

18 Department Reviews of Welfare Schemes

- 18.1** The Department of Employment Affairs and Social Protection (the Department) conducts post-claim approval reviews referred to as 'control reviews' to ensure
- continued compliance with all conditions for receipt of payment
 - continued entitlement to all elements of the payment such as dependent relative.
- 18.2** Reviews can be by home visit, interview, or desk assessment based on review of the relevant file or papers. It also includes mailshot reviews and medical reviews. Costs vary depending on the method of review undertaken. The frequency of review required should generally be based on
- the level of risk inherent in the scheme
 - the risk attaching to the claimant based on their claim profile.
- 18.3** This report examines the Department's performance in implementing planned control reviews. Based on the reported outcomes of reviews undertaken, it also assesses the effectiveness of controls in three schemes — family income supplement, invalidity pension and domiciliary care allowance.

Risk rating by the Department

- 18.4** In general, schemes that are means or income based are more susceptible to fraud and error, while medically based schemes are susceptible to non-conformity with eligibility criteria. In order to assess the level of risk inherent in schemes, the Department carries out fraud and error surveys.¹ The Department uses the survey results to determine the adequacy of its scheme control strategy and whether any revision is required to its review policy.
- 18.5** The Department may also assign risk ratings to individual claims for some schemes. For example, in the case of the invalidity pension scheme, a medical review status is assigned to all new claims indicating when the claim should be next medically assessed. Examples include 'review in one year' and 'do not refer again'.
- 18.6** The Department set a target to carry out one million control reviews in 2016 and has reported that it achieved 95% of this target. Figure 18.1 provides an analysis of where the control review resources were deployed. Where a fraud and error survey has been carried out, the estimated level of excess payments associated with the schemes reviewed is shown for comparison purposes.

¹ See also Chapter 16 *Regularity of Social Welfare Payments*.

Figure 18.1 Overview of Department control reviews in 2016

Scheme	Recipient numbers ^a	Spend 2016 €m	Estimated level of excess payments ^b	Target reviews	Reviews undertaken
Child benefit	1,195,000	2,078	0.5%	317,500	322,421
Jobseekers		2,808		240,000	246,741
- Allowance	218,000		3.1%		
- Benefit	38,000		1.6%		
Illness and disability		2,733		107,700	106,865
- Disability allowance	126,000		4.1% ^c		
- Illness benefit	54,000		6.0% ^c		
- Invalidity pension	56,000		1.5% ^c		
- Domiciliary care allowance	35,000		—		
Supplementary welfare allowance (SWA)		371		170,000	88,626
- Basic SWA	18,000		—		
- Rent supplement	48,000		5.0%		
- Mortgage interest supplement	2,000		—		
One parent family	40,000	501	2.7%	53,000	64,349 ^d
Survivor's (contributory) pension ^e	121,000	1,437	0.7%	6,000	8,076
Family income supplement	58,000	415	0.5%	42,300	50,585
State pensions (including household benefits)		5,874		42,000	44,030
- State pension (contributory)	377,000		2.0%		
- State pension (non-contributory)	95,000		1.9% ^f		
Carer's payment	73,000	686	None	8,500	3,828
PRSI ^g	N/A	9,566 ^h (receipts)	None	13,000	12,695
Total				1,000,000	948,216

Source: Department of Employment Affairs and Social Protection

- Notes:
- a The recipient numbers stated refer to 31 December 2016.
 - b The net loss to the welfare system, taking account of cases where claims disallowed on a scheme are succeeded by valid claims/dependent payments on other schemes or are restored after appeal.
 - c Figures for disability allowance, invalidity pension and illness benefit include the results of cases medically reviewed.
 - d Includes 2,812 reviews of maintenance recovery payments (liable relative assessments).
 - e Widow's/widower's/surviving civil partner's (contributory) pension.
 - f The gross level of excess payment on the scheme is stated. The net loss to the welfare system was not measured when this survey was carried out in 2008.
 - g PRSI reviews include enquiries and inspections by staff of the Department.
 - h Also includes health contribution and national training fund levy.

