



Wisconsin Department of Children & Families

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Wisconsin Shares Child Care Assistance Manual Chapter 2: Program Integrity



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Chapter 2: Program Integrity

County, tribal and W-2 agencies are responsible for preventing and correcting improper payments, establishing and collecting overpayments, and determining which clients and providers shall be referred for overpayment, to the fraud investigation provider, and/or to the District Attorney's office for criminal prosecution. These responsibilities encompass eligibility, authorizations, attendance reporting, and all other activities related to the expenditure of Wisconsin Shares benefits.

2.1.0 Prevention

Prevention of improper payments is crucial to reducing the number and size of potential overpayments. By having a successful Front End Verification process and using data exchange matches, agencies can reduce both potential overpayments as well as the workload associated with them.

2.1.1 Front End Verification

The targeted fraud prevention program involves a process of intense scrutiny of specific elements or circumstances of individual cases or child care providers that exhibit evidence or characteristics of potential program violation. The process is called Front End Verification (FEV). This is intended to prevent issuance of incorrect benefits and involves more in depth verification than verification for eligibility determination.

It is recommended that agencies establish an error-prone case profile for child care cases. Use it to determine if an application, review, or change is proper for FEV. An error-prone case profile is a list of characteristics recognized as common in error-prone cases. Review and update the error-prone case profile periodically to show potential errors that are relevant and cost effective to use.

Following are some "high risk" or relevant characteristics for child care that agencies should use in their FEV reviews.

1. Questionable reporting of earned or unearned income including inadequate verification.
2. Contradictory information or information provided is incomplete or unclear.



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3. Fraud committed or alleged previously by client or child care provider.
4. Questionable reporting of household composition.
5. Questionable approved activities.
6. Close financial or family relationship between parent and provider or employer.

When a FEV referral is made, the eligibility determination may be delayed by 7 working days from the date of the FEV referral. Document the reason for the referral in the case file.

Make referrals for FEV in the CARES system on Screen BVIR (See the CARES Guide, Chapter 9.2.1). This is tracked in the CARES Benefit Recovery subsystem.

2.1.2 Data Exchanges

Child Care case data, goes through data exchanges on CARES. CARES data is exchanged with other automated databases maintained by Federal, State and other agencies. Data is exchanged to verify demographic data, income, eligibility data, and eligibility status. These data exchanges serve to primarily help ES and W-2 workers verify income and eligibility factors. These help to avoid error in issuing benefits.

Matches are periodically initiated on CARES by programs utilizing specific selection criteria and match targeting criteria. Matches serve as a backup tool to detect cases where overpayment of benefits are likely to have occurred. Data Exchange matches do not substitute client's responsibility to accurately and timely report changes. This allows verification and recovery action to be taken.

Agencies are required to examine data exchange information on a timely basis to determine if an overpayment has occurred.

2.2.0 Fraud & Intentional Program Violation (IPV)

A potential fraud situation occurs when an allegation contains information that a recipient is engaging in, or has engaged in conduct that places his/her eligibility for a benefit or level of benefit in question. The allegation usually claims that the recipient has failed to comply with the program eligibility criteria.



Three critical fraud indicators are:

1. Reluctance or refusal to provide needed information about income, resources, or relevant eligibility factors.
2. Failure to report change in eligibility circumstances.
3. Falsified documentation of income or approved activity.

2.2.1 Client Fraud

Some examples of client fraud are:

1. Collusion with the child care provider to receive undue payments. This may also be provider fraud.
2. Concealing or intentionally not reporting income.
3. Submitting false information which if known would result in a decrease or discontinuance of the child care benefit.
4. Concealing circumstances or a change (including hours of care needed for the approved activity), which if known, would result in a decrease or discontinuance of the child care benefit.

Example. Marcia, the absent parent, returns to the household. She is able to care for the child. Because she is able to care for the child, the household no longer needs child care. But Peter, the primary person, did not report the change in the household to the child care worker.

If the investigation shows client fraud and sufficient evidence to support the allegation in a hearing, the agency should assess an Intentional Program Violation (IPV) finding. This finding is in addition to establishing an overpayment.

For an IPV to be established, 1 of the following must occur:

1. IPV or conviction of fraud is found in a Court of Law.
2. Administrative hearing found IPV.
3. Client signed IPV waiver of Administrative Disqualification Hearing form (DES-10797).



