrity must be maintained.

OIG's primary responsibilities include:

- Reviewing all complaints received through the fraud hotline and the portal.
- Monitoring, investigating, and referring recipient and retailer fraud allegations.
- Overseeing the enrollment and reenrollment of providers in the Wisconsin Medicaid Program.
- Overseeing and enforcing the prior authorization policies of the Wisconsin Medicaid Program.
- Monitoring and auditing providers who participate in Wisconsin Medicaid.
- Performing independent, objective assurance and consulting engagements for the Department's programs and operations.

The following sections provide an overview of OIG's activities and accomplishments from 2011 through 2015.

### **Established the Fraud Hotline and Portal**

After its creation in 2011, OIG quickly established a fraud hotline and portal so the public could more easily report complaints of fraud, waste, and abuse in Wisconsin's public assistance programs. The Department reviews any complaints and allegations of fraud, waste, and abuse received through the fraud reporting hotline at 1-877-865-3432 or [www.reportfraud.wisconsin.gov](http://www.reportfraud.wisconsin.gov).

The OIG investigates fraud tips for any type of abuses of public resources such as:

- Billing Medicaid for services/equipment not provided.
- Filing a false application for a Department-funded assistance program such as Medicaid, BadgerCare Plus, WIC, or FoodShare.
- Trafficking of benefits (trading the benefit card for cash, tobacco or alcohol, or buying ineligible non-food items).
- Crime/misconduct/mismanagement by a Department employee/official or contractor.

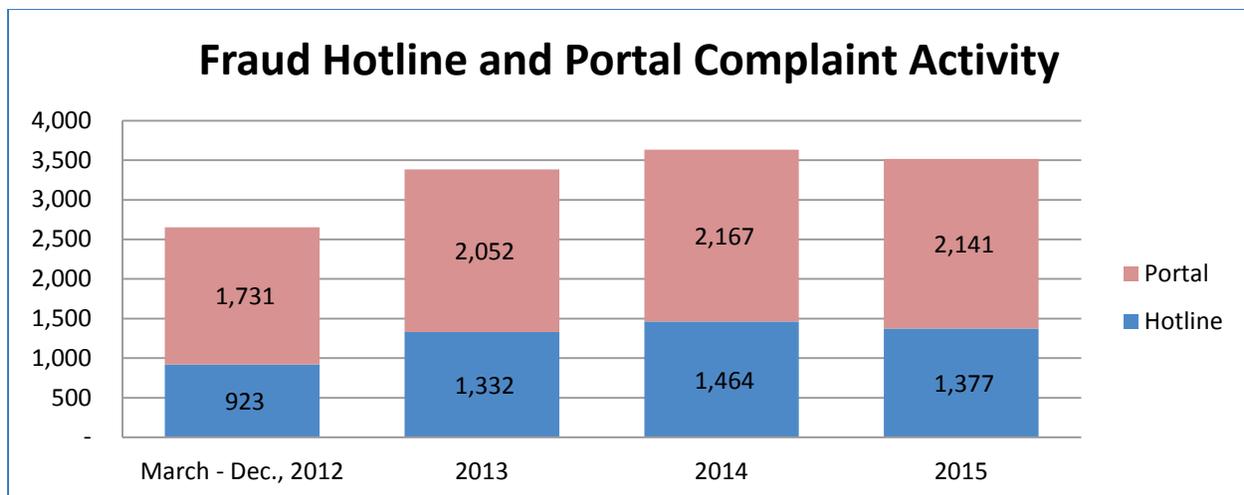
In 2013, the OIG received a complaint about a Wisconsin family who was receiving health care coverage through Medicaid and did not report income from a restaurant they owned. After the OIG investigated, it was determined that there was an overpayment of more than \$10,000 because the family did not meet Medicaid program rules.

OIG also received a complaint in 2013 about a single parent and child who received health care coverage through BadgerCare Plus until OIG discovered that the minor child was living out of state with the other parent. This resulted in an overpayment of \$45,000 because the parent and child did not meet the BadgerCare Plus program rules.

More than 85 percent of the complaints that OIG receives through the fraud hotline and portal are related to recipient waste, fraud, and abuse. The other 15 percent of complaints are related to provider waste, fraud, and abuse and other various concerns.

If OIG finds potential violations of state and federal laws, it refers the allegations to and works with law enforcement, the Department of Justice, the Department of Safety and Professional Services, and/or the Wisconsin Department of Health Services Division of Quality Assurance. If the allegations are substantiated, the Department and local human services agencies can recoup overpayments or refer the case to law enforcement for prosecution.

OIG has received more than 8,000 portal complaints and fielded more than 5,000 phone calls through the fraud portal and hotline since they were launched in 2012.



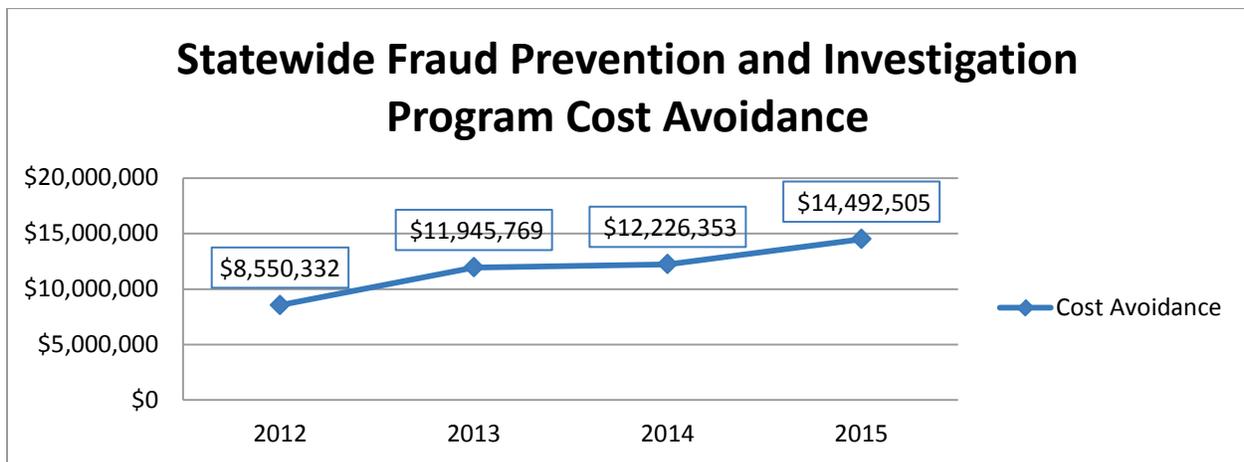
## Collaborates with Counties and Tribes to Operate the Fraud Prevention and Investigation Program

OIG provides technical assistance, investigative support, and prosecutorial support to the income maintenance consortia through the Fraud Prevention and Investigation Program. The goal of this program is to reduce payment errors by establishing local programs that investigate suspected fraudulent activity by recipients of the Wisconsin Medicaid, Badger Care Plus, and FoodShare programs. Local programs may utilize private investigators, local sheriff's departments, or in-house staff to conduct investigations. OIG provides \$1,000,000 annually to seven consortia to fund the program.