18.7 Examination of the Department's review statistics found that

- While there was an overall target of carrying out reviews of 107,700 illness related payments, there was no target set for the number of control reviews for each scheme to be carried out by the medical review assessment section. Expenditure in 2016 on medically-based schemes (excluding carer's payments) was approximately €2.7 billion with in excess of 270,000 recipients at the end of December 2016.
- Of the 106,865 reviews completed of medically-based schemes in 2016, over 70,000 (65%) were as part of initial claim decisions, decision reviews on claims (e.g. where a claimant submits further medical evidence in support of a claim) and reviews following appeals. This means that just 35% (36,865) of medically-based scheme reviews carried out were to verify a claimant's continuing eligibility, including medical eligibility.
- Less than 1% of reviews undertaken in 2016 were in relation to the carer schemes (carer's allowance and carer's benefit) where €686 million was spent. The Department achieved less than half of its review target for these schemes. A fraud and error survey of the carer's allowance scheme is currently underway — this is the first survey of this scheme.

18.8 The allocation of review resources to schemes assessed as posing the highest control risks is an area that the Department monitors on an on-going basis. In this context, it is important to note that the Department's claim reviews consist of a number of different elements

- desk-based examinations and assessments of information available to a deciding officer and from direct enquiries (usually postal-based) with claimants
- face-to-face engagements and interviews by staff members with claimants
- on site, office-based and desk-based assessment of means and related material by social welfare inspectors and community welfare service staff and
- investigations conducted by the Department's Special Investigation Unit (SIU).

18.9 The Department stated that the nature of the review activity undertaken relates to the inherent risk assigned by the Department to the particular scheme. For example, a sample of at least 5% of child benefit claims is reviewed annually by postal enquiry. A similar level of enquiry is undertaken by post of contributory State pension claims. Higher risk schemes, such as jobseekers allowance and disability allowance, will involve an element of postal enquiry (mainly related to updating means data), desk-assessment and face-to-face engagement with the claimant, and medical assessment, as relevant.**18.10** The Department stated that it is now using predictive analytics modelling for its three main working age payments categories — jobseekers, one-parent family and disability allowance. As a result, risk-based reviews are now in place for these schemes aimed at identifying potential cases which have a higher risk of wrongful or fraudulent claiming. Each month, the models identify cases for investigation/review and this allows the Department to target investigative resources at the cases likely to have the highest return/yield in terms of control and anti-fraud savings. The Department intends to expand the use of predictive analytics to other schemes in 2018.

Scheme reviews

18.11 The control review process operated by the Department was examined for three schemes

- Family Income Supplement
- Invalidity Pension
- Domiciliary Care Allowance.

Together, the schemes accounted for approximately €1.2 billion of expenditure in 2016 as set out in Figure 18.2.

Figure 18.2 Scheme profiles 2016

Scheme	Expenditure 2016 €000	Recipient numbers ^a	Number of reviews
Family Income Supplement	415,437	58,000	50,585
Invalidity Pension	644,950	56,000	588
Domiciliary Care Allowance	133,075	35,000	71 ^b

Source: Department of Employment Affairs and Social Protection

Notes: a The recipient numbers stated refer to 31 December 2016.

b Medical eligibility reviews of domiciliary care allowance claims were suspended in 2012 and remain suspended. However, 71 claims were reviewed for other reasons.

Family Income Supplement

18.12 Family Income Supplement (FIS) is a weekly tax-free payment which provides extra financial support to people on low pay and who have children. To qualify, the applicant's average weekly family income must be below a certain amount for the family size. FIS is payable at 60% of the difference between the individual's average weekly family income and the income limit set by the Department with respect to the family circumstances.

18.13 FIS is payable for a 52 week period as long as the claimant and their spouse, civil partner or cohabitant continue to meet the eligibility criteria. To continue to receive a FIS payment after the 52 weeks, a new claim must be submitted and the applicant must continue to meet the qualifying conditions.