Enter the W-2 IPV strike on AISA in CARES.

After 3 separate findings of IPV, the AG is ineligible for further child care benefits.

This provision does not end eligibility until after the 3rd IPV occurrence. After 3 separate IPV findings, the agency shall permanently deny payments to the entire AG.

2.2.2 Provider Fraud

Agencies and the State have the authority to pursue any entity in a civil or criminal action, which receives funds to which it is not entitled. Agencies are required by Wisconsin Administrative Rule (DWD 56.04(5)(b)) to take all reasonable steps necessary to recoup or recover from a provider any overpayments made for child care services.

Some examples of provider fraud are:

1. The provider knowingly reported hours of attendance greater than the actual hours of attendance in order to receive a higher payment.
2. The provider reported the child in attendance at their authorized location when the child was elsewhere.
3. The provider knowingly neglected to report when a child was no longer in care in order to continue receiving payment for that child.

2.2.3 Inaccurate Attendance Reports

If a provider submits false attendance reports, the child care agency may take one or both of the following steps:

Stop issuing new authorizations to the child care provider until the provider submits accurate attendance report.

Stop processing attendance for the provider until the provider submits accurate attendance reports.

If a provider has been paid on the basis of questionable attendance reports that later prove to be false, the agency must recover the overpayment and may at their discretion:



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Suspend the provider from the Wisconsin Shares program for a period of 6 months or

Convert all authorizations to a licensed provider to attendance-based.

A notice must be sent to the provider before taking either of these actions.

2.3.0 Overpayments

2.3.1 Client Overpayments

Agencies administering child care shall take all steps necessary to recoup or recover, from the parent, funds paid to the child care provider when the parent was not eligible for the level of benefits paid.

There are 3 types of overpayments:

1. **Client/Provider Error.** The client or provider report incorrect information or fail to report information. Intentional Program Violation is not established.
2. **Administrative Error.** Overpayment results from agency or system error. The agency commits an error or the system calculates an authorization or payment amount for more than the client was entitled. Can only recover 12 months prior to discovery of the overpayment. The original Overpayment Notice date is the date of discovery.
3. **Intentional Program Violation.** The client or provider willfully reports information or fail to report information in order to receive more benefits, and as a result is found guilty of IPV by the court, administrative disqualification hearing, or by signing the Waiver of Administrative Disqualification Hearing form (DES-10797).

Recover an overpayment from the client when they receive benefits for which they were not eligible such as:

1. The authorized amount of child care would have been less due to inaccurate reporting of income. Consider the excess amount paid to be the overpayment.



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2. The parent was absent from a W-2 approved activity without good cause, while the child was in care. The FEP determines good cause on a case by case basis.
3. There would not have been eligibility if income, household composition, the need for child care or the household composition had been accurately reported.
4. A change in income, the need for child care, or household composition was not reported within 10 days of the change and the change would have resulted in a lesser benefit received.
5. Generally, when the worker did not act upon reported information or entered incorrect information into the CARES system that resulted in an eligibility related overpayment.

Example. After eligibility was determined, the parent started a second job working 14 hours per week. The parent failed to report the job until the next review. At the review, it was determined that the parent was still eligible for child care, but a higher copay should have been used in the authorization calculation.

Example. At the time of authorization, the parent reported having a schedule that varied from 15 to 40 hours per week. The authorization was made based on attendance for 45 hours per week. The worker later found out that the parent typically worked 30 hours and ran household errands for the remainder of the time.

Example. The parent reported a raise in income that was greater than \$250.00 per month but the worker failed to act upon the information. The child was in care during the overpayment period.

Because of the unique ways of calculating child care subsidies, CARES does not produce a worksheet to mail to the client along with the notice of overpayment. You must complete and mail to the client a worksheet showing how the amount of the overpayment was calculated. Use the [Child Care Overpayment Worksheet \(DES-11192\)](#).



2.3.2 Provider Overpayments

Agencies shall take all reasonable steps necessary to recoup or recover, from the provider, any overpayments made for child care services.

