Wisconsin Shares Child Care Subsidy Program

Policy Manual – Chapter 4
Program Integrity

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Division of Early Care and Education

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Acronyms

AE – Administrative or Agency Error
ALJ – Administrative Law Judge
BECR – Bureau of Early Care Regulation
BELP – Bureau of Early Learning and Policy
BPI – Bureau of Program Integrity
BRITS – Benefit Recovery Investigation Tracking System
BV – Benefit Recovery Subsystem of CARES
BVCC – Case Comments screen in BV
BVCI – Claims for an individual screen in BV
BVCL – Overpayment Claim screen in BV
BVCO – Claims for Child Care Providers screen in Benefit Recovery
BVIR – Investigation/ verification referral screen in BV (Read Only)
BVIT – Investigation/ verification Tracking and Findings Screen in BV (Read Only)
BVPA – Client Repayment Agreement screen in BV
BVPI – Post Outcome Information for Investigation Screen in BV (Read Only)
BVPP – Child Care Provider Repayment Agreement in Benefit Recovery
CARES – Client Assistance for Re-employment and Economic Support
CC – Child Care
CCAP – Consolidated Court Automation Programs
CE – Client Error
CRES – Central Recoveries Enhanced System
CSAW – Child Care Statewide Administration on the Web
CWW – CARES Worker Web
DCF – Department of Children and Families
DECE – Division of Early Care and Education
DXQW – Data Exchange Query
DHA – Division of Hearing and Appeals
DOR – Department of Revenue
EBT – Electronic Benefit Transfer
EBT CSAW – EBT Child Care Statewide Administration on the Web
ECF – Electronic Case File
EOS – Enterprise Output Solution
EVFE – Employment Verification Form of Earnings
FEV – Front End Verification
FIP – Federal Improper Payment
FIS – Fidelity Information Services
IPV – Intentional Program Violation
IRS – Internal Revenue Service
LFAM – Licensed Family Child Care Provider
LGRP – Licensed Group Child Care Provider
MECA – Milwaukee Early Care Administration
NPL – Notice Prior to Levy
OLC – Office of Legal Counsel
PACU – Public Assistance Collection Unit
PARIS – Public Assistance Reporting Information System
PE – Provider Error
PLBC – Post Load Benefit Correction
POS – Point of Sale Device
RPA – Repayment Agreement

SISO – Sign-in/ Sign-out Attendance Sheets
SUITES – State Unemployment Insurance Tax Enterprise System
SWICA – State Wage Information Collection Agency
TA – Technical Assistance
TCR – Targeted Case Review
WebI – Web Intelligence
WI – Wisconsin
YS – YoungStar

4.1 Bureau of Program Integrity Overview

The Bureau of Program Integrity (BPI) within the Division of Early Care and Education (DECE) develops and leads the Department of Children and Families (DCF) statewide child care program integrity efforts. BPI upholds the policies and procedures for the Wisconsin Shares program. BPI operates on five guiding principles.

1. Prevention
    - Ensure that all preventative elements of the program are being upheld across state and local agencies. This process includes eligibility determination, child care authorizations, provider applications, and/or local agency verifications and approvals.

2. Detection
    - Maintain a variety of data and reports to detect potential red flags that may require further Technical Assistance or investigation. These specific items are flagged weekly, monthly, or quarterly to identify and/or unusual activity.

3. Investigation
    - Audit and investigate matters that appear to be in violation of Wisconsin Shares and YoungStar policies and regulations. Investigations will be initiated by specific referrals reported to BPI or through Red Flag Reports that trigger concern for further monitoring.

4. Sanction
    - Assess and establish appropriate penalties for any violated policies discovered during an investigation. Enforcement actions are communicated with an explanation of the evidence and consequence(s).

5. Collection
    - Establish overpayments and transaction reversals if Wisconsin Shares funds were issued or used inappropriately. All Wisconsin Shares payments issued in error or used inappropriately *must* be recovered.

4.1.1 Achievement of Goals and Principles

Working in conjunction with local agencies and tribes, BPI adheres to and achieves these five guiding principles through a multitude of processes.

1. Prevention
    - Provide technical assistance (TA) to local agencies on program integrity efforts
    - Require and review local agency fraud plans
    - Implement program integrity checkpoints through eligibility, authorization, and post authorization processes

- Detection
  - Participate in the production and investigation of PARIS Reports
  - Lead the production of the Federal Improper Payment (FIP) Report
  - Identify and review Targeted Case Reviews (TCRs)
  - Develop and utilize various monitoring reports (such as Red Flag Reports)

- Investigation
  - Conduct client and provider investigations
  - Provide guidance on investigation procedures to local agencies and tribes
  - Investigate potential overpayments and Intentional Program Violations (IPVs)

- Sanctions
  - Monitor and establish IPVs
  - Determine and issue sanctions to clients and providers who commit Wisconsin Shares violations
  - Provide guidance on sanction creation and determination to local agencies
  - Approve all permanent suspensions and IPVs

- Collection
  - Enter overpayments for investigations completed by BPI
  - Track investigation appeal outcomes
  - Collaborate with DCF Public Assistance Collection Unit (PACU)

Local and tribal agencies are contractually responsible for identifying discrepancies in client-reported information at eligibility and authorization determinations, preventing and correcting improper Wisconsin Shares subsidies, establishing and collecting overpayments, and determining which client cases will be referred for overpayment and which cases will be referred for fraud investigation or to the District Attorney's office for criminal prosecution (as established in Child Care Contract Scope of Services Exhibit 1). These responsibilities encompass eligibility, authorizations, YoungStar, and all other activities related to the expenditure of Wisconsin Shares subsidies.

Note: Section 49.155 of the Wisconsin Statutes, Chapters DCF 101, 201, 202, 250 and 251; of the Wisconsin Administrative Code; and Chapter 4 of the Wisconsin Shares Child Care Policy Manuals provide authority, guidance, and direction as it relates to program integrity efforts for the Wisconsin Shares and YoungStar programs.

PART A: CLIENT PROGRAM INTEGRITY

4.2 Prevention

The Program Integrity Prevention program involves a review of specific elements or circumstances of individual cases that exhibit evidence or characteristics of potential program violation(s). Prevention actions are intended to inhibit issuance of incorrect benefits, and commonly involve more in-depth verification than the routine verification used for program eligibility determination.

The primary goal of prevention is to ensure accurate benefit issuance, rather than to identify client errors and/or accomplish criminal prosecution. The results of the program integrity prevention activities are used in determining subsidy eligibility and determining the need for further fraud control actions.

4.2.1 Front End Verification

Front end verification (FEV) is one method of fraud prevention. FEV is a process of additional scrutiny of cases that exhibit characteristics of potential program violations or errors. FEV focuses on particular elements or circumstances of a specific case, as defined by their agency's Error-Prone Profile (EPP) (see 4.2.1.1). When a case is referred by an agency worker for a FEV, the identified agency worker (whether an authorization worker or FEV investigator) performs a more in-depth verification than the routine verification for eligibility determination. The identified agency worker will confirm or verify the accuracy of information provided by the client at application, review, or time of a change. The investigator will then provide the eligibility staff with their results for use in verifying eligibility for program services or for fraud investigation referrals when applicable.

FEV occurs during any application, review or change submission. If the results uncover an error, the worker must take the appropriate action to deny or pend eligibility and/or the authorization, and possibly assess sanctions, up to and including overpayments and intentional program violations.

Note: Authorization workers may also complete FEV activities, per agency discretion. Eligibility and authorization workers have the authority to request that the client submit additional materials to verify their information if the provided documentation or information is questionable. BPI encourages eligibility and authorization workers to pursue this course of action before referring a case for FEV by an FEV investigator. The FEV process should be made available for authorization workers to pursue after initial verification requests are made or if a worker continues to have program integrity concerns, per agency discretion.

4.2.1.1 FEV Error-Prone Profile

Agencies must establish an Error-Prone Profile for use by all intake staff and program eligibility workers to determine which criteria meet the requirements for an FEV referral. Measure all cases against the error prone profile in a consistent manner to avoid biased selection for FEV.

An Error-Prone Profile (EPP) is a list of characteristics recognized by the local agency as common to cases containing errors typically resulting in overpayments. Cases demonstrating two or more of these characteristics should be referred for FEV. The EPP allow the agency to allocate administrative and investigative resources to those cases according to their potential for error.

The agency's EPP should be evaluated annually to determine if they are properly identifying error-prone cases. The recommended target is 30% of cases referred to FEV would result in a referral for fraud investigation. If the EPP does not meet the 30% target, the agency should remove individual EPP characteristics as needed. This revision process will ensure relevance of the EPP.

The following characteristics must not be used as part of an EPP:

- Race
- Color
- National Origin
- Ethnic Background
- Sexual Orientation
- Religion
- Age
- Political Belief
- Disability
- Association with a person with a disability
- Marital Status

4.2.1.2 Criteria for an Error-Prone Profile
The following are examples of "high risk" characteristics that may be helpful in the development of an agency's EPP.

4.2.1.2.1 Required Criteria
The following criteria are required to be on an agency's EPP. These have been identified as frequent identifiers of fraudulent activity:

1. Reported income does not coincide with IRS, Wage Match, SWICA, DXQW, SUITES, or State Tax Forms
2. Questionable presence of an absent parent/spouse in the household
3. Questionable shared placement or custody arrangement
4. Client works for or is related to the requested child care provider
5. Past overpayment, IPV, allegation, or conviction of fraud in a government program
6. Multiple hardship requests in a year
7. Client has provided contradictory information or made statements inconsistent with information provided by him/her during a previous contact, in the application form, during a review, or change
8. Case previously was referred for FEV which resulted in either denial or reduction of benefits
9. Improper use of EVFEs such as multiple EVFEs submitted rather than paystubs, W2 Wage and Tax Statements, or tax documents

4.2.1.2.2 Residence Criteria

Suggested error-prone residence indicators include:

1. Conflicting documentation or verification differing from that reported by the applicant
2. Recent arrival (within the prior three months) in the agency's area (exclude migrant farm workers and the homeless)
3. Highly mobile families who rarely stay in one location for more than two or three months (except migrant farm workers and the homeless)

4.2.1.2.3 Household Composition Criteria

Suggested error-prone indicators for household composition include:

1. Household reports large increases or decrease in household size or a frequently fluctuating household size
2. Unusual or questionable household composition
3. Landlord is the absent parent, friend, family or ex-spouse of the applicant
4. The landlord's address is the same as the client, but the landlord is not listed as a household member
5. Employable household members listed on the application, and then later reported as having moved
6. Collateral contact statement is inconsistent with the client's statement of household size
7. Client reports someone else pays the rent for several months, but that person is not listed in the home

4.2.1.2.4 Income Criteria

Suggested error-prone indicators for income include:

1. Quarterly income significantly greater or less than reported income
2. No prior state wages reported after 6 months of working
3. No new hire reporting
4. Client reports zero income and claims that someone else pays the bills
5. Suspicion of unreported income
6. Paycheck stubs and/or EVFEs appear fraudulent or modified

4.2.1.2.5 FEV Referral Steps

Agency staff may initiate the FEV referral in BRITS on the referral screen. To procedure for an FEV referral is as follows:

1. Conduct the client interview for eligibility and compare case characteristics to the Error-Prone Profile.
2. Specify any error-prone reason(s) of concern and refer the case using the Front End Verification filter in the BRITS referral.*
    a. In the referral, provide specific information on why the case is being referred (this may be done in the comment field).
3. Adjust or deny eligibility after receiving the results of FEV prior to the final determination. The applicant will be contacted and given an opportunity to

resolve discrepancies between the information s/he provided and the information obtained through FEV.

4. Determine any benefit savings resulting from FEV and enter this in the Post Investigation Screen in BRITS.

**Note: Eligibility and/or authorization workers may attempt to gather this information prior to requesting an FEV. An FEV referral should be requested if the any of the general criteria are met, or if the worker has additional program integrity concerns that were not resolved through the additional documentation provided by the client.*

4.2.1.2.6 FEV Specialist Functions

FEV Specialist Functions can be performed by any agency employee or contracted service provider(s). It is recommended that an agency have a minimum of one staff assigned to complete FEV tasks and a trained staff to serve as backup.