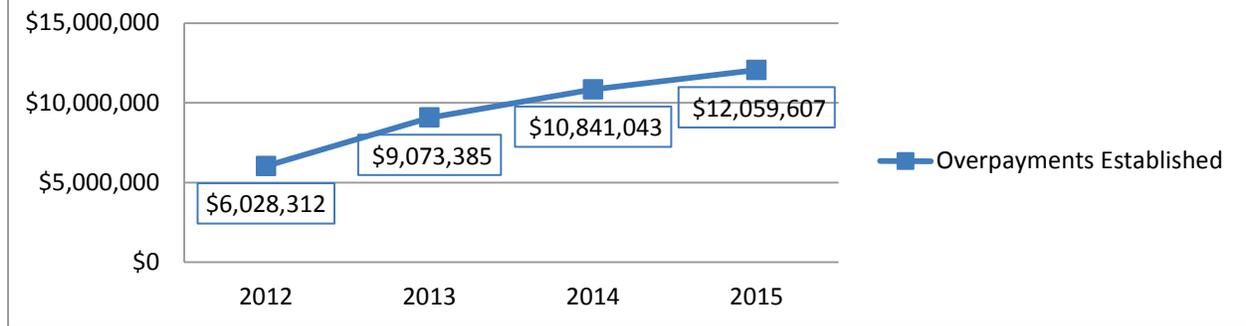
Investigations conducted by the Fraud Prevention and Investigation Program can result in case denials, reductions, and/or terminations.

In 2015, a Whitefish Bay couple was charged with public assistance fraud in the amount of \$115,000 as the result of an OIG investigation through the Fraud Prevention and Investigation Program. They were alleged to have received benefits they were not entitled to for several years. The investigation was launched after OIG received an anonymous complaint that included a copy of the couple's FoodShare QUEST card.

Measuring the performance of the Fraud Prevention and Investigation Program is based on the amounts of overpayments established and cost avoidance achieved. Overpayments established is the amount of Medicaid and/or FoodShare benefits that were determined, during a fraud investigation, to be overpaid. Cost avoidance is measured by the amount of future benefits that will be saved (e.g., benefits that we would not have to pay out in the future because we identified the fraud) as the result of the fraud investigation.



## Statewide Fraud Prevention and Investigation Program Overpayments Established

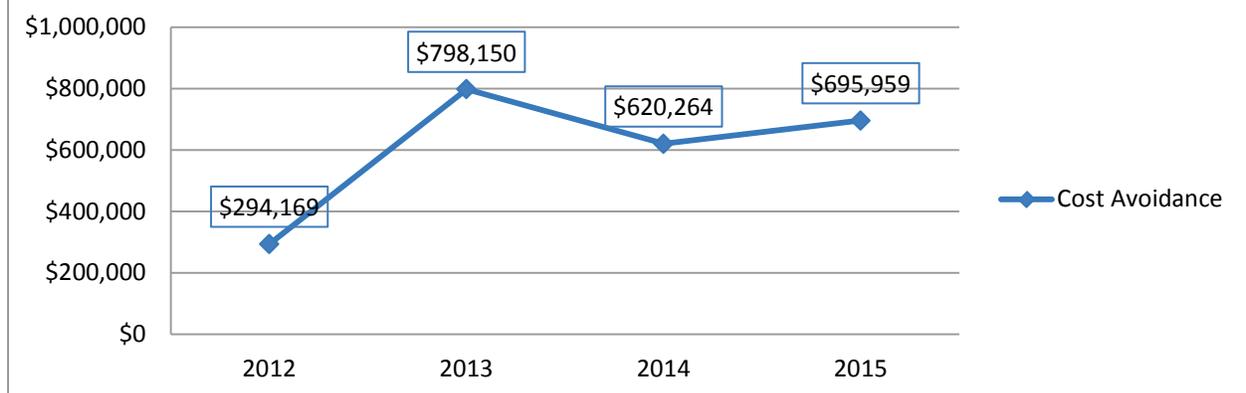


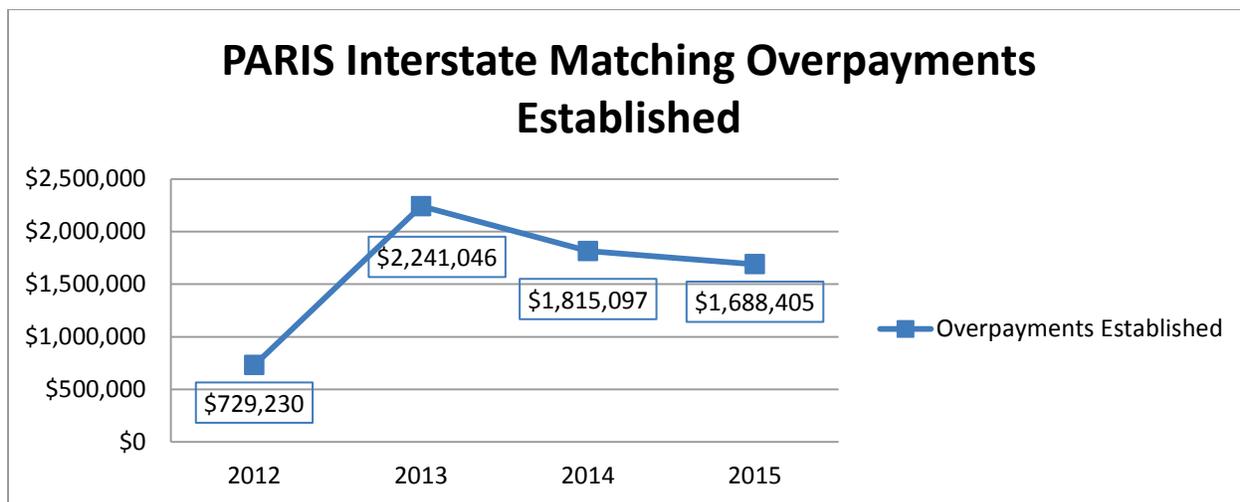
### Public Assistance Reporting Information System (PARIS)