18.14 In the course of the examination, it was found that some claims had been automatically renewed in the years 2014 and 2015 without being subject to the normal annual checking procedures. It was noted by the examination that in one particular case, the FIS payment calculation had incorrectly included a child dependent. The child was over 18 years of age and no longer qualified to be considered for the purposes of the FIS calculation. Had the claim been subject to the normal annual checking procedures, this error may not have arisen.

18.15 Data provided by the Department indicated that, due to resource issues, 8,925 claims had been automatically renewed by the FIS Section of the Department for the period May to October 2014 and 1,710 cases had been automatically renewed in respect of a two week period in 2015. The Department indicated that the 8,925 cases selected for automatic renewal in 2014 were selected on the basis that they had been in payment for the previous three years and the variation in means over that time period was €20 or less and that the situation was therefore likely to be unchanged. The 1,710 recipients selected for automatic renewal in 2015 were selected on the basis that they had already completed and returned a renewal application form. These recipients had their FIS claim automatically renewed at the then existing rate of payment. The Department advised that all recipients automatically renewed had been written to advising them of the basis of the renewal and requesting that they notify the Department if their circumstances had changed.

Invalidity Pension

18.16 Invalidity Pension is payable to those who are permanently incapable of work because of a disability or illness and who have sufficient social insurance contributions. To qualify for invalidity pension, an applicant must have been incapable of work for at least 12 months, and be likely to be incapable of work for at least another 12 months or have an incapacity such that they are likely to be incapable of work for life.

18.17 Once a claim has been put in payment, the main change in eligibility conditions that can occur is where a recipient becomes capable of work again, and for those in receipt of a qualifying dependant allowance, there is a change in the dependent circumstances. In December 2016, over 7,000 invalidity pension claims were in receipt of an adult dependant element with almost 14,000 in receipt of a child dependant element.

18.18 The Department's procedures require that when a claim is approved for payment, a medical review status is assigned indicating whether the claim should be reviewed in the future and if so, when the review should take place e.g. review in one, two or three years or a 'do not refer' status may be assigned.

18.19 A previous examination¹ noted that 11% of invalidity pension cases randomly reviewed by the Department had been found to be no longer eligible. In response to a report recommendation, the Department accepted that all cases without any review status should be medically reviewed as soon as possible and acknowledged the need to increase its capacity to carry out medical control reviews.

18.20 In November 2015, following the completion of a fraud and error survey of the scheme, the Department revised its review policy for the invalidity pension scheme. The estimated level of excess payment (including medical ineligibility) identified by that survey was 1.5%.

¹ Chapter 20, *Report on the Accounts of the Public Services 2012*.

- 18.21** The revised review policy for invalidity pension gives priority to undertaking medical reviews, on the basis that customer circumstances in relation to meeting the medical criteria are more likely to change than other circumstances. It identifies the following allocations for medical review
- cases with a short review referral date i.e. one and two years (to account for 35% of review cases)
 - cases where the claimant is under 40 years old and cases referred by the Scheme Section (40% of reviews)
 - claimants in payment for more than two years who have never previously been reviewed (20% of reviews)
 - 5% of reviews to be drawn from the 'do not refer again' (DNRA) review status category and claims with a duration greater than nine years.
- 18.22** The examination team noted the following matters with regard to invalidity pension scheme reviews undertaken by the Department in 2016
- The Department exceeded its target proportion of priority cases for review in two risk categories — cases with a short review referral date and cases where the claim is in payment for more than two years and not previously reviewed. The Department did not achieve its target in the other two categories.
 - 588 claims were reviewed — a review rate of 1%. This represents a reduction of over 40% compared to 2012, while claim numbers have increased by 10% since then.
 - 257 of the 588 reviews were carried out by medical assessors. Of those cases, 43% were initially deemed medically ineligible. According to the Department, as at September 2017
 - 8 (3% of the medically reviewed cases) are no longer in receipt of invalidity pension
 - 7 (3%) were found eligible by an appeals officer
 - 38 (15%) have been found eligible by a deciding officer, following the submission of further medical evidence¹
 - 57 (22%) have submitted further medical evidence which has been referred to the medical assessors for an opinion.
 - Also, one out of 16 cases drawn from the DNRA review status category was deemed medically ineligible.
 - At the end of December 2016, over 9,000 cases had a medical review status requiring medical review in one or two years.
- 18.23** The previous examination noted that around 12% of cases in payment did not have any medical review status recorded. In response to the finding, the Department stated that since August 2010, a medical review status had been assigned to all new claimants and to any cases that had been medically reviewed.