The FEV specialist tasks may include:

1. Verify that a case meets the criteria for an FEV referral. If it does not, the FEV specialist should close the referral.
2. Determine which FEV activities are appropriate for the referred case.
3. Estimate the approximate time needed to perform FEV activities. When possible, complete FEV activities prior to the issuance of benefits.
4. Verify the information that prompted the referral.
5. Report the results of the FEV to the agency supervisor who will notify the eligibility worker and/or supervisor of the findings. These individuals should take any necessary action
    a. If the FEV results show a possible prior fraudulent overpayment, include that information in the report.

4.2.1.3 Front End Verification for Authorizations

At the time of authorization, additional consideration shall be given to ensure that the authorized hours are for the appropriate duration, and that the authorization would not put the child care provider in violation of licensing, certification, or subsidy regulations (For licensing, certification, and subsidy requirements, see the Wisconsin Shares Child Care Policy Manuals Chapters 1 and 2).

If an authorization is likely to result in an agency or client error, do not issue or re-issue the authorization. This should be determined by reviewing and verifying the clients' documents and all information used to complete the authorization.

The local agency has the authority to:

- Refuse to issue new child care authorizations
- Require the client to clarify or correct a concern prior to issuing the authorization, (DCF 201.04(5)(c)(1)
- Revoke an existing authorization (DCF 201.04(5)(C)(2))

Additional information on requirements for creating a child care authorization may be found in the Wisconsin Shares Child Care Policy Manual Chapter 2.

4.2.1.3.1 Agency Refusal to Open an Authorization

The child care administrative agency may refuse to issue an authorization to a client if:

- The client is attempting to transfer child care to a new provider mid-month without proper notice or approval (see Chapter 2.2.13 for details).
- The client has not verified all necessary information within the eligibility time line.
- The client has been suspended from the Wisconsin Shares program, (see 4.5.4.3).

4.2.1.3.2 Authorization Utilization

To assist with utilization monitoring efforts, agencies should monitor the Expunged Funds Report. These reports detail cases in which funds have aged off of the EBT cards after not being utilized for the 90-day period. If cases are identified, the agency should perform a detailed review. This includes, but is not limited to: interviewing the parent and/or the provider, and completing employment verification. The authorization should be adjusted if it is discovered that the parent(s) do not require as many funds as are being issued to the card.

Note: Funds are used by the client in a last in-first out system, meaning if a parent receives their subsidy on March 1, and their following month's subsidy balance on April 1, the remaining March funds will not be accessible until the April funds have been utilized. See Chapter 3 for additional details.

4.2.2 Parents who are also Child Care Providers

Parents who are also licensed or certified child care providers may not receive Wisconsin Shares authorizations for their own children. If a provider requires child care, they must apply for and receive a waiver. The waiver authorizes care for the provider's child(ren) at another provider. The waiver request shall be in writing on the form provided by DCF (DCFR-432-E). The waiver shall be granted or denied by the local agency within 10 business days of receipt of the completed waiver application. Waivers must be granted for individual children under the following circumstances:

- The parent/provider is a foster parent.
- The parent/provider is a kinship care relative with a court order for placement and is receiving a kinship care benefit for the child.
- The parent/provider is a legal guardian receiving subsidized guardianship payments for the child.
- The child has a special need and the child's parent/provider is unable to care for the child at the provider's own home or group center, as verified by a physician or other qualified medical professional.
- The child's parent is a dependent minor parent who is enrolled in high school or a course that is approved by the state superintendent of public instruction for granting a high school graduation equivalency and resides with a person who is considered a parent and also a child care provider.

The waiver may be granted in the following scenario, but additional criteria must be met.

- The parent is requesting child care assistance to do an activity in s. 49.155(1m)(a), Stats., other than providing child care. This does not apply to certified providers who are not allowed to hold outside employment. Require the activity to be outside the hours or operation with proper verification, as established in 201.04(2j)(6).

Note: For any questions about granting a waiver, please contact BPI (DCFBPITArequest@wisconsin.gov).

4.2.3 Agency Fraud Plans

Local agencies are required to annually submit an Agency Fraud Plan for review to the BPI. The submission of the annual Fraud Plan to the Department is required by the annual Child Care Contract Scope of Services Exhibit 1. The Scope of Services requires that the Fraud Plan identify agency operations, outline procedures and show responsibility for ensuring program integrity as required under the Child Care Fraud Plan Guidelines. Under the contract, local agencies must follow all policy and procedural requirements in s. 49.155, DCF 201, and the Child Care Policy Manuals Chapters 1-4.

4.2.3.1 Subcontracting

Under the terms of the Contract, local agencies may subcontract for all or part of the required program integrity activities. The local agency is responsible to ensure that subcontractors are following all required fraud investigation and overpayment procedures as required by s. 49.155, DCF 201, and the Child Care Policy Manuals Chapters 1-4.

4.2.4 Technical Assistance

The BPI provides Technical Assistance (TA) to all agencies on all aspects of the integrity process. The BPI will assist local agencies and tribes, and offer TA. Local agencies may contact BPI directly with program integrity questions, clarifications, and concerns.

BPI will:

- Make TA resources available on the SharePoint
- Make Wisconsin Shares data reports accessible on WebI
- Offer program integrity trainings
- Offer customized trainings for local agencies
- Speak one-on-one with local agency staff

Note: To receive TA, please contact BPI via the TA Mailbox (DCFBPITArequest@wisconsin.gov).

4.3 Detection

4.3.1 Referrals

Referrals are a formal request for an investigation of suspected fraud on the part of clients, providers, or both. Agencies must develop procedures for how referrals are received, processed, and substantiated. All client referrals and investigations should be recorded in BRITS.

Please send all fraud referrals through the appropriate channels (such as the fraud mailbox). Do not send referrals directly to BPI staff.

Note: The Department has the authority to issue referrals pursuant to: DCF 250.12(1), and 251.12(1), Wis. Admin Code.

4.3.1.1 Screenings

BPI encourages agencies to develop an internal screening process for determining which referrals should be closed prior to investigation, or opened for a full investigation.

4.3.2 Data Exchanges

CARES data is exchanged with other automated databases maintained by Federal, State and other agencies. Data is exchanged and verifies that demographics, income, eligibility criteria, and eligibility status is accurate. These data exchanges serve to primarily help workers cross reference information to verify income and eligibility factors. These help to avoid error in issuing benefits.

Agencies are required to examine data exchange information on a timely basis to determine if an overpayment has occurred. Data Exchange Reports to review for referrals include State Wage Income Collect Agency (SWICA), also known as State Wage Records.

Note: SWICA matches are generally listed on the monthly EOS report and on the CWW Dashboard that identifies discrepancies in data between SWICA and CWW. SWICA discrepancies may identify any bonuses, commissions, or overtime that the client may not have reported to the local agency. This income impacts the client's eligibility, and therefore warrants an investigation.

4.3.3 Red Flag Reports

Red Flag Reports are systematically-generated reports that identify potential errors. Each report identifies a set list of criteria that have been flagged for review. Agencies should utilize these reports as a source of referrals for further review. The client red flag reports are located in WebI.

Examples of client red flag reports:

- Atypical Parent Schedule Report [Unusual Parent Schedule]
- Second, third shift, weekend care and shared placement [Multiple Providers]

- Children with authorizations higher than 50 hours
- Two or more uses of the hardship policy per year [Hardship]
- Previous IPV issuances by Wisconsin Shares or other public assistance program (listed in BRITS and CWW)
- Low authorization utilization [Expungement Report]
- Three or more card replacements in a year [Lost or Stolen Card Report]
- Children authorized to multiple providers [Multiple Providers Report]

4.3.4 Public Assistance Reporting Information System (PARIS) Report
The PARIS report is a quarterly report that displays information for individuals who are receiving benefits in FoodShare, Wisconsin Shares, Badgercare, and/or TANF in multiple states. The PARIS report helps to identify individuals who are not eligible to receive child care, due to the fact that they are a resident of a different state (who originally claimed to be a resident of WI), or a resident of Wisconsin who is also identified as receiving the same benefits in another state. Cases identified as fraudulent receive a sanction as described in Section 4.5.

Agencies are required to investigate cases sent to them for review as a result of a PARIS report. Agencies should follow established procedures and timelines for completion.

Note: Quarterly assessment of PARIS reports will soon be a BRITS function.

4.3.5 Federal Improper Payment Report
Every three years, BPI must submit the Federal Improper Payment (FIP) Report to the federal government. This report documents how the Child Care Development Funds (CCDF) is being spent, and what program integrity efforts are being implemented to protect the funds.

Agencies are required to cooperate with Department staff to identify and correct any discovered errors. Agencies may be required to complete a corrective action plan in order to prevent future errors of the same manner.

4.3.6 Targeted Case Reviews
Targeted Case Reviews (TCRs) are reviews of local agency eligibility and authorization determinations. TCRs are completed on a quarterly basis and consist of a random sample of cases from local agencies.

Agencies are required to correct any discovered errors. Agencies may be required to complete a corrective action plan in order to prevent future errors of the same manner.

4.3.7 Audits
Additional audits may be performed by BPI to further support the agencies in removing errors from the Wisconsin Shares program, and to recognize their accomplishments in correctly completing case eligibility and authorization processes.

Agencies are required to correct any discovered errors. Agencies may be required to complete a corrective action plan in order to prevent future errors of the same manner.

4.4 Client Investigations

Client investigations determine whether a client is receiving a benefit that they are not eligible to receive, or if the client has violated any Wisconsin Shares policy. Local agencies should have an established process for completing client investigations. It is recommended that local agency complete client investigations within 30 calendar days once assigned.

4.4.1 Evidence and Tools

Client investigations should result from a BRITS referral that identifies a reason for review. The fraud investigator will analyze documents, case files, and policy to determine whether a client is receiving subsidy funds that they are ineligible for (overpayment due to agency error or client), and whether they have submitted false information or materials to the Department or agency to obtain, maintain, or maximize the subsidy funds. All of the investigation materials and tracking should be maintained in BRITS.

4.4.2 Information to Verify for the Investigation

There are various types of errors and evidence investigators should seek to gather during an investigation. Several examples of evidence to gather and sources to consult are described below.

4.4.2.1 Questionable Employment

If the referral was created due to notification that the client is no longer participating in their approved activity, verify that the client's wages reflect this for the referral period. Please note that investigators are not limited to the following actions:

1. Check wages in DXQW or SUITES.
    a. Determine if the client is self-employed.
    b. View the Electronic Case File (ECF).
    c. Review income related notes and case summary details.
    d. Verify a signature was collected at the most recent eligibility interview.
2. Verify employment.
    a. Mail an Employment Verification Form of Earnings (EVFE) and a Request for Information Letter*.
    b. Verify that the work number provided by the client is the employer's accurate phone number.
3. Verify that child care was utilized and paid for during the time period in question.
    a. If child care services were not utilized or paid for, an overpayment should not be assessed, and the case can be closed in BRITS. Document the closure reason in the BRITS comments section.

Note: Contact BPI via the Technical Assistance Mailbox if the agency requires these forms.

4.4.2.2 Questionable Household Composition

If there is an investigation questioning household composition, investigators may utilize the following resources to verify household composition. Investigators are not limited to the following actions.

1. Conduct a home visit and a client interview (preferably recorded).
2. Request a copy of the lease.
3. Verify with other programs if the members listed in their household are the same as on the child care case.
4. Conduct surveillance.
5. Request a copy of the utility bill.
6. View public records such as voting history, social media, and CCAP.

4.4.2.3 Questionable Need for Child Care

For a referral inquiring whether a client required child care (either because they were not working during the hours attended, or there was another eligible household member available to provider care for the child), investigators may utilize the following resources to verify the need for child care. Investigators are not limited to the following actions.

1. Verify the parent's work schedule. Compare against the provider's Sign-in/Sign-Out (SISOs) Forms to see if the child was in care during the parent's work schedule.
2. Verify the previously excluded parent or individual filling the parent role was not available to provide care when the child was in care. Employment verification can be utilized for this.
3. Verify hours of work and shift (if questionable).