The Public Assistance Reporting Information System (PARIS) is a federal database that matches recipients of public assistance from across the nation to determine if benefits are being received in two or more states. A quarterly file from the PARIS database identifies recipients who may be receiving benefits in multiple states. OIG staff verifies the benefit status for each individual with staff from other states. When it is confirmed that an individual is receiving duplicate benefits, an overpayment amount is determined. According to federal policy, an individual that receives duplicate benefits may be banned from the program. These investigations can result in case denials, reductions, and/or terminations.

PARIS fraud detection and prevention efforts are measured by overpayments established and cost avoidance.

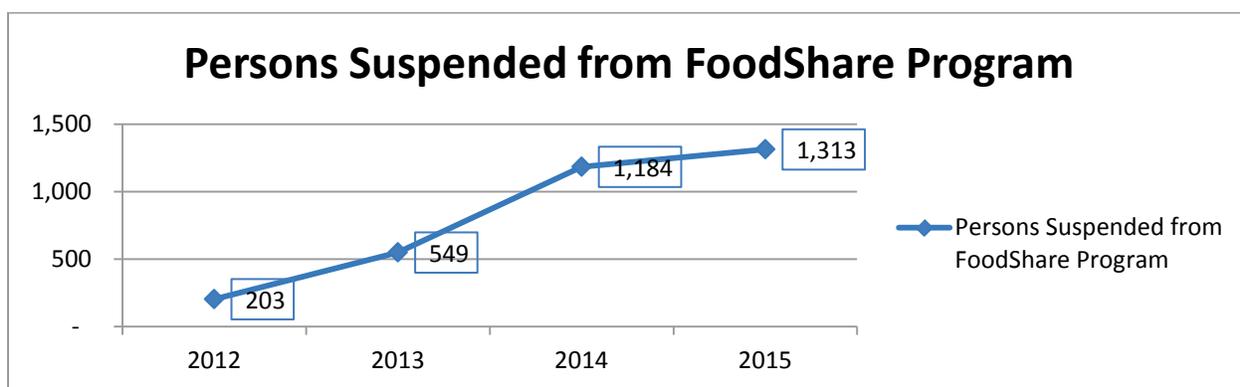
### PARIS Interstate Matching Cost Avoidance





### Detecting FoodShare Intentional Program Violations

OIG is required by federal regulations to closely monitor FoodShare program rules to detect recipients who have intentionally violated FoodShare program rules in order to fraudulently receive benefits. OIG is required by federal law to suspend recipients who intentionally violate FoodShare program rules from the FoodShare program. Since its creation, OIG has increased monitoring and training to ensure consistent application of the intentional program violation sanction policy statewide, which has resulted in an increase in intentional program violations pursued each year.



### Piloted the FoodShare Replacement Card Pilot

In 2013 OIG staff used a report to identify 1,739 FoodShare recipients who had requested six or more replacement FoodShare QUEST cards in the previous 12 months. In total, these recipients had requested 12,235 cards in 12 months. In March 2013, OIG sent letters to these recipients to explain the penalties for QUEST card misuse or trafficking. These letters also notified the recipients that if they continued to request replacement cards, OIG may conduct an investigation of their activity.

This pilot was successful. When OIG reviewed the same report in September 2013, 1,266 of the recipients that received letters in March 2013 had not requested another replacement card. In addition, the total number of replacement cards requested decreased to 800 cards in the six months after the 1,739 recipients received the warning letter.

The Wisconsin Legislature enacted legislation in 2015 to make this pilot project part of an ongoing program integrity activity for the FoodShare program.

### **State Law Enforcement Bureau Investigations**

In the FoodShare program, the state agency is responsible for investigating recipient fraud while the federal government is responsible for investigating vendor fraud—the state agency is not able to investigate detected vendor fraud. In CY 2013, OIG entered into an agreement with United States Department of Agriculture Food and Nutrition Service to conduct State Law Enforcement Bureau (SLEB) investigations of alleged FoodShare program vendor fraud. This agreement allows OIG to pursue fraud investigations that previously fell only under the jurisdiction of the USDA, and provides OIG with the tools and authority to investigate vendors who are defrauding the FoodShare Program. OIG currently has five signed agreements with SLEB and will continue to create awareness of the availability of SLEB Investigations to local law enforcement agencies throughout Wisconsin. By increasing the number of SLEB agreements, OIG will have additional tools and resources that will help improve the integrity of the FoodShare program on both the recipient and vendor side and create stronger relationships with local law enforcement agencies across the state.