¹ Social welfare legislation provides that, where a medical assessor provides an opinion in respect of a person's entitlement, the deciding officer (or an appeals officer) shall have regard to that opinion. Where a question arises as to a person's continuing eligibility for a payment, that payment remains in place while any further medical evidence is examined.

- 18.24** The Department provided data relating to 55,532 cases in payment at end-December 2016. The examination examined the last review date associated with the cases and the review status indicator given to each case at the date of that review. The analysis indicated that
- 6,805 cases had been reviewed within the time frame and another 26,957 were classified as not for review.
 - Approximately 2,900 cases were reviewed within one year of the review date indicator assigned to them.
 - In total, 4,395 out of 55,532 (8%) cases had no future review date recorded against the claim on the Department's databases.
 - 2,729 cases had no medical review status when they were migrated/ transferred from a legacy control database to the Department's medical review system.
 - 1,513 were given a review status of 'normal' or 'standard' but no review date indicator.
 - 153 cases were given a 'null' review status with no review date indicator.
 - The records indicate that approximately 4,000 of 30,262 cases registered since 2011 (13%) had no medical review status assigned. These cases had been assessed initially as medically ineligible but had been granted invalidity pension as a result of an appeal or claim review.
 - 4,081 cases were last reviewed 3 to 5 years ago but had review indicators of 2 years or less assigned to the claims.
 - 3,594 cases were last reviewed 6 to 10 years ago but had review indicators of 3 years or less assigned to the claims.
 - 6,656 cases were last reviewed 11 to 20 years ago but had review indicators of 3 years or less.
 - 73 cases were last reviewed over 20 years ago, but had review indicators of 2 years or less.
- 18.25** The examination noted that there were approximately 220 claim category/medical condition codes. The Department does not use the codes in targeting reviews at medical conditions which are deemed to pose a greater risk.

Domiciliary Care Allowance

- 18.26** Domiciliary Care Allowance (DCA) is payable to carers of children under 16 that have a severe disability that requires constant care and attention substantially in excess of that required by another child of the same age. Recipients of DCA are also automatically entitled to the annual carer's support grant and may also, subject to satisfying the qualifying conditions, be entitled to carer's allowance. Since June 2017, recipients of DCA can register their child for a medical card with the Health Service Executive (HSE).¹

¹ There may also be other entitlements available to recipients of DCA e.g. entitlements from the Department of Education and Skills such as special needs assistants in schools.