4.4.2.4 Fraudulent Documents

In cases in which fraudulent documents have been submitted by the client, investigators may take any of the following actions (but are not limited to):

1. Possible fraudulent documents:
    a. Leases
    b. EVFEs
    c. Pay Stubs
2. Contact the landlord to determine accuracy of the lease.
3. Verify household composition using CLEAR, Credit Reports, or Voting Records.
4. Verify EVFE and/or pay stubs with the employer.
5. Conduct a client interview.

4.4.3 Data Tracking Requirements

Agencies must maintain records of the total number of client investigations completed as well as the types and amounts of errors that were the result of investigations. This information will be tracked and monitored in BRITS. See section 4.5.8 for more details.

4.5 Sanctions

The sanctioning process allows Department and local agencies to establish the appropriate penalties for any discovered violations. The authority for these actions is established under 49.151, 49.152(1), and 49.195, Wisconsin Statutes and DCF 101.21, DCF 101.23 and DCF 201.04(5)(a), Wisconsin Administrative Code.

Sanctions include (but are not limited to):

- Overpayments (for Administrative Error, Client Error, and Intentional Program Violations)
- Intentional program violations (IPV)
- Referrals for criminal prosecutions

4.5.1 Overpayments

Overpayments are issued when a client received a benefit for which they were not eligible. Overpayments may be a result of: Administrative Errors, Client Errors, and/or Client Intentional Program Violations (IPV).

The Department, local agencies and tribes shall take all reasonable steps to recover any overpayment made due to administrative error, client error, or intentional program violation, as established in DCF 201.04(5)(a), when the client was not eligible for the level of subsidy received.

The client is liable for all overpayments and sanctions described in 4.5 unless otherwise noted.

4.5.1.1 Establishing a Client Overpayment

The Department and local agencies shall establish all client overpayments. Claims for incorrect payments due to an intentional program violation or client error may be established for up to six (6) years prior to the notification date of the overpayment, also known as the date of discovery (893.43, Wisconsin Statutes). Administrative error overpayments may be established up to one year after the date of discovery. The claim ends the month the error last occurred, and extends back 12 months or when the error first became effective, whichever is most recent. The overpayment period for a non-client error cannot begin more than 12 months prior to the notification date of the overpayment (DCF 101.23).

All client overpayments should be entered in to Benefit Recovery (BV) within 30 days after the overpayment has been determined. Overpayment notices will be systematically generated by BV, however manual notices must be sent to the client as well (see section 4.6.1.2 for additional details).

4.5.1.2 Overpayment Calculations

To calculate an overpayment:

1. Determine Overpayment Period
2. Verify funds have not been recovered from the provider for the same overpayment period.

3. Apply Credits.

4.5.1.2.1 Overpayment Period

The overpayment period must be established with a begin and end date. The overpayment period depends on whether:

1. The change was reported timely or untimely (see 2.2.13), or
2. The client presented false information at the time of the application, review, or notice of change.

Timely reported changes will not result in an overpayment. Any timely reported changes that result in a reduction in subsidy amount will not be applied in EBT CSAW until the first of the next month. This includes instances in which an individual is no longer eligible or if their circumstances in their case have changed. See 4.5.1.2.1.1.3 for adverse action directions.

Untimely reported changes that result in an alteration or end to eligibility or an authorization should begin on the date of change and end on the last day of the current month. In income cases where the date of change is unknown, the begin date should be from the pay check that placed the client over or above the reporting requirements.

Example: Mary has an authorization for her daughter. On November 10, Mary and Ted were married. The agency discovered this December 15. The change was not reported timely [Mary had 10 calendar days to report her marital status change]. Therefore, an overpayment would be assessed from the date of change on November 10 through the last day of the current month (December 31).

4.5.1.2.1.1 Overpayment Period Exceptions

There are three circumstances in which the general untimely reported overpayment guidelines are not applicable. These include:

1. Incorrect Information at Time of Application or Review
2. Unreported Income Change
3. Adverse Action

4.5.1.2.1.1.1 Incorrect Information at Time of Application or Review

If a client has presented incorrect information and/or fraudulent documentation at application or review, the overpayment begins on the first day of the authorization and the ends on the last day of the current month.

Example: Melissa and Ted have been married since 2014. On April 7 2015, Melissa applied for Wisconsin Shares and purposefully did not disclose that she was married. This was discovered in August 2015. An overpayment (and IPV) would be assessed from the date of application, in this case April 7 2015 through, the last day of the current month (August 31 2015).

4.5.1.2.1.1.2 Unreported Income Change

In instances in which a client fails to report an increase in income that is over $250 per month, there are two possible options for the overpayment begin date.

- If the increase in income occurred in the prior month, but did not cause the client to go over the income reporting requirement until the following month, the overpayment should begin with the first of the month (for the month that was over income).
- If the increase in income occurred in the same month, the overpayment should begin on the date of the check issuance that put the client above the $250 reporting requirement.
  Note: The begin date is the date of receipt of income, not the first date of the pay period.

If the date of change (date of raise, increase in income, etc.) is not known, default to the second option above. The overpayment end date for both options would be the last day of the current month.

Example (First of the month): John is budgeted for an AG size of 3 for $2500. John receives a raise at work in May. He does not report this to the agency. The agency becomes aware of the income change in August. John receives his first paycheck with the raise on June 10. He receives his second check with the raise on June 24. His second June check puts him above the $250 per month increase in income reporting requirement. John's overpayment will begin on June 1 through the last day of August (the month in which the overpayment was discovered).

Example (Check Issuance): Tom is budgeted for an AG size of 3 for $2500. Tom receives a raise on June 8. He does not report this to the agency. The agency becomes aware of the income change in August. John receives his first paycheck with the raise on June 25, which puts him above the $250.00 reporting threshold, because he was not over the income reporting requirement the entire month. Tom's overpayment will begin on June 25 through the last day of August (the month that the overpayment was discovered).

4.5.1.2.1.1.3 Adverse Action

Eligibility overpayment cases may be impacted by adverse action. If an eligibility period occurs within the last 10 days of the month, this change will not take effect in the next month, but rather the month after. For each adverse action situation, please follow 2.2.13.

4.5.1.2.2 Verify Funds

To verify funds have not been recovered from the provider for the same overpayment period as the client overpayment, enter CSAW and view negative adjustment history for the time period in question. If no overpayment has been assessed against the provider for the children in question, an overpayment may be assessed against the client. If an overpayment has been assessed for that client, during that time period for the same reasons, do not take an overpayment.

If calculating an overpayment for a month in which funds would have expired for the client, workers must verify that the funds were spent. Calculate overpayments only on the amount spent and not the amount loaded to the card. This information can be found in EBT CSAW on the Transactions Screen or in the Expunged Funds Report in WebI. Document this step thoroughly on the Overpayment Calculation Worksheet.

Overpayments should be calculated in PLBC; however, if the client has expired funds for months of the overpayment, the overpayment amount calculated should be adjusted so that the overpayment reflects the amount spent, not the amount loaded to the EBT card.

Example: Mary has an overpayment from March 7 through the last day of the current month (August 31), for a total of $500. To determine if she has any credits, the worker reviews the expungement report for Mary for March. It has been four months since Mary received the March subsidy, so if she did not spend those funds, they would have been removed from the card. Mary did not spend $50 in March. Her overpayment will receive a $50 credit. Therefore, her overpayment would now be $450.00.

4.5.1.2.3.2 Unreported Employment Exception

When establishing an overpayment for unreported loss of approved activity, do not take an overpayment for the periods of time where the client was participating in another, unreported approved activity.

Example:

- Steve completes his child care application on September 19, and receives an authorization for while he is working for Pick ‘N Save.
- On January 16, Steve stops working for Pick ‘N Save. This is not reported to the agency timely.
- Steve begins employment with Walgreens and works there from February 28 through April 16.
- He begins employment with Target on April 23, and is currently still employed there.
- The agency discovers his unreported employment change in May.

Steve’s overpayment is from January 16 through April 22. He has no amount to credit from expunged funds or past months on the card. However, Steve will be credited for being in an approved activity from February 28 - April 16, and from April 23 through May. Therefore, his overpayment period would be from January 16 through February 28, and from April 17 through April 22.

4.5.2 Entry of Overpayment in BV

After the overpayment calculation is complete, the overpayment must be entered into the BV system (CARES) on the BVRF and BVCL screens. To complete the BVRF, a BRITS Referral Number will need to be entered. BV will process the claim, identify the liable individual, and generate the appropriate notices and worksheets (as applicable). These include:

- The original overpayment notice*
- Repayment Agreement
- Monthly Dunning Notices

If an overpayment is adjusted or closed due to new information or due to a fair hearing decision, a notice must be manually updated, created, and mailed. The updated notice must be mailed the same day the actions are completed.

**Note: Please note that a manual notice must also be sent (see 4.6.1.2 for details).*

4.5.3 Correcting a Client Overpayment

If a client overpayment has been entered in BV, and must be corrected, a Write-Off and Adjustment Request Form must be completed and submitted to PACU.

4.5.4 Overpayment Classifications

There are three types of client overpayments: Administrative Errors, Client Errors, and Client IPVs. Each is described in detail below.

4.5.4.1 Administrative Error(s)

Administrative Errors (also referred to as agency errors) are defined as an overpayment that was a result of an agency entering erroneous information that led to the client receiving subsidy for which they were not eligible. Administrative Errors include those that affect eligibility and authorizations.

4.5.4.1.1 Eligibility Administrative Errors

There currently are two eligibility related administrative errors (but are not limited to)**:**

1. Incorrect Entry of Client Information that Impacts Eligibility
2. Failure to Enter a Timely Reported Eligibility End

General procedure:

1. Use PLBC to update the client case to reflect the correct information.
2. Assess for a positive or negative adjustment using the date of the incorrect entry (typically, the date of the creation of the authorization) to the end of the current month.
3. If an overpayment occurred, create a referral in BRITS and a claim in BV.

Note: See Chapter 1 for eligibility information.

4.5.4.1.1.1 Incorrect Entry of Client Information that Impacts Eligibility

If an agency enters incorrect client information in CWW or EBT CSAW and this information impacts eligibility, and is an administrative error. An incorrect entry may include: verification information, name, address, birth dates, SSN, parent schedule, approved activity, rate type, etc. Assess for a positive or negative adjustment in PLBC for all impacted months.

Example: Tom entered a client's income incorrectly in CWW. If it had been entered correctly, the client would have been above the FPL and therefore not eligible for Wisconsin Shares. Once discovered, the authorization must be ended the last day of the current month, and a negative adjustment should be assessed using PLBC for each impacted month. The overpayment should be from the date of the authorization to the end of the current month. This amount must then be entered in BV.

4.5.4.1.1.2 Failure to Enter a Timely Reported Eligibility End

If a client timely reported a change in their case, and the agency failed to enter the change timely, this is an administrative error. Timeliness of entry is determined by the policy set forth in 2.2.13.

Note: If a client does not timely report a change to eligibility, this is a client error (See 4.5.4.2.2).

Example: Michelle calls on March 13 to report that she received a raise on March 10 (timely). The worker did not enter this information until April 7. With the updated income, Michelle is above the 200% FPL and is no longer eligible for Wisconsin Shares. If the change had been completed timely by the worker, eligibility would have ended at the end of March. Therefore, an Administrative Error occurred, and an overpayment should be assessed from April 1-7, if Michelle paid the provider any of their April funds.

4.5.4.1.2 Authorization Administrative Errors

There are several authorization related administrative errors, including (but not limited to):

1. Incorrect Entry of Authorization Information
2. Incorrect Provider or Provider Location Authorized (with or without payment)
3. Incorrect Entry of an Adjustment
4. Inappropriate Hardship Authorization

General Procedure:

1. Using PLBC, update the case to demonstrate the correct information.
2. If the authorization is continuing, end the current authorization and create a new authorization with the correct information. If it is not, end the authorization the last day of the current month.
3. Assess for a negative adjustment using the date of the incorrect entry (typically the date of the creation of the authorization) to the end of the current month.
4. If an overpayment occurred, create a claim in BV.