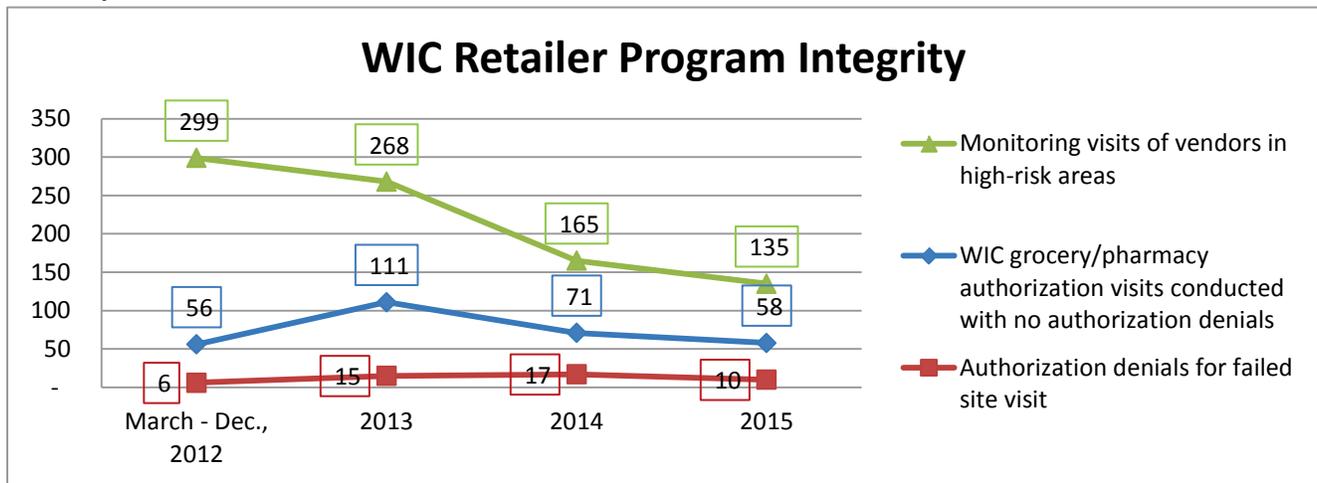
### **Monitoring WIC Vendor Integrity**

OIG is responsible for certifying and monitoring retailers that participate in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

OIG reviews and approves or denies all retailer applications to redeem WIC benefits and conducts pre-authorization site visits before certification. Approximately 1,200 retailers are certified to redeem WIC benefits statewide. OIG also coordinates regular retailer monitoring inspections in high-risk areas and conducts retailer inventory reviews and investigations to assure WIC program integrity. OIG actively seeks disqualification, corrective action (including criminal prosecution), monetary penalties, and reimbursement for retailers that violate WIC program rules.

In 2015, OIG staff, the West Allis Police Department, agents from USDA Food & Drug Administration, and the Wisconsin Department of Revenue conducted a joint operation to serve search and arrest warrants to four persons in West Allis for actions related to misusing Special Supplemental Nutrition Program for WIC benefits, illegal distribution of infant formula, and receiving stolen property.

The chart below represents the number of authorization and high-risk monitoring visits conducted annually.



### Implemented eWIC

In 2015, OIG staff played a key role in implementing the transition from paper WIC checks to an electronic benefit transfer (EBT) system for delivering WIC benefits. OIG was responsible for working with retailers to make sure they had the equipment and training necessary to make this transition as well as making sure that all eligible WIC food items had the correct coding so transactions could be completed through EBT. The eWIC project involved more than 1,240 retailers and was implemented on time and within budget.

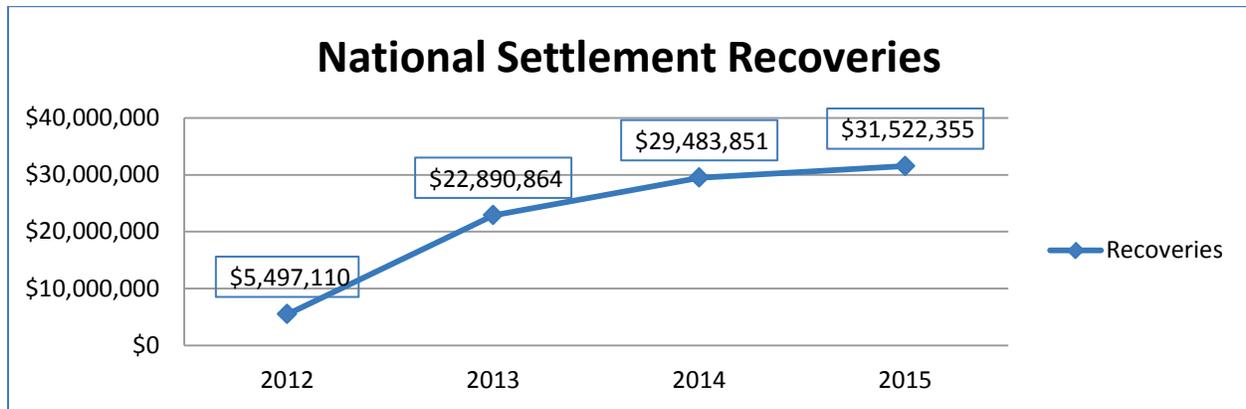
By bringing online EBT processing into the WIC program, OIG now has additional tools to improve accountability and program monitoring, reduce errors, and make it easier to detect and prevent fraud. eWIC will improve WIC processing for grocery stores, pharmacies, and WIC participants by improving customer service and reducing confusion about which items are authorized for purchase.

### National Corporation Settlements

OIG provides support and assistance to the Wisconsin Department of Justice in its pursuit of settlements with national corporations involving actions such as off-label marketing of drugs, misreported best prices impacting Medicaid rebates, and average wholesale pricing manipulations. These activities result in national companies reimbursing Wisconsin’s Medicaid program for the company’s improper actions. These are one-time payments to the Department and are funds that the Department is not able to predict when they will be received, how much the settlement will be, or how many settlements we will receive in a given year.

When the Department receives a settlement, it is deposited into one of the appropriations that support the Medicaid program. Settlement revenues have been used to fund Medicaid benefit costs and at other times portions have been returned to the General Fund.

Since 2012, approximately \$89 million has been recovered from these national settlements.



### Oversees Medicaid Provider Enrollment

There are approximately 70,000 certified Medicaid providers in Wisconsin. OIG is responsible for oversight of the initial certification of Medicaid providers as well as the re-enrollment of these providers every three years. Before becoming Medicaid certified, the provider must complete the certification process and attest to understanding the federal and state regulations, policies, and procedures.

The provider enrollment certification process serves as a safeguard that helps ensure Medicaid providers understand their responsibilities. If providers are not properly certified, the state risks disallowance of millions of dollars in federal reimbursement, risks the misuse of state dollars, and could adversely affect quality of care and recipient access to services.

### Oversees Prior Authorization for Medicaid Program

OIG is responsible for ensuring that services paid by Wisconsin's Medicaid Program are medically necessary and provided in a cost-effective manner. This is completed by requiring that certain services and products be reviewed through the prior authorization process before payment can be made for them.

Prior authorization is written permission issued by the Department of Health Services to a certified Medicaid provider before certain services can be provided to a recipient. In some instances, providers will need to get prior authorization before performing the service (for example, bariatric surgery or private duty nursing) or get prior authorization after a certain threshold has been met (for example, personal care hours). Only a small percentage of all covered services require prior authorization.