- 18.27** The rate of DCA is €309.50 per month and the scheme is not means tested. At year end 2016, there were 31,960 families in receipt of DCA relating to 34,627 children. Expenditure in 2016 was €133 million — 10% higher than the level in 2015. Both expenditure levels and recipient numbers have grown by approximately 30% since 2012.
- 18.28** Until June 2012, the Department's review policy for DCA claims in payment involved reviewing each case on a date recommended by the medical assessor. In some cases, the medical assessor recommended that the case did not require referral again (DNRA cases). The Department confirmed that the average DNRA rate between 2011 and August 2017 was 16%.
- 18.29** A claim review involved the completion of a report by the parent/guardian explaining the current care being provided as well as an up to date medical report from the child's general practitioner. A departmental medical assessor reviewed the information returned and provided an opinion on the child's continued eligibility. That opinion and a review of the other qualifying conditions were considered by a deciding officer to establish if a revised decision was warranted.
- 18.30** The Department took over responsibility for the scheme from the HSE in 2009. In case reviews carried out in 2010 and 2011, the Department found that a large proportion of claimants were no longer entitled to the allowance. A review in February 2012 of a small sample of cases that transferred over from the HSE found that 45% of the sample were ineligible. However, the Department points out that there were factors contributing to the high rate of non-eligibility found, including
- Department staff carrying out the reviews were unfamiliar with the scheme
 - inadequate time had been allowed for parents to comply with the review process
 - the results did not take account of potential outcomes of further reviews or appeals.
- 18.31** Following the 2012 review, the Minister for Employment Affairs and Social Protection established an inter-departmental review group to examine the policy objectives and the administrative, medical assessment and appeals processes for the scheme. As part of its work, the group was to research best practice in other countries and get a medical expert to review the medical guidelines. The review group comprised representatives from the Department, other relevant departments, and parent/advocacy groups, as well as relevant experts.
- 18.32** The Department's medical review of DCA cases was suspended in June 2012, pending the outcome of the review group's work. No action was taken with regard to 41 cases that transferred from the HSE in 2009 that were considered ineligible. Further action with regard to those cases was postponed until a review process was put in place for all cases transferred from the HSE.
- 18.33** The recommendations of the review group were brought to Government in April 2013 and it was agreed that the Department should implement the administrative changes recommended, with the policy recommendations to be considered in the context of the 2014 Budget.

- 18.34** Some of the key recommendations in relation to reviews of entitlement under the DCA scheme were
- a review policy is an appropriate and necessary part of the management of the scheme
 - most claims will have review dates set for a three or five year interval but it is acknowledged that it may be appropriate to review some claims in a shorter/longer time frame
 - some claims will continue to be classified as DNRA due to the severity of the child's condition and its expected duration
 - improvements implemented in relation to notice of review dates and advance notice of review should continue to operate
 - parents/guardians should receive an additional communication with 21 days' notice from the deciding officer to give them an opportunity to provide additional information before the review decision is made in cases where the deciding officer is considering terminating payment.
- 18.35** A Domiciliary Care Allowance Implementation Group was established to oversee implementation of the recommendations of the report. It has a similar composition to the review group.
- 18.36** Despite the recommendation that reviews should continue, medical reviews have still not recommenced for this scheme.
- 18.37** The delay has been attributed by the Department to a decision to await the outcome of its appeal of a High Court decision in which the Department was held to have adopted a fixed policy position in a case where the medical assessor's opinion was unthinkingly and unquestioningly endorsed by the deciding officer when refusing to grant a domiciliary care allowance application.¹ The Court of Appeal decision delivered in April 2016 reversed the earlier decision of the High Court. The finding was that while the deciding officer was found to have routinely followed the opinion of the medical assessor (an opinion to which they were statutorily required to have regard) in every (or at least almost every case), this did not mean they were adopting a fixed policy decision.
- 18.38** The Department put together a proposal for recommencing reviews in August 2016. This is being worked on by the Department in conjunction with the Implementation Group before giving final approval to proceed.

¹ B v Minister for Social Protection [2014] IEHC186.

Conclusions and recommendations

- 18.39** The Department had a target to review 107,700 illness and disability claims in payment in 2016. While just under 107,000 reviews were reported, almost two-thirds of those were related to new claims, fresh information provided to the Department or claimant appeals. Significantly fewer medical reviews than planned are being carried out.

Recommendation 18.1

The number of cases being medically reviewed each year needs to be increased due to the assessed risk associated with medically-based schemes.

Accounting Officer's response

Agreed. The Department accepts the need to increase the number of cases being medically reviewed and has invested significantly in this area. The Department has successfully appointed new medical practitioners as medical assessors and currently has 30.5 full-time equivalents, including the Acting Chief Medical Officer. In addition, a recruitment process is currently underway to ensure a panel is available to fill any vacancies arising in 2017 in order to maintain these numbers.