4.5.4.1.2.1 Incorrect Entry of Authorization Information

This error occurs in any case where an agency or department worker entered any incorrect information during the authorization process. This may include: an incorrect entry of parent schedule, child care need schedule, incorrect override amount, etc. The parent is liable for this overpayment.

Example: Susan is creating an authorization. The client is authorized for 40 hours a week, but Susan overrides the amount and enters 50 authorized hours a week by accident. The authorization must be corrected, and an overpayment should be assessed from the date of the authorization through the end of the current month. She also must end the current incorrect authorization and create a new authorization with the correct information.

4.5.4.1.2.2 Incorrect Provider or Provider Location Authorized

If a client is authorized to receive services to the wrong provider, it is an administrative error. This may occur if a client reported a change in provider timely and the agency did

not update the authorization, or the incorrect provider was inadvertently selected during the authorization process. The procedure is different if a payment was made (see below).

Note: For cases in which the client did not timely report a timely change (see 4.5.4.1.2.3).

1. Contact the Child Care Subsidy and Technical Assistance Line for assistance.
2. The Child Care Subsidy and Technical Assistance Line will provide assistance with when to end the incorrect authorization, and how to create a new authorization to the correct provider.
3. If a payment was made, complete the Voluntary Repayment (VP) process (4.12.1.1), and cancel any remaining funds for the inaccurate provider that remains on the card using PLBC.
    a. If the provider declines the VP process, an overpayment must be calculated for the erroneously received funds and a claim created in BV. The client will be liable for this overpayment.
4. Determine if the incorrect provider received a YoungStar adjustment for the incorrect authorization. If yes, contact BPI via the Technical Assistance mailbox and BPI will initiate the recoupment. The inaccurately authorized provider is liable for this overpayment.

Example (Without Payment): Suzy has an authorization to ABC Child Care Location 1. However, when she looks at her authorization on the Parent Portal the address is wrong. She calls to report this to the agency. The agency realizes that an authorization was made to the incorrect location. The worker informs Suzy of the error. With direction by the CC Subsidy and Technical Assistance Line, the worker ends the incorrect authorization and creates a new authorization. The CC Subsidy and Technical Assistance Line staff removes the inaccurate funds using PLBC. The worker must also determine if the incorrect provider received a YoungStar adjustment for the authorization in question. If they did, they must notify BPI. The funds will load overnight to Suzy's card.

Example (With Payment): Tina has an authorization to ABC Child Care Location 1. Tina pays her provider half of her subsidy amount via the telephone IVR system. Her provider then informs her that she never received payment. Tina calls to report this to the agency. The agency realizes that they authorized to the incorrect provider location. The worker informs Suzy of the error. With direction from the CC Subsidy and Technical Assistance Line, the worker ends the incorrect authorization and creates a new authorization to the correct provider. The CC Subsidy and Technical Assistance Line staff removes the remaining inaccurate funds. The funds will load overnight to Suzy's card. The worker initiates the Voluntary Repayment (VP) Process with the incorrect provider. The provider agrees to return the funds. The worker contacts the CC Subsidy and Technical Assistance Line to assist with the processing of the VP Process. The worker also sees that the incorrect provider received a YoungStar payment for the inaccurate authorization. The worker must notify BPI of the YoungStar error.

4.5.4.1.2.3 Incorrect Entry of an Adjustment

An administrative error occurs if a worker incorrectly enters a positive or negative adjustment in PLBC.

If the incorrect entry was a:

- Positive adjustment and not justified, an overpayment will be assessed in the amount of the positive adjustment.
- Negative adjustment and not justified, the claim will need to be corrected in BV, and the case corrected in PLBC (if applicable).

4.5.4.1.2.4 Inappropriate Authorization of Hardship
If a worker or agency authorizes a hardship without the proper documentation or is inconsistent with the policy in Chapter 2, this is an agency error. An overpayment for the client will be assessed.

4.5.4.2 Client Error(s)
Client Errors are unintentional or inadvertent error(s) made by a client who reported incorrect information or failed to report a change in information to the Department or local agency.

Client error overpayments can be established up to six (6) calendar years from the date of discovery (893.43, Stats.).

4.5.4.2.1 Timely Reported Eligibility or Authorization Ending Changes
Any timely reported changes by the client will not result in a client overpayment for the current month. However, an Administrative Error may be applicable. See section 4.5.4.1 for details.

4.5.4.2.2 Untimely Reported Changes that End Eligibility or Authorization
Untimely reported changes that result in the loss of eligibility will result in a client error and overpayment. Examples of untimely reported eligibility ending changes include (but are not limited to):

1. Loss of Approved Activity
2. Income Change that Exceeds Eligibility Limit
3. Loss of any Non-Financial Eligibility Criteria
4. Temporary Absence from Employment

General Procedure:

1. End the existing authorization at the end of the current month.
2. Assess for an overpayment in PLBC beginning the date of change through the last day of the current month.
3. Enter the overpayment in the BV system.

4.5.4.2.2.1 Loss of Approved Activity
This error occurs when a client lost or discontinued participating in their approved activity and did not report it timely, and continued to use the subsidy.

Example: The agency learns on May 23 that Stacey lost her job on April 10, and did not report it within the 10 day timely reporting period. The agency worker must end the authorization immediately (effective the last day of May). Next, she should assess for an overpayment for the dates Stacey was ineligible to receive benefits- in this case from April 11 - May 23. The worker should enter a PLBC request for each impacted month (one for the end of April, and one for May) in order to calculate the overpayment, and then create a claim in BV.

4.5.4.2.2.2 Income Change that Exceeds Eligibility Limit

This error occurs when a client experiences a change in income that places them above the eligibility limit for their assistance group size. This is typically a result of an increase in income, gaining subsequent employment, a change in household composition, loss of an approved employment activity, or the receipt of unreported income (such as commission, bonus, etc.).

Example: Tom has an authorization for his son. He has reported his income as $975.00 a month. Tom receives a significant raise from his employer on March 7, but did not report this to the agency. Tom receives his first paycheck with the raise on March 21. This puts him over income and above the $250 per month increase in income reporting requirement. The agency discovers his unreported income in June and updates his eligibility with the new income information. Tom is now above the 200% FPL, and is no longer eligible to participate in Wisconsin Shares. Tom's eligibility and authorization are ended immediately. Tom has an overpayment from March 21 through the last day of June. This is calculated in PLBC then entered in BV.

4.5.4.2.2.3 Change in Non-Financial Eligibility Requirement

This error occurs when a client losses any non-financial eligibility requirements, and does not report it timely. This includes: marital status, mailing address, change in approved activity schedule, etc. The only exception is the loss of child support cooperation. See Chapter 2 for a full list of non-financial eligibility criteria.

Example: June and Phil have a child in common. Phil moves in with June on May 17. With Phil's income, the family is now over the FPL for their AG size and is no longer eligible to participate in Wisconsin Shares. This is discovered in November. The worker updates their eligibility information and verifies that the family is no longer eligible for the Wisconsin Shares program. The overpayment is calculated from the date of change (May 17) through the last day of November. This is calculated in PLBC, and then entered in BV.

4.5.4.2.2.4 Temporary Absence from Employment

Local child care agencies may authorize subsidy amounts to parents during temporary absences from employment in the limited situations, such as a break in employment, absence in child care, and continuance in employment with the same employer (See 2.8 for additional criteria). Temporary absences may be issued for a range of 4 to 6 weeks.

If the client's temporary absence does not meet the criteria established in 2.8, or extends past the maximum number of weeks of leave, an overpayment should be assessed.

Example: Jim and his family went on vacation for the summer (3 months), did not utilize child care in Wisconsin, or report this change to the agency. Jim continued to pay his child care provider. This is a violation of Chapter 2.8 policy and is an overpayment.

4.5.4.2.3 Timely Reported Change with Continuing Eligibility

Any timely reported change(s) that impact eligibility or the authorization, but do not result in a loss of eligibility, must be addressed. Any changes that result in a positive adjustment for the current month must be entered in PLBC. Any timely reported changes that result in a decrease in subsidy amount will *not* result in an overpayment for the current month. See Sections 1.9.1and 2.2.13 for additional information about the alteration of the authorization for these changes.

4.5.4.2.4 Untimely Reported Change with Continuing Eligibility

Untimely reported changes that impact the authorization, but do not result in a loss of eligibility may still result in an overpayment. The client has ten (10) calendar days to report the following changes:

1. Change of Provider
2. Change in Approved Activity
3. Banking
4. Change in Income
5. Change in Household Composition
6. Change in Child Care Need
7. Failure to Report Correct Price
8. Temporary Absence from Approved Activity
9. Inappropriate Payment of Previous Provider in Hardship Situation

General Procedure:

1. End the existing authorization immediately (effective the end of the month).
2. Create a new authorization (with next month for the begin date) based on the verified change.
3. Assess for a positive or negative subsidy adjustment in PLBC (if applicable).
4. Enter the overpayment in BV (if applicable).

4.5.4.2.4.1 Change of Provider

If a client does not report timely that they changed their provider, it results in a client error. Once notified of the error, the agency must correct this case immediately. The procedure for this error is handled differently based on payment to the provider.

1. Contact the Child Care Subsidy and Technical Assistance Line for assistance.
2. End the incorrect authorization immediately and create a new authorization to the correct provider.

3. If a payment was made, complete the Voluntary Repayment (VP) process (4.12.1.1), and cancel any remaining funds for the inaccurate provider that remains on the card using PLBC.
    a. If the provider declines the VP process, an overpayment must be calculated for the erroneously received funds and a claim created in BV. The client will be liable for this overpayment.
4. Determine if the incorrect provider received a YoungStar adjustment for the incorrect authorization. If yes, contact BPIA via the Technical Assistance mailbox, and BPI will initiate the recoupment. The inaccurately authorized provider is liable for this overpayment.

4.5.4.2.4.2 Change in Approved Activity

All changes to approved activity, including the employer, activity type, hours, etc., must be reported timely to the agency. If not, this is a client error.

Example: Christina works for a local grocery store. Her authorization is for 40 hours a week. Christina's hours are cut from 40 to 20 hours a week effective July 7. She does not report this to the agency. This is discovered by the agency in September. The agency immediately ends her current authorization at the end of the current month, and creates a new authorization with a begin date of next month with the correct, verified information. Calculate an overpayment from July 7 through the last day of September, in PLBC with separate entries for each impacted month, and entered in BV.

4.5.4.2.4.3 Banking

Banking is the process of paying in advance for child care services that have not yet been provided, and will not be provided within a month's time, with the assurance of the provider that these funds can be applied to later child care services that will be provided in future months. This does not apply to cases where parents are paying to hold a spot for their children, while they are absent (see 2.8).

Example: Sally's children attend My Day Care Center. My Day Care Center charges $200 a week per child. For August, Sally's Wisconsin Shares subsidy is $1650. Sally's bill for the month at My Day Care Center is only $1600. The owner of My Day Care Center tells Sally that she should pay her the additional $50 as a "rainy day" fund. These funds could be used at some point in the future if Sally needs more care, her subsidy decreases, or for any other reason. Sally agrees and issues the additional funds to the provider. This is an example of banking.

4.5.4.2.4.4 Change in Income

This error occurs when a change in income is not reported timely. The change must be above the $250 per month income increase threshold or below the $100 income decrease reporting threshold. This may include a failure to report any additional income such as commission, bonuses, or alimony.

For situations where the client has received an increase in income, the overpayment should begin the first of the month where the check received put them above the $250 reporting requirement or under the $100 reporting requirement.

There is a monthly income budget in CWW. The overpayment should begin the month where the client's monthly budgeted income goes above the $250 reporting requirement or below.

Note: If the change in income is due to a loss of approved activity, see 4.5.4.2.4.2. For any overpayment date range exceptions, see 4.5.1.2.1.1.

Example: Mark is budgeted for an AG size of 3 for $2500. Mark receives a raise at work in May. He does not report this to the agency. The agency becomes aware of the income change in August. Mark receives his first paycheck with the raise on June 10. He receives his second check with the raise on June 24. In June, his total budgeted income for the month is $3000. He is thus above his budgeted income and above the income reporting requirement of $250. Mark's overpayment thus will begin on June 1 through the last day of August (the month where the overpayment was discovered).