Prior Authorization is intended to:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payments.
- Assess the quality and timeliness of services.
- Determine if less expensive alternative care, services, or supplies are usable.
- Promote the most effective and appropriate use of available services and facilities.
- Curtail misutilization practices of providers and recipients.

One specific benefit area that is subject to prior authorization is personal care services.

Personal care services provide recipients with specific activities of daily living necessary to maintain their place of residence in the community. Covered services include activities such as bathing, feeding, toileting, mobility, and dressing.

Overall, personal care services are recognized at the state and national levels as one of the most problematic benefits in the Medicaid program as it relates to waste, fraud, and abuse. The Federal Health and Human Services Office of the Inspector General has identified home health care and personal care as particularly vulnerable to fraud and abuse and has focused much of the attention of its Health Enforcement Action Teams on those provider types. The number of referrals for personal care services to State Medicaid Fraud Control Units is greater than the number of referrals for any other Medicaid benefit.

Currently, Wisconsin Medicaid does not require that an independent entity assess or evaluate the prescribed personal care services. A registered nurse employed or under contract with a personal care agency, which ultimately bills Medicaid for the services, performs the assessment and submits the request for authorization of services.

The Department has identified a potential conflict of interest in allowing the personal care service agencies that provide and bill for the care to also assess the need for those services. Allowing staff who are employed by the personal care agency to perform assessments could incentivize the provider to request more services than are medically necessary.

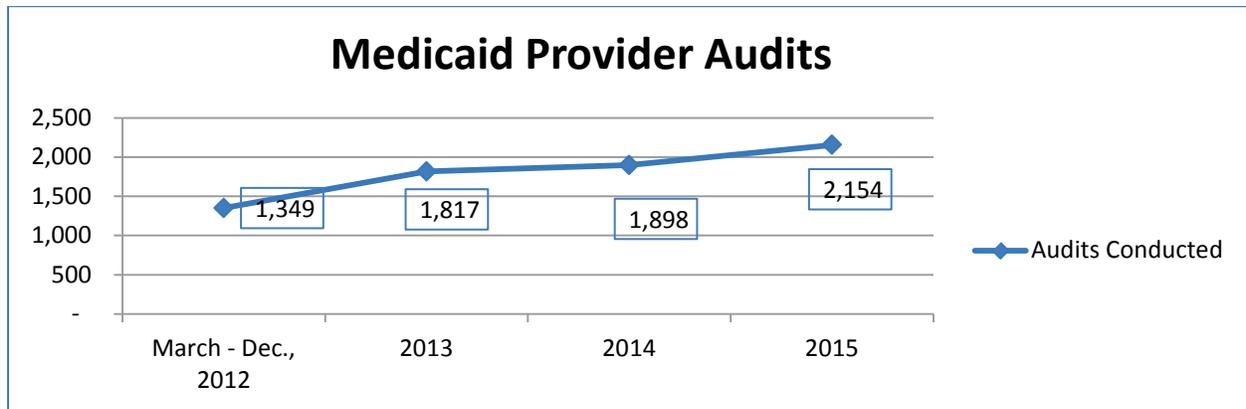
The 2015-2017 biennial budget contains a provision that will reform personal care services to Medicaid recipients by requiring an independent assessment for all prescribed fee-for-service personal care services to ensure that the right amount of care is being provided to recipients at the right time, in the right settings, and reduce fraud and abuse in the Medicaid program.

## **Conducts Audits of Medicaid Providers**

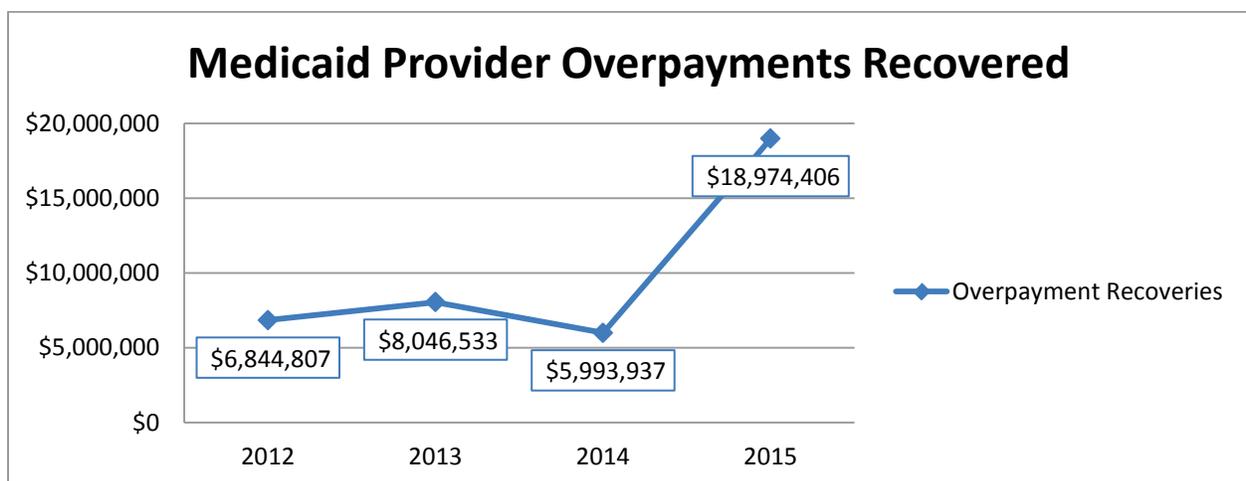
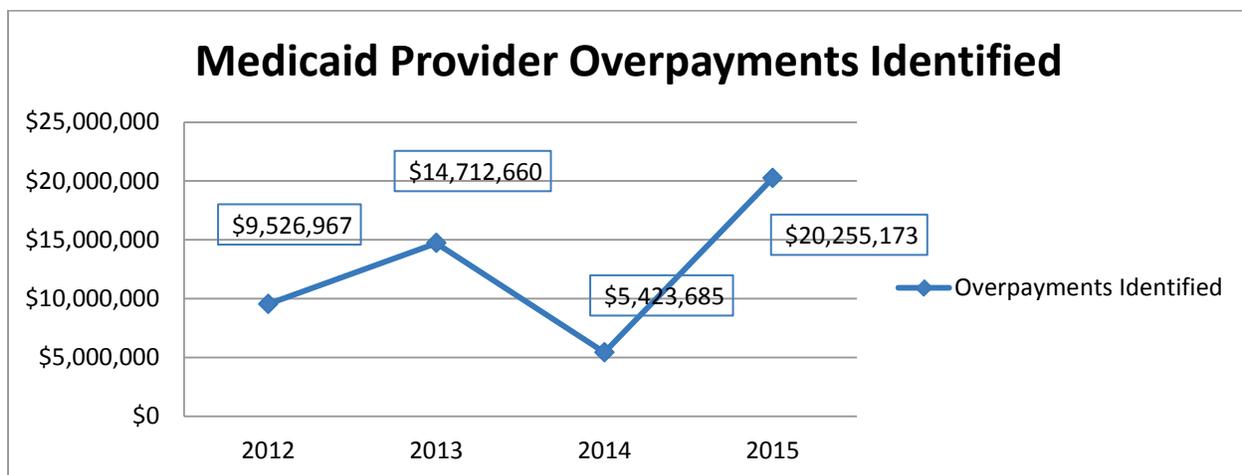
OIG is responsible for conducting audits of Medicaid providers, including:

- Auditing Medicaid providers to ensure compliance with Medicaid rules and regulations.
- Reviewing, monitoring, and researching provider billing to detect and identify potential fraud, waste, and abuse.
- Investigating allegations of fraud, waste, and abuse.
- Providing education and technical assistance to the provider community through the audit activities.
- Recommending new policies, or changes to existing policies that promote and protect the Medicaid program.

OIG conducts more than 2,000 audits of Medicaid providers annually. These audits may focus on any of the services that Medicaid provides to recipients including pharmacy, home health, personal care, physician, transportation, durable medical equipment, and therapies.



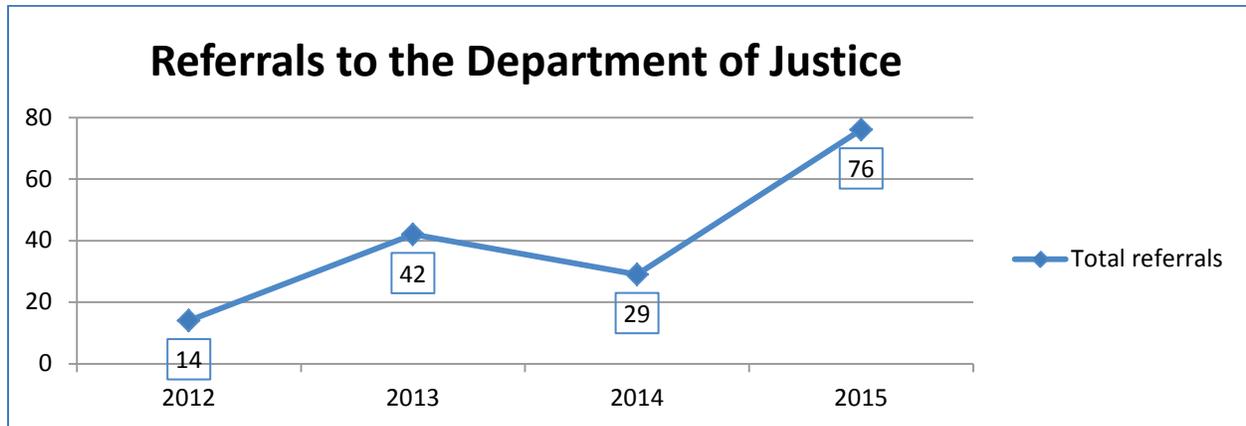
After an audit is completed, findings may show that a recoupment is necessary. The graphs below show the identified and recovered overpayments.



If there is a suspicion of potential fraud, OIG is required by federal law to refer these certified Medicaid providers to the Wisconsin Department of Justice. OIG has referred more than 160 cases since 2012.

In 2013, a registered nurse was convicted of one count of Medicaid fraud and ordered to pay \$45,786 for submitting falsified medical records and submitting false claims for payment, including submitting claims for services not provided. The nurse has been terminated from participation in Wisconsin Medicaid.

In 2011, OIG uncovered 11 providers who were submitting claims to Wisconsin Medicaid for orthotic devices for recipients who did not receive the device, nor did they have a need for it. The providers were subsequently prosecuted and received sentences from two years on probation to six years in prison and ordered to pay restitution of more than \$1.5 million.

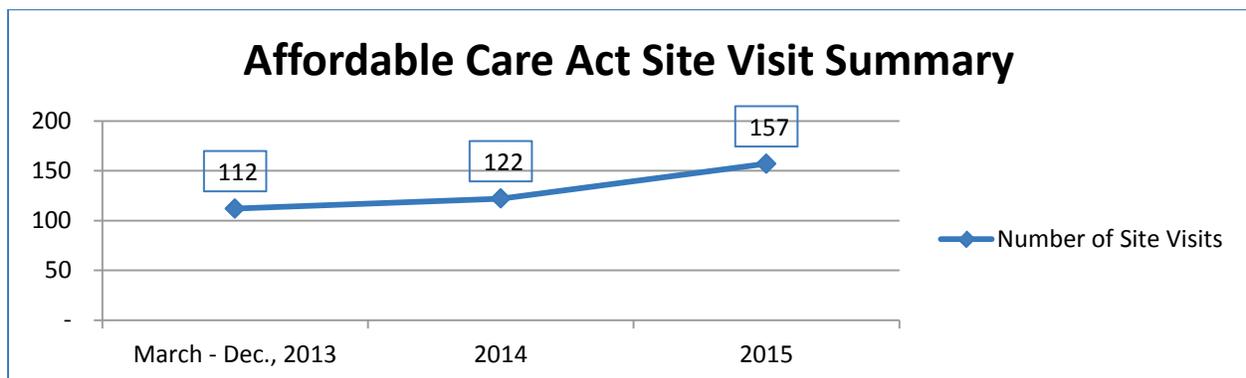


### Conducts Federally Required Program Integrity Activities

There are a number of program integrity activities that the federal government requires OIG to complete including conducting onsite provider visits, utilizing recovery audit contractors to identify and recoup overpayments, and performing audits of the electronic health record incentive program.