Medical assessor resources in 2016 were concentrated on the processing of new applications for illness, disability and caring-related schemes, against a backdrop of increased claim levels across these schemes.

Over the past six months, the Department has focussed on developing efficiencies within the Medical Review and Assessment Service, including changes to information technology. As a consequence, the number of people awaiting a medical opinion at claim stage for the Department's long-term schemes has fallen from over 10,000 at the end of April 2016 to less than 2,000 at September 2017. This has facilitated the Department to allocate additional medical assessors to complete control reviews.

- 18.40** 4,395 (8%) of invalidity pension cases at the end of 2016 had no medical review status/ future review date assigned to them. The Department uses medical review status for risk categorising claims. In the absence of a medical review status, those cases may potentially never be selected for review. Even when a review status was assigned, it was evident that cases were not reviewed within the planned time. Significant delays were noted, such as around 10,000 cases due for review within three years that had not been reviewed for at least five years and in many cases, for ten years.

Recommendation 18.2

All files should have a medical review status (including 'do not refer again', if appropriate) and a process should be started to update the files. The Department should consider whether greater use could be made of the medical condition codes (of which there are 220 recorded in the system) to target reviews of claimants with medical conditions that are subject to change.

Accounting Officer's response

Agreed. The Department accepts that the absence of medical review data should not result in the exclusion of any cases from the Department's control activities and undertakes to profile both the 2,729 cases which were migrated from the legacy PENLIVE system and the 1,666 cases on MRCM with no review date, who do not have a DNRA review type recorded, to ensure they are not excluded from the Department's control activities. This profiling exercise will be completed by the end of 2017, with sample cases liable for review from then onwards.

While the examination has highlighted the absence of review dates in respect of certain invalidity pension cases, the absence of these dates does not necessarily mean that these cases would have been excluded from the Department's control activities. The criteria used to identify cases for medical review require 35% of medical review cases to be selected by review referral dates, the remainder are selected by reference to, variously, the age of the claimant and the duration of claim.

As part of the project to move illness benefit from the legacy IT system (ISTS) to the Department's BOMi platform (due for completion by April 2018), the Department's medical assessors have amalgamated the current incapacity codes and mapped them to ICD-10 codes¹ with a view to optimising the use of medical information to target reviews as quickly as possible.

The Department has continued its regular engagement (via individual and group practice visits and presentations at medical events) with medical practitioners and has provided guidelines, education and a GP-specific booklet about the Department's schemes and their conditionality. The Department has also engaged with the Irish College of General Practitioners and the Irish Medical Organisation around the introduction of diagnosis coding and closed certification and it is expected that the more accurate coding of diagnoses on medical certificates will facilitate more targeted reviews of claims in payment.

- 18.41** Due to resourcing issues in the Department, over 10,000 FIS claims were automatically renewed in 2014/2015 without being subject to the usual checking procedures. There is a risk that some claimants may have received a benefit to which they were not entitled because of the automatic renewal.

Recommendation 18.3

Where normal controls are bypassed and claims are automatically renewed, the Department should take additional steps to reduce the risk of erroneous payments occurring.

Accounting Officer's response

Agreed. The improvement in FIS claim processing times since 2015 means that a recurrence of the circumstances which resulted in the decision to automatically renew some FIS cases are unlikely to arise again. All FIS payments are now fully reviewed on a yearly basis.

¹ International Statistical Classification of Diseases and Related Health Problems 10th Revision – World Health Organisation.

18.42 With the exception of new claims which are medically assessed at the outset, no medical reviews of domiciliary care allowance cases have taken place since mid-2012. In general, the only cases to have left the scheme in this period are cases where the child reaches age 16. At 31 December 2016, 31,960 families were in receipt of domiciliary care allowance for 34,627 children (9.5% increase from prior year).

18.43 Although a 2013 working group recommended an appropriate control policy and procedures be developed for the domiciliary care allowance scheme, this has not been completed.