4.5.4.2.4.5 Change in Household Composition

This error occurs when a change in household membership (either an addition or subtraction) was not reported timely. Examples of household membership include: marriage, separation or divorce, or presence of another adult to care for the child during child care hours, a baby, legal or child in common, etc.

Example: Sally has an authorization for an AG of 2. Sally and Phil have a child together. Phil moves in with Sally on January 5. This is not reported to the agency, and is discovered in April. The agency updates eligibility and confirms that with Phil included in the AG and income budget, they remain eligible. The old authorization is ended for the end of April, and a new authorization is created with a start date of May 1. An overpayment should be assessed from January 5 through the end of the current month using PLBC. The overpayment should be entered in BV.

4.5.4.2.4.6 Change in Need of Child Care

This error occurs when there is an unreported change in need of care. This may occur due to a loss of employment, change of hours, addition, or misrepresentation of another parent to the assistance group, etc. This may also include changes in shared placement that are unreported.

Example: Steve has an authorization for his daughter. Steve marries Jill October 14, but does not report the change. Steve works first shift and Jill works second shift. Steve's authorization allows him to receive child care during first shift. However, due to the change in assistance group, Jill is available to provide care during first shift. Therefore Steve would receive a client error for household membership change and change in need of child care. Calculate and establish and overpayment from the date of change (October 14), through the end of the current month.

Example: Lily has her daughter during the week when her authorization is issued. The child's father and Lily agree to a new placement schedule where he has their daughter on Wednesdays and Thursdays. Lily does not update the agency of this change. Lily requires less child care now since the child's father is providing care. Lily does not notify the agency of her shared placement updated. Lily is thus receiving benefits for which she is not eligible. Calculate an overpayment from the date of change through the last day of the current month, and update the case.

4.5.4.2.4.7 Failure to Report Correct Price

This error occurs when a client who works for their provider fails to report an employee discount price, or fails to report any other discounted rate such as foster parent.

Example: Sandy works for her child care provider, 123 Day Care. Sandy requests an authorization for Wisconsin Shares and informs the agency she works for 123 Day Care. Sandy does not inform the agency of the discounted rate. This is discovered six (6) months after the authorization was granted. This is a client error and the overpayment would be from the date of the authorization through the end of the current month.

4.5.4.2.4.8 Temporary Absence from Approved Activity

Section 2.8 describes when agencies may authorize subsidy amounts during temporary absences from employment. If the client's temporary absence does not fall under these criteria, or extends past the maximum number of weeks of leave, a client error and overpayment should be assessed. For additional details, see also 4.5.4.2.2.4.

4.5.4.2.4.9 Inappropriate Payment of Previous Provider in Hardship Situations

A client error may be assessed in situations where a hardship was correctly authorized, but payment was made to the previous provider that was not necessary. To determine the validity of the payment, an in-depth audit may be conducted to determine whether the payment was warranted or unwarranted. If unwarranted, an overpayment and client error may be assessed.

Example: Tamika was awarded a hardship, and after changing providers, paid her previous provider her remaining funds. BPI conducted an investigation and determined that the previous provider should not have received those funds, because no care was given for that child and the funds were not being used to hold a spot for the child. Therefore an overpayment should be assessed using PLBC to calculate the amount for the funds submitted to the provider that were not warranted.

4.5.4.3. Intentional Program Violations (IPVs)

An IPV is issued to a client who *intentionally* makes a false or misleading statement, misrepresents or withholds facts, or intentionally commits any act that constitutes a violation of federal or state law for the purpose of using, presenting, transferring, acquiring, receiving, possessing, or trafficking benefits under this chapter (Wis. Stats, sec. 49.151 (2)).

The Department and/or agency must pursue an overpayment to recover any misappropriated funds. Any overpayments established for IPVs may be established for up to 6 years after the cause of action (Wis. Stats, sec. 893.43).

Note: An individual does not have to receive payment or services prior to the agency imposing an IPV.

IPVs are determined by the administering agency, including the Department, local agencies, or tribal agencies under contract with the Department. A Child Care IPV *must* be approved by BPI prior to its entry in CWW. The Client Intentional Program Violation Request Form (DCF-2893-E) must be completed and submitted to BPI via the Technical Assistance mailbox (DCFBPITArequest@wisconsin.gov). Once approved (see Section 4.5.4.3.3.2), an IPV must be entered in CWW within 30 calendar days.

4.5.4.3.1 Subsequent IPVs

If the agency discovers that more than one act of fraud has occurred at the same time, the agency may only impose one IPV penalty. Agencies can only impose subsequent IPV penalties after the individual has completed an IPV penalty period, has re-applied, and violated the program rules again. For example, after an individual has completed a 6-month penalty period for a first IPV, re-applies, and then violates the program rules again, the agency can impose a second IPV penalty.

Example: A client receives a first IPV in January for misrepresenting her household composition (second parent was found to be in the household). Her IPV Sanction period is from February to July. In July, she is notified that her sanction period is almost complete. In July, she re-submits an application for Child Care so that when her sanction period is done, she can be found eligible. On her application, she claims that she is the only adult in the household again. This is flagged for a FEV referral. The investigation reveals that the second parent still resides within the household. She therefore submitted false information, meeting the criteria for a subsequent IPV. However, she supplied the false information while still serving her first IPV. Therefore, a subsequent IPV cannot be pursued. However, eligibility should be denied until the correct information and verification is supplied.

4.5.4.3.2 IPV Penalties

If the appropriate individuals (4.5.4.3.3.3) approve the IPV, the agency must impose an IPV penalty for the appropriate period of time. When an IPV is determined, the agency must deny subsidy funds and services to the individual for the following durations:

1. For a First Violation (1R) – the client will be suspended from the Wisconsin Shares program for six (6) months.
2. For a Second Violation (2R) – the client will be suspended from the Wisconsin Shares program for 12 months.
3. For a Third Violation (3R) – the client will be permanently suspended from the Wisconsin Shares program.

The IPV denial period will be imposed for the time specified under Wisc. Stats. sec. 49.151(2) whether the case is open or closed. Only the individual(s) determined to have committed an IPV must receive the penalty.

4.5.4.3.2.1. IPV Sanction Period

The Child Care IPV penalty period begins the first day of the month following the IPV determination or the first day of the month after adverse action.

Note: Adverse Action impacts case changes submitted the last 10 days of the month in CWW. Any changes submitted during adverse action take effect the month after the subsequent month, i.e. if a change is submitted the end of June the change will take effect August 1.

See Chapter 2.2.13 for when to end authorizations and eligibility based on adverse action.

Example: A client loses their job on October 1 and does not report it. The client contacts the agency requesting additional care on November 1 and does not provide the updated information. This is discovered by the agency May 15. The IPV date range (and overpayment in this scenario) would be October 1 through May 31. The IPV is submitted to BPI June 5, and approved June 10. The IPV Penalty in CWW would begin the month after the IPV is approved, in this case July 1.

Example: A client loses their job on October 1 and does not report it. The client contacts the agency requesting additional care on November 1 and does not provide the updated information. This is discovered by the agency June 15. The IPV date range (and overpayment in this scenario) would be October 1 through June 31. The IPV is submitted to BPI June 23, and approved June 30. This case is impacted by adverse action, thus the sanction period will not begin until August 1.

4.5.4.3.2.2. Imposing an IPV Penalty

More than one adult in the Assistance Group may be determined to have committed an IPV and can be subject to the penalty. An IPV can be issued to either a primary or second person on a case; however, the IPV is most often applied to the primary person who completes the application, is responsible for reporting program changes, and is at least 18 years old. In a two-parent household, the IPV may be applied to the other person if that individual is at least 18 years old, part of the assistance group, and responsible for the intentional violation. Further, if both parents have committed an IPV, both may be sanctioned.

Local agencies are responsible to investigate whether a program violation was intentional. To insure uniform application of the IPV policy, all IPV determinations must be reviewed and approved by the appropriate identified bodies (Section 4.5.4.3.3.2).

If the IPV results in an overpayment, the local agency must also establish the overpayment, and support PACU in the recovery of the overpayment.

4.5.4.3.3 IPV Approval Process

4.5.4.3.3.1 Client IPV Biweekly Meetings

To proceed with an IPV request, an agency must submit an Intentional Program Violation Request Form (DCF-F2893-E), and attend the biweekly client IPV meeting. All IPVs to be heard at the meeting must be submitted to the TA mailbox by Monday at noon, the week of the meeting. Please title all IPV request emails as "IPV Request, Case Number #, 1R/2R/3R."

Note: If submitting a subsequent IPV request, a summary of the previous IPV(s) must be supplied in the Previous IPV Issued Summary section of the IPV Request Form.

During the meeting, each IPV received for the two-week period will be heard. Each investigator will present the case to the required attendees. The required parties will approve or deny the requested IPV. Meeting attendees may elect to appear for the meeting in person or over the phone.

4.5.4.3.3.2 Approval Tier

Below is a description of the individuals who are required to attend the meetings to grant or deny the IPV.

1) Required attendants at the IPV meeting for first (1R) IPVs, include:
    - The investigator: Submits request and presents the case.
    - The agency supervisor (typically investigator's supervisor) or designee: Approves or denies the request.
    - BPI Supervisor: Approves or denies the request.
    - OLC Representative: Determines whether the IPV would be upheld in legal proceedings.

2) Required attendants at the IPV meeting for second (2R) IPVs, include:
    - The investigator: Submits request and presents the case.
    - Local agency Child Care Coordinator or Economic Support (ES) or Income Maintenance (IM) Supervisor*, or designee: Approves or denies the request.
    - BPI Bureau Director: Approves or denies the request.
    - OLC Representative: Determines whether the IPV would be upheld in legal proceedings.

    **Note: In some agencies this may be the same person as that approving the first.*

3) Required attendants at the IPV meeting for third (3R) IPVs, include:
    - The investigator: Submits request and presents the case.
    - Local agency Child Care Coordinator, ES or IM Supervisor, or agency staff designee: Approves or denies the request.
    - BPI Bureau Director: Approves or denies the request.
    - OLC Representative: Determines whether the IPV would be upheld in legal proceedings.

- The Administrator for the Division of Early Care and Education or designee: Approves or denies the request.

Note: If the agency would like to pursue a third IPV, the local agency should discuss the request with their local agency Human Services Director and the local agency's legal counsel, prior to pursuing the request.

4.5.4.3.4 Additional Enforcement Actions
After the agency determines the IPV has occurred, the agency may decide to take additional enforcement action(s). The additional enforcement action(s) include:

1. Refer for possible criminal prosecution: The agency should communicate with its' Agency legal counsel to discuss and establish thresholds and criteria regarding when to refer individuals to local law enforcement or the district attorney for consideration of possible criminal prosecution.

See Section 4.5.6 for additional information on criminal prosecution.

4.5.4.3.5 Classifications of IPVs
IPVs are entered in CWW in the following classifications:

1. Misrepresentation of income
2. Misrepresentation of Household Composition
3. Misrepresentation of Child Care Needs
4. Misrepresentation of Residency
5. Providing False Documentation
6. Providing False Identification or SSN
7. MyWIChildCare Abuses
8. Collusion with Child Care Provider

It is possible for an IPV to fall under multiple categories. For example, child care need and household composition tend to be related. If an IPV has more than one classification, all should be identified in CWW. In addition, even if there is more than one IPV classification, the IPV will only be all encompassing.

4.5.4.3.5.1 Misrepresentation of Income
An IPV for misrepresentation of income may be assessed if a client intentionally fails to disclose supplemental income such as commissions, bonuses, alimony or other additional funds; if a client intentionally fails to disclose unearned income, such as income from a rental property; or if a client intentionally misrepresents employment or approved activity information such as: employment status, hours worked, or salary and/or wages, etc.