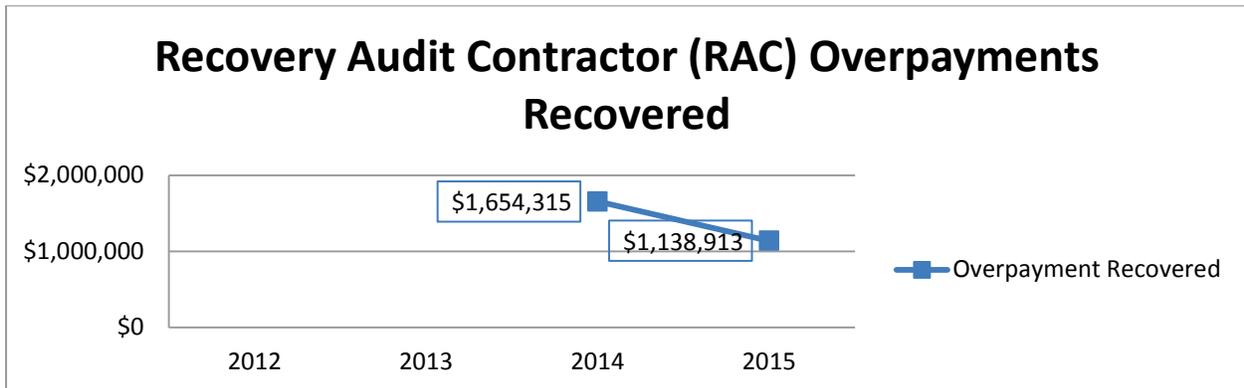
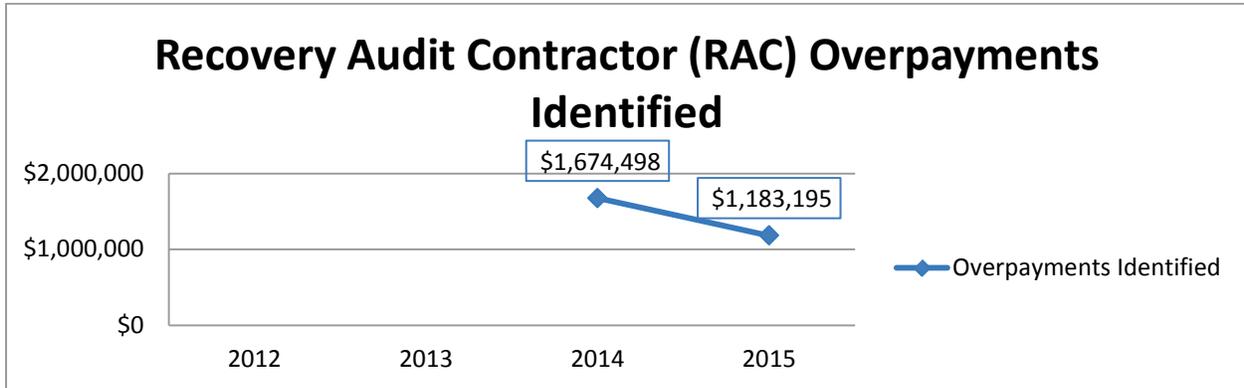
### Conducts Onsite Provider Visits

The federal Affordable Care Act requires OIG to conduct screening of providers with a moderate to high risk of waste, fraud, and abuse prior to the provider receiving Medicaid certification. While OIG does not have the authority to deny Medicaid certification based on the results of the onsite visit, OIG is allowed to determine if a provider will require close monitoring to ensure they are following the program rules. OIG also uses the visits to screen providers for potential future audits. OIG has conducted 391 onsite visits on moderate-to-high-risk providers since 2013.



### Utilizes Recovery Audit Contractors to Identify and Recoup Overpayments

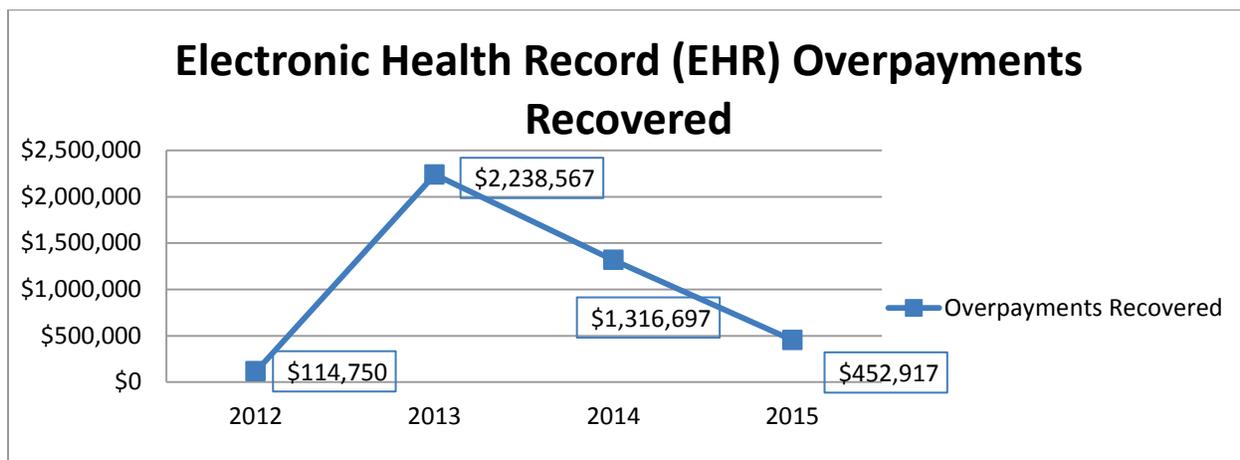
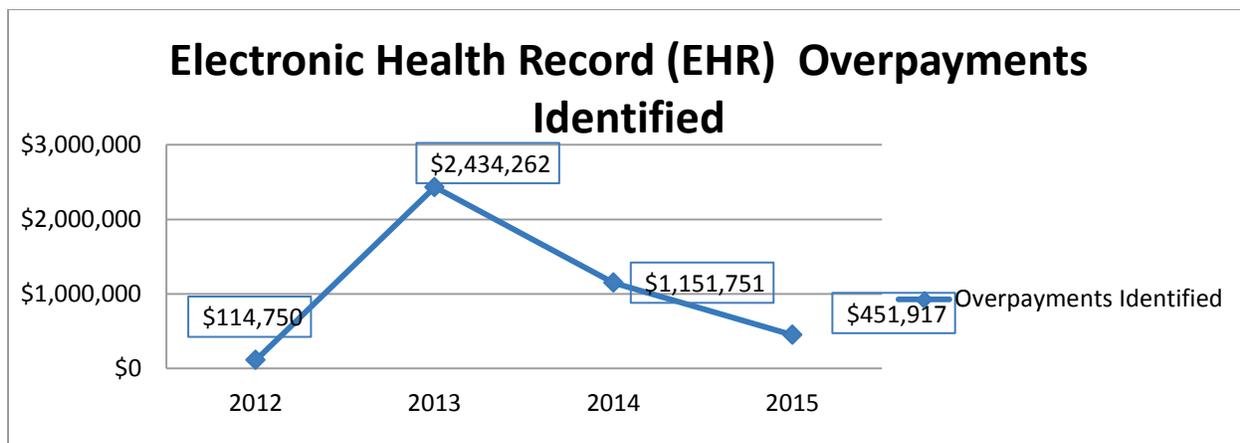
Medicaid Recovery Audit Contractors (RAC) are required by federal law and expand the Medicare Recovery Audit Contractor program to include the audit of Medicaid providers. Specifically, states are required to contract with Recovery Audit Contractors to identify overpayments and underpayments by the state Medicaid agency, and to recoup overpayments. The contractor is used as a resource extender to OIG's in-house audits. Since its implementation in 2013, Wisconsin has recovered more than \$2.5 million in inappropriate Medicaid payments.