Recover an overpayment from a provider when they have received payment for care they did not provide or when operating outside of regulation:

1. The provider recorded incorrect hours of attendance which caused an overpayment. This applies to both enrollment and attendance based authorizations.
2. Generally when the worker entered incorrect authorization or provider information or failed to act on reported information resulting in an authorization related overpayment.
3. The provider did not report to the local agency when a child stopped attending day care.
4. The provider was not properly regulated during the hours for which attendance was paid (e.g. license was suspended, had more children in care than the regulation allowed, care occurred at a location other than the authorized location, etc.).

Example. The provider accidentally reported 30 hours of attendance instead of 20 hours of attendance on an attendance-based authorization.

Example. The worker issued an enrollment-based authorization of 50 hours for a school-aged child that should have been for only 20 hours.

Example. The parent has decided to change providers. The provider knows the child will no longer be in attendance but fails to notify the agency or indicate the termination on the attendance form.

Example. The parent reports changing providers. The worker issues a new authorization for the new provider but fails to end the authorization for the previous provider.



2.3.2.1 Providers who are Over Capacity

The Child Care Subsidy authorizes payment and issues reimbursement for regulated care. This helps ensure the safety and well being of children that are served by Wisconsin Shares. Providers that are out of compliance with their regulation may be subject to overpayments for the period in which they were out of compliance as they are not considered properly regulated during that period.

If a provider is found to have more children than their regulation allows, they are considered to be out of compliance for the period of time that they exceed capacity. When determining the overpayment, consider all children in care at the time that the provider is over capacity to be improperly authorized. Whenever possible, use the actual hours that the provider is over capacity. For partial hours, if the amount is 30 or more minutes round up to the nearest hour. Request copies of the providers sign in/sign out attendance logs if needed.

If the provider does not have the times that children signed in and out available, consider the entire day that the provider was over capacity to be an overpayment.

Share the information with regulators so that appropriate regulatory action can be taken.

Calculating the Overpayment:

For Attendance Authorizations – Determine the number of hours that the provider was over capacity. During these hours, consider all children who are authorized on an attendance basis to be overpaid.

Example: Mary Jones is a Regular Certified provider. On April 12, she had seven children in care between 10:00 am and 1:00 pm. Two children were authorized and reported as attending for the full day. One child was authorized and reported as attending from 8:00 am – 12:00 pm. Overpayments for three hours each at the child's "effective rate" would be calculated for the two full day children. Another overpayment for two hours would be calculated for the subsidy child who attended in the morning.

For Enrollment Authorizations – Determine the number of hours that the provider was over capacity for the week. During these hours, consider all children who are authorized on an enrollment basis to be potentially overpaid. For each child with an enrollment authorization:

- ❖ Determine the number of hours that the child was in attendance during a period the provider was over capacity.



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- ❖ Subtract this number from the hours authorized to calculate the revised payable hours allowable for that week.
- ❖ If the original authorization is 35 hours or less, calculate the difference between the original authorized level and the new payable hours allowed and multiply the difference by the effective hourly rate to determine the overpayment for that week.
- ❖ If the original authorization is greater than 35 hours, calculate the payable hours allowed for that week.
 - If this amount is less than 35, subtract the payable hours allowed from 35 and multiply the difference by the effective hourly rate to determine the overpayment for that week.
 - If this amount is 35 hours or more, there is no overpayment due since the payable hours allowed still represent a full time authorization.

Example: Linda Smith is a Licensed Family provider who was over capacity from 2:00 pm – 5:00 pm on October 12. Jeff and Mary are subsidized children with 35 hour/week enrollment authorizations and attended all day on October 12. David is a subsidized child with a 45 hour/week enrollment authorization and attended all day on October 12 including the hours that the provider was over capacity. Jeff and Mary both have payable hours of 32 hours due to the over capacity and thus have 3 hours x the hourly rate as their overpayments. David payable hours of 42 hours and thus has no overpayment since he is still over 35 hours (full time).

If School Bank Hours were claimed for the child during the week, the first hours identified for overpayment will be the school bank hours. These hours are calculated at the agency hourly rate rather than the effective hourly rate.

2.3.2.2 Providers Claiming Attendance Outside of Regulation

Providers who claim attendance for children during times that they are not regulated or at a location that is not authorized/regulated are considered to be out of compliance with their regulation for the time period in which this care occurred. Payment for attendance outside of regulation is an overpayment.

Calculate the overpayment using the same method as in 2.3.2.1.