Example: It is discovered that a client did not inform the agency of an increase in wages. The individual has had contact with the agency since the change and has not reported this increase. Therefore, it is found that the client has been intentionally not informing the agency of the change to receive benefits that they otherwise would not have been eligible for. An IPV is approved by BPI. An overpayment is calculated from the date of the income increase, to the last day of the current month. Once the IPV is created in CWW, the eligibility will be ended, which will end the authorization in EBT CSAW.

4.5.4.3.5.2 Misrepresentation of Household Composition

An IPV for misrepresentation of household composition may be assessed if a client intentionally fails to disclose or mispresents information regarding their household composition. This may include intentionally misrepresenting information regarding a marriage or divorce, living situation, and/or intentionally and falsely claiming another child lives in the household.

Example: Steve has an authorization for his daughter. Steve marries Jill in October, but fails to report the marriage. Steve contacts the agency several times to share other case updates, but does not inform the agency of his marriage. This is discovered in February. An IPV request should be submitted to BPI, with an overpayment from the date of change in October through the end of February. Once the IPV is approved and created in CWW, eligibility will end, which will end the authorization in EBT CSAW.

4.5.4.3.5.3 Misrepresentation of Child Care Need

An IPV for misrepresentation of child care needs may be assessed if a client intentionally fails to disclose information regarding their true child care needs. This may include utilizing child care while not in an approved activity (without reporting to the agency that they are not in an approved activity, or utilizing child care when another parent is available to provide care).

Example: Tonya and Alejandro have a child in common. They move in together in February. Tonya has an authorization for their child and does not report this timely. Tonya works first shift and Alejandro works second shift. Tonya's authorization allows her to receive child care during first shift. However, due to the change in assistance group, Alejandro is available to provide care during first shift. Tonya has contacted the agency multiple times since they moved in together, and has not disclosed this information. An IPV for misrepresentation of child care need and an overpayment would be assed for the client.

4.5.4.3.5.4 Misrepresentation of Residency

An IPV for misrepresentation of child care needs may be assessed if a client intentionally fails to disclose information regarding their residency. This may include: receiving the Wisconsin Shares subsidy when the individual is not a resident of Wisconsin, or receiving the Wisconsin Shares subsidy while also receiving benefits from another state, when the individual is a resident of Wisconsin.

Example: Kelly is a resident of MN, but applies and is authorized for a Wisconsin Shares subsidy. Kelly was not eligible to receive this benefit. An IPV should be issued, and an overpayment should be created for the entire period of time Kelly was receiving the Wisconsin Shares subsidy.

Example: Sally is a resident of Wisconsin and is on Wisconsin Shares, but applies for Iowa's Child Care Subsidy Program (even though she does not live there). A worker in Wisconsin discovers this. The worker should report the fraud to Iowa and open an investigation to determine if Sally has committed other fraud in Wisconsin. Do not open an IPV or overpayment for this scenario alone.

4.5.4.3.5.5 Providing False or Fraudulent Documentation

An IPV should be assessed any time a client submits fraudulent documentation in order to receive subsidy.

Examples of frequently received fraudulent documents include:

- Employment Verification Form:
  - Not completed by the employer
  - Incorrect wages or work hours
  - Forging a supervisor's signature
- Forging a document to demonstrate they are working
- Creating false pay stubs to substantiate approved activity claims
- Creating a false place of work

4.5.4.3.5.6 Misrepresentation of Hardship Need

An IPV should be assessed if a client misrepresents or provides false information in order to obtain a hardship authorization. See 2.2.12 for situations that qualify for hardship.

Note: This should be coded as a Misrepresentation of Income in CWW during the IPV entry.

Example: Erika claimed that she had a fight with her boyfriend, and that he had kicked her and her children out of their home. Therefore, traveling to the current provider was impossible. The agency awarded a hardship to her in March. An investigation uncovered that she had been living with her boyfriend the entire time, and instead had cashed out the benefits with the hardship provider. Submit an IPV Request Form, and calculate an overpayment for the amount of the Hardship awarded in March. This claim must then be entered in BV.

4.5.4.3.5.7 Using the Child Care Subsidy (as a client) to Pay Themselves as a Provider

An IPV should be assessed if a client uses Wisconsin Shares to authorize payment to themselves as a provider. This is prohibited by 49.155 (3m)(d)(1), Wisconsin Statutes.

Note: This should be coded as a Misrepresentation of Child Care Need in CWW during the IPV entry.

Example: Tim is the Licensee for a large group child care center. He also has children on the Wisconsin Shares program. Tim has his children authorized to his child care center. This is a violation of Wisconsin Statutes. An IPV and overpayment should be assessed for the entire time period that Tim was using his Wisconsin Shares funds to pay himself for child care for his own children.

4.5.4.3.5.8 Providing False Identification or SSN

An IPV should be assessed if a client misrepresents or provides false identification or Social Security information, such as SSN.

4.5.5 Collusion

Collusion occurs when multiple parties such as providers and parents cooperate in order to defraud the Wisconsin Shares program, so as both parties receive financial benefit.

General Procedure:

1. Both the client and the provider will receive an IPV. Submit the necessary requests to BPI for approval.
2. Establish overpayment: The overpayment should be calculated from the time that cash refunds began to be issued through the end of the current month. Providers and parents are jointly and severally liable for an overpayment related to collusion, DCF 201.04(5)(bm).

Examples of collusion and sanctions are discussed below (but are not limited to):

4.5.5.1 Cash Refunds or "Kickbacks"

Accepting a cash refund for any portion of the subsidy amount or an incentive from a child care provider is considered a kickback, and is contrary to § 49.155 (4), Wisconsin Statutes. Incentives may include any type of financial or material rewards for parents of Wisconsin Shares enrolling their children at their location, except those which directly benefit an eligible child.

Example: Leslie is a parent on Wisconsin Shares. Her children attend 123 Child Care. The owner of 123 Child Care and Leslie decide to cash out the Wisconsin Shares subsidy and split the cash. IPV for both the client and provider should be requested, and an overpayment established with joint liability.

4.5.5.2 Paying for Care for Children Not on the Case

Using the Child Care Subsidy to pay for care not provided for children on the Wisconsin Shares case. If this is discovered, an overpayment should be assessed for the dates of inaccurate payment.

Example: Cassandra's daughter, Kim, is authorized to ABC child care. Cassandra's sister Joann, asks Cassandra to pay for her child, Jose. Cassandra uses her subsidy fund to pay the child care provider for care provided for both children. IPVs for both the client and provider should be requested, and an overpayment established with joint liability.

4.5.5.3 Possessing a MyWIChildCare Card, Account Number, or PIN

Giving a MyWIChildCare card, account number, or PIN, to a provider or other individual, with knowledge that the other person would be issuing payments with the card is against program rules. For it to be collusion with the provider, the provider must be the recipient of the card, and use the card, account number or PIN, to pay issue payment to themselves.

4.5.5.4 Issuing Payment for Child Care Not Provided

Using the child care subsidy to pay a provider who has not provided child care for the children on the case (example: authorized to the provider, but the child is not attending the facility, or has not attended the facility for over 30 days). This frequently is attached to cases of kickback issuances.

Example: Keisha has two children, a 12-year-old and a 3-year-old. She has an authorization for both children to Suzy Cuties. Keisha's 12-year-old never attends Suzy Cuties. Keisha issues payment to Suzy Cuties for both children, regardless of the fact that the 12-year-old never attends. The provider never notifies the agency that she is receiving payment for a child that she does not provide care for. Therefore, Keisha is receiving funds that she does not require, and the provider is receiving funds for care not provided. IPVs for both the client and provider should be requested, and an overpayment established with joint liability.

4.5.5.4 Shell Company

Setting up a false company or providing false documentation of parent employment, such as: providing fraudulent verification letters claiming that the parent works for the company or the provider "hiring" a parent so they have a full time authorization, even though the parent only works part-time with a different employer

Example: Tina works part-time for Stop N' Go. Her children attend ABC Day Care. When speaking to her provider, the provider informs Tina that if she claims to work for ABC Daycare she can have a full time authorization and get more subsidy funds. She and the provider agree to split the difference of the additional funds starting in March. This is discovered by the agency in September. IPVs for both the client and provider should be requested, and an overpayment established with joint liability from March through September.

4.5.6 Criminal Prosecution

Cases of collusion and other highly egregious cases may be referred for criminal prosecution. BPI must be notified of any cases referred for criminal prosecution.

If the local agency or tribe is unable to pursue criminal prosecution or if a case is highly egregious, the case should be referred to BPI for further investigation. Direct all referrals to the BPI Fraud Mailbox (dcfmbchildcarefraud@wisconsin.gov) with the subject line "Referral for Criminal Prosecution". A representative from BPI will be notified and will contact the agency who submitted the request for additional documentation and information.

Reasons for referring a case to BPI for criminal prosecution include:

- Children are not attending child care
    - Multiple no access visits during peak times when children should be present.
    - Small number of children present during site visits, with a high number of authorizations. This may be accompanied by parent's always paying the entirety of their subsidy amount.
    - An egregious number of overpayment instances.
    - Parents stating their child stopped attending the provider, but authorized funds continue to be withdrawn from the parent's EBT card.
    - Children attending the child care during periods of unapproved temporary absences.
- Envelope Cases
    - Suspicions that parents and/or teachers are being paid to enroll their children while the children do not actually attend the center.
    - Referrals stating that individuals show up to pick up checks or cash, but are never seen working at the center.
- False shifts
    - Common for 24 hours per day centers.
    - Numerous employees reporting working third shift.
- False employments
    - Provider sets up a false company in order for the parents to obtain authorizations and to remain compliant under the 40% rule.
    - Parent obtains verification letter stating that he or she works for the center or a company owned by the provider, but this parent never actually works for the center or the company.
    - Numerous parents work for the same false company owned by the provider or a provider relative.
- Cushioned Employments
    - Provider hires parents so that the employee has a 40-hour authorization, however the parent does not work at the center.
    - Parent's authorization is for a different shift than they are receiving care for (Example: Parent works first shift, but is receiving second shift care).
- Collusion
    - Reports of a parent – provider agreement to defraud
    - Suspicions that parents and/or teachers are being paid to enroll their children while the children have not and do not attend the center for a prolonged period.

4.5.7 Appeal Process

Clients have the right to appeal three sanction decisions: 1) the overpayment amount, 2) the issuance of an IPV (if applicable), and 3) the denial of benefits while the appeal is occurring. Clients must submit their appeals in writing and indicate which decision they wish to appeal.

4.5.7.1 Fair Hearing Tracker

Agencies should utilize the Fair Hearing Tracker tool in CWW. This system assists agencies with scheduling and tracking appeal steps. It is recommended that agencies view the Fair Hearing Tracker daily to check for any new appeals or updated appeals.

4.5.7.2 Overpayment Appeal Process

When an overpayment has been established against a client, he/she will receive both a system-generated Child Care (CC) Overpayment Notification and a manual CC Client Overpayment Notice that lists the reason for the overpayment, amount of the overpayment, overpayment period, and their right to a fair hearing. The client may contact the Department or local agency or tribe, whose contact information will be on the overpayment notice, to request an explanation for the overpayment. The Department or local agency may resolve the issue by either giving an explanation to the client of how the overpayment occurred, or the overpayment can be adjusted or deleted if the client can provide documentation to verify and support his or her position.

If the Department or local agency is unable to resolve the issue, or the client wants to appeal the overpayment decision, the request for a hearing may be made in writing or orally to the local agency or to the Division of Hearings and Appeals (DHA) within 45 days of the date of the notice. If an oral request is made to the local agency, the request must be submitted in writing by the local agency and signed by the petitioner. A local agency receiving a hearing request shall immediately date-stamp the request and forward it to DHA.

In the event of a hearing, the client and a representative from the Department or local agency, depending on who established the overpayment, must present testimony and evidence to an ALJ who will determine whether to uphold the Department or agency's action.