### Performs Audits of the Electronic Health Record (EHR) Incentive Program

The federally funded Electronic Health Record (EHR) Incentive Program provides incentive payments to eligible professionals and eligible hospitals to adopt, implement, or upgrade to certified EHR technology. These incentive programs are designed to support providers in this period of health IT transition and instill the use of EHRs in meaningful ways.

OIG is required to conduct audits on behalf of the federal government to verify the federal incentive payments made to eligible professionals and eligible hospitals are in compliance with the guidelines. Approximately \$4 million has been recovered for incorrect payments since the inception of the EHR program.



## Conducts Internal Audits

OIG performs independent, objective assurance and consulting activities designed to add value and improve the Department's operations by conducting internal audits. Internal audits help the Department accomplish its objectives by bringing a systematic, disciplined approach to evaluate the effectiveness of risk management, internal control, and governance processes.

In 2015, OIG completed an investigation documenting a theft of more than \$50,000 by a former DHS employee, resulting in two convictions on eight felony check fraud charges for the former employee and her daughter. Internal controls, policies and procedures, and IT systems in the program area were strengthened as a result of the investigation.

Since its inception, OIG has completed internal audits related to:

- Vital Records System and Operational Controls Audit (2013)
- Non-Emergency Medical Transportation (NEMT) Services Procurement Process Review of Request for Proposal (RFP) #160 DHCAA-SM (2013)
- Health Information Portability and Accountability Act Compliance Assessment Report (2014)
- Assessment of Division of Quality Assurance Immediate Jeopardy Procedures—Nursing Homes for Compliance with CMS Guidelines (2014)

- Investigation of Improper Activities by a State Employee of the Wisconsin ADAP/Insurance Assistance Programs (2015); Analysis of Control Factors Contributing to Improper Activities by an Employee of the Wisconsin ADAP/Insurance Assistance Program (2015)
- Investigation of Improper Activities by a Former State Employee in the FoodShare Wisconsin Program (2015); Factors Contributing to Misappropriation by a Former State Employee within FoodShare Wisconsin (2015)

In addition, OIG completed two other confidential employee investigations in 2015.

### **Conducts Reviews of Independent Audits**

OIG conducts reviews of independent audits submitted by municipal and non-municipal agencies that the Department contracts with. OIG collects and reviews audit reports to assess whether audits meet the applicable audit standards and whether the audit reports show issues of concern to the Department. OIG reviews approximately 500 audits annually of Department contractors and sub-recipients.

### **Conclusion**

OIG appreciates the opportunity to share with you our progress since Governor Scott Walker created the Office in October 2011. This is the first of what we anticipate to be an annual report on the activities of OIG. OIG looks forward to strengthening our relationships with partners at the federal, state, and local levels, increasing the level of transparency in OIG's operations as well as enhancing our program integrity efforts through the improved use of data analytics.

## **Appendix A: Examples of the Success of the Office of the Inspector General in Preventing and Detecting Waste, Fraud, and Abuse**

- In 2013, OIG received a complaint about a Wisconsin family who was receiving health care coverage through Medicaid and did not report income from a restaurant they owned. After OIG investigated, it was determined that there was an overpayment of more than \$10,000 because the family did not meet Medicaid program rules.
- OIG also received a complaint in 2013 about a single parent and child who received health care coverage through BadgerCare Plus until OIG discovered that the minor child was living out of state with the other parent. This resulted in an overpayment of \$45,000 because the parent and child did not meet the BadgerCare Plus program rules.
- In 2015, a Whitefish Bay couple was charged with public assistance fraud in the amount of \$115,000 as the result of an OIG investigation through the Fraud Prevention and Investigation Program because they were alleged to have received benefits they were not entitled to for several years. The investigation was launched after OIG received an anonymous complaint that included a copy of the couple's FoodShare QUEST card.
- In 2015, OIG staff, the West Allis Police Department, agents from USDA Food & Drug Administration, and the Wisconsin Department of Revenue conducted a joint operation to serve search and arrest warrants to four persons in West Allis for actions related to misusing Special Supplemental Nutrition Program for Women, Infants and Children (WIC) benefits, illegal distribution of infant formula, and receiving stolen property.
- In 2013, a registered nurse was convicted of one count of Medicaid fraud and ordered to pay \$45,786 for submitting falsified medical records and submitting false claims for payment, including submitting claims for services not provided. The nurse has been terminated from participation in Wisconsin Medicaid.
- In 2011, OIG uncovered 11 providers who were submitting claims to Wisconsin Medicaid for orthotic devices for recipients who did not receive the device, nor did they have a need for it. The providers were subsequently prosecuted and received sentences from two years on probation to six years in prison and ordered to pay restitution of more than \$1.5 million
- In 2015, OIG completed an investigation documenting a theft of more than \$50,000 by a former DHS employee, resulting in two convictions on eight felony check fraud charges for the former employee and her daughter. Internal controls, policies and procedures, and IT systems in the program area were strengthened as a result of the investigation.