Care outside of regulated hours: Identify the children who were cared for during unregulated hours and the associated hours of attendance. All hours reported that were outside the hours allowed by the provider's license or certification are considered to be overpayment hours.



Example: Sue Jones is licensed to provide care from 6:00 am to 6:00 pm. Her sister, Mary Jones, works from 3:00 to 11:00 pm and Sue provides care for her children from 2:30 to 11:30 pm. In calculating the overpayment, consider the hours from 6:00 to 11:30 pm (5 ½ hours) to be overpayment hours.

Care at a location other than the authorized location: Identify the children and associated hours that were cared for at an unauthorized location. All hours reported that took place at an unauthorized location are considered to be overpayment hours. This does not include organized field trips.

Report all instances of children being cared for outside of regulated hours or location to the regulating agency (County Certifier or DCF/Bureau of Early Care Regulation).

2.3.2.3 Establishing Overpayment Claims for Providers

Agencies must make efforts to establish all claims within 30 days of discovery of the overpayment.

Because of the unique ways of calculating child care subsidies, CARES does not produce a worksheet to mail to the provider along with the notice of overpayment. You must complete and mail to the provider a worksheet showing how the amount of the overpayment was calculated.

2.3.3 Determine Overpayment Period

Determine what weeks are overpaid based on if the overpayment began at the time of application, or at some time during an ongoing case. When information that makes a group ineligible or eligible for a lesser benefit is not reported at the time of application, the overpayment begins with the date that benefits were first issued.

When you receive information that makes a group ineligible or eligible for less benefits during an ongoing case, the overpayment is calculated from the 1st full week an incorrect overpayment occurred.

For client overpayments, use BVRF to make the initial overpayment referral in CARES (See Chapter 9.1.0 in the CARES Guide). Use BVCL to enter the overpayment claim (see Chapter 9.3.3 in the CARES Guide).



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For provider overpayments, enter the negative adjustments in CSAW for each affected week and authorization. CSAW will update the CARES BV system and the provider overpayment information will display on BVCO.

Example. A family has been receiving child care assistance continuously. At a review on 05-28-08, the worker learns that the parent received a raise starting with his 03-26-08 paycheck. The raise was \$75 per week and should have been reported within 10 days. The family is still eligible for child care, however the copayment should have been \$20 per week more. The payment is reduced by \$20 a week beginning the week of 06-01-08.

The 1st full week after the change is 03-30-08 through 04-05-08. This is the 1st week of the overpayment. The worker calculates the amount overpaid from 03-30-08 through 05-31-08. She enters the referral period on BVRF as 03-01-08 through 05-31-08.

Example. A family began receiving assistance on 12-15-07. At a review on 5-28-08 the worker learns that the parent received a raise starting with the 3-24-08 paycheck. The raise makes the family ineligible for child care. The worker ends the authorization effective 6-01-08. Because the parent failed to report the change timely, there is no 10 day notice to the parent nor the provider.

The first full week of the overpayment is 3-30-08. The overpayment referral period is 3-30-08 through 5-31-08.

Determine the client overpayment based on the weeks when no payment or a lesser payment should have been made if the correct information would have been used when making the payment or authorization.

2.3.4 Recovery of Client Overpayments

Recover client overpayments by using a repayment agreement. Negotiate the monthly amount of the repayment with the client.

Negotiate this amount so that the claim will be repaid in equal installments within three (3) years or less. The monthly amount of the repayment agreement for persons in W-2 Trial Jobs may not exceed the monthly subsidy paid to the employer.

All clients for whom an overpayment has been calculated are required to complete and sign a repayment agreement.



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Once the repayment agreement has been completed, put the data on BVPA in CARES. CARES will send the client a benefit recovery notice.

In the event of unsuccessful collection efforts and after the 3rd dunning notice, the Department will begin centralized collection efforts. Tax intercept and wage garnishment may be used to obtain repayment of delinquent claims.

Repayments for delinquent claims may also be collected through the use of the Department of Revenue (DOR) Tax Offset program.

2.3.5 Recovery from Providers

All overpayments made to providers must be collected, whether due to error or fraud. The collection method depends on the provider's status in CSAW. CSAW will send an adjustment notice when a positive or negative adjustment is entered.

For situations where an authorized provider cares for children, and later it is discovered that technically the client was not eligible or entitled to that service, do not penalize the provider for giving care in good faith. In these situations, pursue recovery from the ineligible client.