The types of documents that may be used as evidence and exhibits during a client hearing include:

- Original overpayment notices that include the hearing rights (system generated and manual CC Overpayment Notice (DCF-F-DWSW11250-E)
- Calculation of the overpayment (Child Care Overpayment Worksheet DCF-F-452-E or its functional equivalent)
- Documentation or witnesses to support, corroborate and explain the basis for the overpayment

- Any other supporting documentation of the overpayment

The ALJ decides whether the agency was correct in its findings and calculations. If the agency's determination is upheld, the agency and client will receive a decision dismissing the appeal. If the client's appeal is upheld, the ruling remands the matter to the agency to rescind or recalculate the overpayment amount. The agency must carry out the remand order within 10 calendar days.

4.5.7.3 IPV Appeal Process

When an IPV is established against an individual in Cares Worker Web (CWW), a system-generated notice will be issued. If multiple individuals on one case each receive an IPV, each will be issued a system-generated notice. Each individual has their own appeal rights for the IPV established against them.

The client has 30 calendar days from the date of the IPV notice to request an appeal by sending a letter of appeal to the DHA with a copy of the IPV notice. Requests for a hearing sent to any entity other than DHA do not constitute a proper request.

DHA will notify DCF Office of Legal Counsel and the local agency human services staff of all appealed IPVs by sending an acknowledgment of receipt of appeal as well as a copy of the appeal letter. DHA assigns an ALJ to the case and DCF either assigns an attorney to represent the Department or contacts the local agency's legal counsel to alert them of the case. DHA will also send a notice to the client and their attorney, if they are represented, that an ALJ has been assigned to the appeal.

Each local agency is responsible for ensuring program integrity in the Wisconsin Shares program. The contract between the local agencies and the Department requires the local agency to provide legal representation as necessary at all hearings. An agency's corporation counsel is strongly urged to provide representation at all client IPV hearings. The DCF OLC is available to provide training and technical support.

4.5.7.3.1 Pre-Hearing Conference Call

The ALJ will send notice to the Department or local agency, and the petitioner/client to schedule the pre-hearing conference call. During the conference call, the date, time, and place of the hearing, as well as the date to exchange witness lists and exhibits will be determined. The Department, local agency and the client may discuss the appeal process and general facts of the case during the call, at the discretion of the ALJ.

4.5.7.3.2 Witness Lists

Witness lists should be created and include the name, address, and phone number of every witness each party will testify during the hearing. If necessary, DHA can assist in subpoenaing a witness. If the local agency is handling the case, they are responsible for creating and submitting their witness list.

4.5.7.3.3 Exchange of Exhibits

The DCF OLC or local agency legal staff is responsible for submitting all exhibits that will be used in the hearing to the ALJ and opposing party. The exhibits for an IPV hearing should include documents, such as:

- Copy of IPV letter
- Copy of overpayment letter
- Any amendments to the Department's or local agency's original overpayment calculation
- If emails are included, redact any information regarding other individual's names
- Any documentation relevant to the case such as pay stubs, EVF-Es, leases, a CCAP case print out, or DOT records
- A copy of the Child Care Rights and Responsibilities from a renewal/SMRF
- Anything else relevant to the investigation

4.5.7.3.4 Hearing

The individual who requested the IPV will be expected to attend and serve as the witness on Wisconsin Shares policies and testify to the facts of the case, the investigative findings and enforcement action(s).

4.5.7.3.5 Final Decision

A final decision will be issued to all involved parties on the case. Either party can request a rehearing within 20 calendar days if able to show a serious mistake in the facts or the law, or if there is newly-discovered evidence that was unavailable at the time of the hearing. The client can also appeal the decision to the circuit court within 30 calendar days of the final decision.

4.5.7.3.6 Dismissal

At various stages during the appeal process, the case may be dismissed. Appeals may be dismissed because they were filed untimely, because the parties have settled the case, or because the client has abandoned the appeal.

4.5.7.3.7 Remand

A final decision by DHA may be to remand an IPV determination if the Department or local agency has not met its burden to prove that the individual committed an IPV. Any remanded IPVs must be deleted in CWW, and related overpayment's codes changed in BV.

4.5.8 Data Tracking Requirements

Agencies are required to maintain data and total counts of the following information to be provided to the department each year in their Agency Fraud Plans:

- Total number of Administrative Errors*
- Total number of Client Errors*
- Total number of Client IPVs requested and approved
- Total Number of client investigations completed

- Total amount of overpayment for each sanction type
- Total number of client appeals for overpayments and IPVs
- Total number of client remands
- Total number of client remands not completed within the 10-day grace period
- Total number of collusion cases investigated
- Total number of collusion cases presented to the DA, and accepted by the DA
- Total number of collusion cases referred to BPI

**Note: The rows with asterisks demonstrate that some or all of the data may be found in the BRITS Data Warehouse. For example, if an agency logs all of their administrative errors in BRITS, then the BRITS Data Warehouse would fully encompass all of the data. However, there may be certain circumstances where the data in BRITS is not all encompassing.*

4.6 Collections

Once a sanction and a monetary overpayment are established, agencies must cooperate with the PACU to retrieve the state and federal monies that were deemed inappropriate for the parent to have received. Collections may occur as a result of overpayment linked to an administrative error, client error, IPV, or collusion. If a client does not return payment, the client will be listed as delinquent. Determining delinquency means CARES sends three Dunning notices to the client before referring him/her to CRES for further collection. These can occur over the life of the debt.

Note: DCF has authority for all collection actions described in this section through Wisconsin Statutes, s. 49.152, 49.155(7m), 49.195, and 49.85, Stats.; and Administrative Code DCF 101.23 and DCF 201.04(5).

4.6.1 Overpayment Recovery Process

All overpayments made to a client whether due to an Administrative Error, Client Error, or Intentional Program Violation, must be formally established in order to be repaid by the client.

To enter a new claim into the benefit recovery (BV) subsystem of CARES, an overpayment referral must be established via the Benefit Recovery Referral (BVRF) screen. The BVRF must be linked to a BRITS referral. To do so, enter the BRITS referral number in the Investigation Referral field on the BVRF.

System-generated and manual overpayment notices must be mailed to the client and meet the notice requirements to the client.

4.6.1.1 System-Generated Notice

Once an overpayment amount has been determined, enter the overpayment information on the Benefit Recovery Claim (BVCL) screen to create an overpayment claim. This will generate a Child Care (CC) Overpayment Notification that is mailed to the client's last known address in CARES. This notice informs the client of the reason for the overpayment, the amount, the overpayment period, claim number, and fair hearing

rights. A Repayment Agreement (RPA) will be sent separately on the second business day of the following month that the claim was entered (see 4.6.1.5 for additional details).

Overpayment notices are generated to all liable individuals on the claim and mailed to the individuals' last known address in CARES. If the person liable for the claim is no longer active on the case but is active on another case, CARES generates a separate overpayment letter to the primary person on that case. CARES generates an overpayment notice to the person who is liable for the claim even if the person liable is not the primary person.

4.6.1.2 Manual Notices

The Department or the local agency establishing the overpayment is required to mail a CC Client Overpayment Notice (DCF-F_DWSW-11250-E). This notice informs the client of the same information as the system-generated CC Overpayment Notification; however, it includes a more descriptive reason for the overpayment.

The Department or local agency is also required to mail CC Overpayment Worksheet (DCF-F-452-E) or its functional equivalent that shows the calculation of the overpayment. These notices are mailed to the client's last known address in CARES.

4.6.1.3 Notice to Additional Liable Individuals

If an individual is manually added as liable for an overpayment, the notice for the newly added person will automatically be generated from CARES.

Liability for a child care overpayment extends to any parent, non-marital co-parent or stepparent. A "parent" can mean a custodial parent, guardian, foster parent, treatment foster parent, legal custodian or a person acting in the place of a parent.

However, the added individual must be manually mailed the same CC Overpayment Notice (DCF-F_DWSW-11250-E) that was mailed to the primary person liable for the overpayment and the Child Care Overpayment Worksheet (DCF-F-452-E) or its functional equivalent that shows the calculation of the overpayment.

4.6.1.4 Statute of Limitations

Claims for incorrect payments due to an IPV or client error may be established for up to six (6) years prior to the notification date of the overpayment, also known as the date of discovery (893.43, Wisconsin Statutes).

The overpayment period for a non-client error (also known as administrative error) claim ends with the month the error last occurred and extends back 12 months or when the error first became effective, whichever is most recent. The overpayment period for a non-client error cannot begin more than 12 months prior to the notification date of the overpayment, DCF 101.23(3)(c).

4.6.1.5 BVPA – Client Repayment Agreement

All clients are required to complete and sign a repayment agreement (RPA). If the overpayment is under $500, monthly installments of at least $50 per month must be paid. If the overpayment is over $500, the payment plan must result in the balance paid in full within 36 months.

Benefit Recovery Repayment Agreement (BVPA) screen in CARES is used to record all returned client repayment agreements. The local agency must record the repayment options properly on BVPA, or the agency may submit the BVPA to PACU for entry. Failure to make the appropriate entries on BVPA may result in incorrect collection action for the client.

A RPA can be made by contacting the local agency or PACU to negotiate a repayment amount, if the balance cannot be paid in three (3) years or 36 months. If the client cannot make the $50 installment per month, the negotiated monthly repayment amount may not be less than $20 per month per liable person. Failure to return a repayment agreement or to make a payment t will result in delinquency and further collection actions.

If multiple persons are jointly liable for an overpayment, each will receive a separate RPA; however, an individual and their spouse may both sign one RPA. Each liable individual is responsible for the debt until it is repaid in full; therefore, if one liable individual misses a payment or becomes delinquent, the other individual is still responsible for the debt.

All RPAs and payments must be sent to the PACU. Any outstanding repayment agreements must be returned to the local agency or to PACU no later than the 25 of the month. Repayment summary notices are automatically generated when a monthly payment is made. A client will receive a repayment summary notice for all payments recorded in BV. The notice provides the current balance.

4.6.1.6 Dunning Notices

If a client fails to return a RPA, fails to make a payment or to make a payment equal to the monthly amount or an amount arranged with the agency or PACU, they will receive a Dunning Notice. A Dunning Notice is a past due notice that informs the client that they are required to pay the balance of the debt and that failure to complete and return a repayment agreement could result in delinquency and further collection action.

If a client receives three (3) Dunning Notices over the life of the debt, he/she is determined to be delinquent and the debt is referred to the CRES collection system for additional collection action including levy, warrant/lien and Department of Revenue (DOR) state tax intercept. The referral date is noted on BVPA as “Referred to CRES”.

If a client is delinquent on a current CC overpayment, and receives another overpayment, the second overpayment is automatically considered delinquent, without the client receiving any additional Dunning Notices.

4.6.1.7 Posting a Client Payment

If a local agency receives a check payment for an overpayment, the check must be sent to the PACU for posting to the debt. If an agency receives a cash payment, the agency must deposit the cash and make a check payable to the PACU for the amount of the payment.

4.6.2 Delinquency Collections Process

4.6.2.1 Referrals to Central Recoveries Enhanced System (CRES)

At the end of the first business day of each month, a cycle will run that looks at the prior months' claim creations, repayment agreements, and received payments.

- If a new claim was entered, CARES will automatically generate an RPA to each person liable for the debt.

- If an RPA exists, CARES will review the BVPA to see if a returned RPA was entered.
    - If it was, the system checks for payments received for the month. All payment amounts must total at least the installment amount on BVPA. If all payments for the previous month do not equal to at least the total installment amount, CARES generates a Dunning Notice.
    - If it was not entered on BVPA or if a repayment was not equal to the monthly amount or an amount agreed upon in the RPA, CARES generates a Dunning Notice.

- If a repayment agreement has not been entered on BVPA, but a payment has been made, CARES will generate a Dunning Notice. If a client alerts the worker to this situation, the worker can reset the Dunning Notice, if the payment satisfies the amount in the repayment agreement; otherwise, no action is necessary by the worker.

If a client receives three (3) Dunning Notices over the life of the debt, CARES determines the client to be delinquent and the client is referred to the Central Recoveries Enhanced System (CRES) for additional collection action including levy, warrant/lien and Department of Revenue (DOR) for state tax intercept. The referral date is noted on BVPA as "Referred to CRES."

4.6.2.2 Levy

A levy is an involuntary collection from a third party, such as an employer or financial institution, which holds a debtor's earnings or property. The PACU has authority to levy any amount over $1,000 from an account at a financial institution and/or up to 25% of a debtor's disposable wages to repay a delinquent child care debt. Any debt referred for levy action must be at least $300.