For all providers (active and inactive), record the overpayments by entering the amount of the negative adjustment in CSAW for the specific authorizations and weeks for which the overpayment took place.

Recovery will occur in one of the following ways depending on the providers status:

1. If the provider is active and has a current authorization that they are receiving payment for, CSAW will deduct 50% of the provider's future payments until the negative adjustment has been satisfied.
2. If the provider is not active and/or is not receiving payments, the negative adjustment will be automatically referred to the benefit recovery (BV) system in CARES and the repayment agreement process will begin.

The definition of an inactive provider for recovery is as follows:

- a. Have not received payments at any location for the past 6 weeks, and
- b. Do not have any special payments outstanding, and
- c. Do not have any open authorizations against which attendance can be logged for the past 6 months, and



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d. Do not have any attendance that is yet to be paid.

When the recovery process is outside of CSAW, use the Child Care Cash Collections/Repayments CORE Profile #9006 form (DES-11087), to record the collection. Retain the collection and forward the form to the DCF Finance Bureau on a monthly basis. DCF records the collection on CORE and reduces the agency payment accordingly.

Submit the completed original form plus 2 copies of the Child Care Cash Collections/Repayments CORE Profile #9006 along with the reimbursement claim form to the DCF Finance Bureau by the end of the month following the month of collection. Address information is at the bottom of the claim. Do this by the end of the month following the month of collection. Additionally, enter the repayment amount in CSAW using the Provider Overpayment Returns screen.

2.4.0 Fraud Referrals

Fraud referrals are issued either by the agency or the Department to the local or state investigator. A fraud referral directs the investigator to conduct an investigation where there is documented information to suspect that a program violation occurred. An identification of inconsistencies or errors is needed to refer the case to a fraud investigator for further analysis.

Where the W-2 agency and the ES agency are different, and there is suspected fraud on a case that involves all programs, both agencies need to establish, with their investigative service that 1 referral is received jointly from the W-2 and ES agency.

When a fraud investigation is made on a regulated child care provider, the appropriate regional Bureau of Early Care Regulation or certifying agency must be notified of the referral. Notify these agencies of any further action taken on the fraud referral. The revocation of a license or certification is a separate action which may or may not be the result of a fraud referral.

A fraud investigation is an in-depth analysis that may involve a review of an entire case file as well as an examination of the particular elements that caused the review. The investigation is directed toward determining the accuracy of fraud allegations and the intent to commit fraud. The investigation may lead to prosecution or disqualification.



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The time from the date of the fraud referral to the date the fraud investigator's initial report is delivered should be 90 calendar days or less.

The decision to refer to the district attorney is the agency's responsibility. Use the information provided by the investigation report to help make the decision to refer for prosecution. Referral to the district attorney must meet the following criteria:

1. The misrepresentation or concealment was done knowingly and deliberately.
2. The purpose of the misrepresentation or concealment was to get child care funding to which the person was not entitled.
3. Had the facts been known to the agency, the child care funding would have been denied, discontinued, or reduced.

2.5.0 Appeal Process

Clients who believe that an agency decision regarding any component of Child Care is incorrect may request a fair hearing through the Division of Hearings and Appeals within 45 days of the agency's decision.

Providers who believe that an agency decision relating to a child care authorization, payment or overpayment can request a fair hearing through the Division of Hearings and Appeals. For active providers, CSAW will continue to recover the overpayment during the appeal process by reducing issuance by 50%.

2.6.0 Confidentiality & Routine Disclosure

Adhere to DCF confidentiality policies. Do not unnecessarily divulge any information about the client, provider, or reasons for the investigation. Agency records and data are confidential and shall be open to public inspection or disclosure only to the extent required by state or federal law.

Agencies may disclose information from the record to any official conducting an investigation, prosecution, or civil proceeding in connection with administration of a DCF program to the extent necessary. The official must submit a written request to obtain the information. The request must include the identity of the person requesting the information, his/her authority to request, the violation being investigated, and the person being investigated. Do not apply this restriction to the district attorney or the fraud investigator.



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Agencies are encouraged to coordinate child care benefit recovery efforts. In most cases, agencies which centralize the benefit recovery functions with one person or work unit are encouraged to have that person or unit perform the child care benefit recovery function as well.