1. Notice Prior to Levy (NPL): PACU sends a NPL to the debtor by certified mail. This notice is a demand for payment in full within 10-days and a notification that

further legal action is intended to collect the debt. There are no appeal rights attached to this notice.

2. Levy Issuance**:** If the debtor does not respond within 10 days after the NPL is sent, the Department will serve the levy on the debtor. If an employer match is found, and no acceptable arrangements have been made, a levy notice is sent by PACU via certified mail to the employer. A copy of the levy is also sent by certified mail to the debtor's last known address. The levy notice contains the debtor's administrative hearing rights on the levy action along with instructions for how to request a hearing. The debtor has 21 days from the date of the notice, to request a hearing on the levy action through the DHA. If the debtor is granted a hearing, the levy action will continue throughout the hearing process. If the debtor requests an appeal, the subject matter of the appeal is limited to prior payment and/or mistaken debtor identity.

4.6.2.3 Warrant/Lien

Another collection method used is to issue a warrant, which becomes a perfected lien on real and personal property, such as a home. The overpayment amount must be over $300 in order for a warrant/lien to be issued and is only valid in the county where the warrant is docketed. The debtor has 21 days from the date of the notice to request an appeal, which is limited to issues of prior payment and mistaken debtor identity. If the debtor requests an appeal, the warrant will remain in effect during the appeal process. When the amount in the warrant and all costs due the Department has been paid, the Department shall issue a Satisfaction of the Warrant that states the outstanding balance has been paid in full.

4.6.2.4 DOR State Tax Intercept

If a debt is considered delinquent, the debt is certified to the Department of Revenue (DOR) to offset tax refunds and/or credits. The debtor is sent a notice to their last-known address, 30 days prior to certification of an overpayment that the Department. The notice informs the debtor that the Department intends to certify the delinquent overpayment to the DOR and that the debtor has 30 days from the date of the letter to request an appeal.

If the debtor requests an appeal, the Department will not certify the amount to the DOR during the appeal process. The certified amount represents the total outstanding balance due, and the certification will remain until the debt(s) are paid in full. If the debtor requests an appeal, the appeal is limited to the tax intercept matter.

If the debtor has filed for bankruptcy, the debtor must inform the Department because all collections actions are ceased during a bankruptcy. All bankruptcy notices must be forwarded to PACU for handling.

4.6.2.5 Delinquency Collections Appeal Process

In client collections cases, the local agency that established the overpayment is also responsible for handling the delinquency collections appeal process for levy, warrant/lien and DOR tax intercept.

The required documents for delinquency collections hearings include:

- Original overpayment notices that include the hearing rights (system-generated and manual CC Overpayment Notice (DCF-F-DWSW11250-E)
- Calculation of the overpayment (CC Overpayment Worksheet DCF-F-452-E or its functional equivalent)
- The decision from any prior hearing
- Three (3) Dunning Notices from the benefit recovery (BV) system
- Signed repayment agreement (RPA), if one exists
- Delinquency collection notice(s) -- notice prior to levy, levy notice, DOR certification notice of tax refunds or credits, and notice of warrant docketed
- Any other supporting documentation that will support the reason for the overpayment

PACU will provide the agency with copies of the appropriate delinquency collection action notices, which include levy notices, warrant notices and tax offset notices. If you have not received the documentation prior to the hearing, contact PACU at 1-800-943-9499 or dwspacu@wisconsin.gov.

PACU receives all requests for collection related appeals and will forward the Request for Summary to the local agency. The agency must complete the Request for Summary and return it to DHA. DHA will then process the appeal and notify the agency of the scheduled hearing date and time.

According to statute, the only issues to be determined in collections hearings are the identity of the debtor and whether the debt has been repaid. However, occasionally the ALJ undertakes a review of the merits of the case. In this case, the agency should be prepared to defend the underlying overpayment determination. If the ALJ expands the inquiry in any way beyond the identity of the debtor and the balance currently due, the agency employee should object for the record and then proceed with the hearing. Immediately following the hearing, please contact the DCF OLC.

4.6.3 Retention of Records

The Department and local agencies are responsible for retaining all records, including letters and notices sent by the agency, for a minimum of three years after an overpayment claim reaches a zero balance or are written off.

4.7 Confidentiality and Routine Disclosure

Agencies and tribes shall not unnecessarily disclose any information about the client, provider, or reasons for an investigation, to any person without permission. 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 governmental 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 or her authority to request the information, the violation under investigation, and the individual being investigated. However, this does not apply to the DA or to fraud investigators (49.83, Wisc. Stats).
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PART B: PROVIDER PROGRAM INTEGRITY

4.8 Prevention

4.8.1 Agency Refusal to Authorize to a Child Care Provider

The child care administrative agency may refuse to issue an authorization to a licensed provider if:

- The licensed or certified child care provider refuses to submit documentation of their prices in response to an agency request.
- The parents need for child care does not match the provider's hours of operation.
- Adding the child would put the provider overcapacity.
- A child care provider is pending a criminal charge alleging that they have committed a serious crime or have been convicted of committing a serious crime as defined in s. 48.685 (1) (c) 3m.
- The child care provider has been convicted or is pending conviction of a crime the offense substantially relates to the care of children or the department or county department determines that the offense substantially relates to the operation of a business, 49.155(7)(b1).
- The child care provider has been convicted of a serious crime (such as abuse or neglect), 49.155(7)(b)(3).
- The Department or agency reasonably suspects that the person has violated any provision under the Wisconsin Shares program, 49.155(7).
- If more than 40 percent of all children enrolled by the provider are children of employees, 49.155(3m)(e). The Department or local agency finds a provider to be in violation of this rule, the provider shall be given a six-week notice prior to ending authorizations for those children (see 4.9.1.3).

The local agency may limit the number of children authorized to a certified or licensed family provider for the period of time that it appears the provider may be over the capacity. Before authorizing to a family provider, when they appear to be over their capacity, the provider must show why he/she would not exceed the applicable group size limitation. Providers can show that they are not over their regulated capacity by submitting information listing the children in care, the hours and times of care, the child's age and the child's relationship to the provider.

Child care provided when the provider is over capacity is not eligible for subsidy payment as the provider is out of compliance with their regulation during this period of time.

4.9 Detection

4.9.1 40% Rule

According to s. 49.155(3m), if more than 40 percent of the total number of children attending a licensed provider are children of employees of the provider who receive

Wisconsin Shares, the Department and local agencies may refuse authorizations. This is commonly referred to as the 40% rule. Authorizations may not be made to certified providers that employ parents who participate in Wisconsin Shares.

Child care funds may only be distributed to a child care provider licensed under s.48.65, if at least 60 percent of the children for whom the child care provider is providing care are "qualifying children". A qualifying child is defined as:

- He or she is not a child of an employee of the child care provider *and*
- He or she does not reside with an employee of the child care provider

On a monthly basis, the local agency must monitor child care providers by obtaining the Parent Employment List in EBT CSAW, documenting the status of each provider and reporting this to their Bureau of Regional Operations (BRO) child care coordinator. For those providers that are out of compliance, the local agency shall send a 6-week notice, 2-week notice, and Ending Wisconsin Shares Authorization Notice for all Wisconsin Shares children of employees to those providers that do not come into compliance.

4.9.1.1 Out of State Providers

Providers in surrounding states, such as Minnesota, Illinois, Iowa or Michigan, who accept children in the Wisconsin Shares subsidy program are also subject to the 40% rule and must be monitored by the local agency. CSAW only identifies Wisconsin Shares authorizations, it does not identify private pay, or out-of-state subsidy children; the local agency will need to research and determine if the presence of private pay or out-of-state subsidy children increase the provider's numbers and brings them into compliance.

If an out-of-state provider accepts children participating in Wisconsin Shares, the provider can count children from their "home state" as qualifying children (children attending the facility who are not children of employees) when calculating the 40% rule.

It can be documented within CSAW by the local agency when a provider appears to inaccurately exhaust their 40%.

Example: For example, XYZ daycare is located in Sometown, MN. 15 children attend the daycare of which 9 are from Minnesota and 6 are Wisconsin Shares children, whose parents all work for the provider. The provider would not be in violation of the rule as they would be right at 40% (6 non-qualifying children divided by 15 total children).

4.9.1.2 Calculation of the 40% Rule

To calculate the actual percentage of qualifying children:

- Determine the total number of children (both authorized and private pay) for the child care provider for all locations combined.

  Note: A child can have more than one authorization. Only count the child, not the child's number of authorizations to that provider.

- Determine the total number of “non-qualifying” authorizations for the child care provider for all locations. Non-qualifying authorizations are for children who reside with employees of the child care provider or whose parent has reported his or her employer as being this child care provider.

- Take the number of “non-qualifying” authorizations and divide that number into the total number of children attending the child care provider. If the resulting number is greater than 0.40, the provider is not in compliance with the 40% rule.

Example: On January 1, 2011, ABC123 daycare has only one location with 15 Wisconsin Shares authorizations and 60 private pay children, for a total of 75 children. Of the 15 Wisconsin Shares children, seven of them are children of employees of the provider and are considered “non- qualifying” children. However, in EBT-CSAW this provider will appear to be violating the rule and the Parent Employment List screen will say “47% of parents appear to be employed by the provider.” The calculation should be based on the total number of children (authorized and private pay). Thus, the total number of children is 75, divided by 7 (the number of non-qualifying children), = 9%. This provider is not in violation of the 40% rule.

When the local agency can reasonably determine that a licensed group or family center is caring for a large number of children, but only a small percentage include subsidy children, it is reasonable to reach the conclusion, although EBT CSAW shows a possible non-compliance, that the larger numbers of private pay children brings the provider into compliance. The local agency is not required to identify the actual number of private pay children, rather a notation may be made by the local agency that the provider is in compliance.

An exception exists to the 40% rule where the parent works for another business that is owned by the same provider. This allows the employer to mitigate the 40% rule, but should still be flagged and reviewed by BPI.

Example: Tiffany works for Big University, and her children attend the day care center at Big University. Technically, Tiffany works for the same company that operates the day care. This does not violate the 40% rule.

4.9.1.3 Enforcement

If a provider has been found to not be in compliance with the 40% rule, agencies should take the following actions to correct the behavior.

1. Six-Week Notice: Initial Violation < 30 days

   If a provider has been verified to be out of compliance with the 40% rule, the local agency should send a six-week notice (on the local agency letterhead) to the provider and copy their BRO Child Care Coordinator. This notice informs the provider that they are currently out of compliance and that if the provider does not come into compliance within six weeks, all authorizations for children of parents employed by the provider will be terminated. Six-Week Notice Template.

2. Two-Week Notice: Continued Violation > 30 days
   For providers who have received a six-week notice and appear on the subsequent months report, the local agency should issue a two-week notice (on the local agency letterhead) to the provider and copy your BRO Child Care Coordinator, informing them that all authorizations to children of employees of the provider will be ended in two weeks due to the provider continuing to be out of compliance. Two-Week Notice Template.

3. Ending Wisconsin Shares Authorizations
   Within seven days of sending the two-week notice, the local agency should end the authorizations to the children of employees of the provider, effective the end of the month, unless the provider has given sufficient documentation to show that the provider is now in compliance. This will allow EBT CSAW to issue a notice over night the seven- day notice to both providers and parents that the authorizations are ending.

If the provider documents that he or she is in compliance prior to the authorization end date, the local agency should restore the authorizations to their original end dates. If the provider documents that he or she is in compliance after the authorizations have ended, the authorizations may be restored with the begin date of the day that the provider gave sufficient documentation to show that the provider is now in compliance.

In instances where authorizations are for parents who reside in a different local agency than the provider, the local agency in which the provider is located is responsible for monitoring and enforcing this policy. The responsible local agency will need to copy the other local agency on both the six-week and two-week notices and work with the local agency responsible for the authorization to have those authorizations ended if necessary.

4.9.1.4 Repeat Violations

After repeat offenses of the same violation and/or the non-corrective action of the initial notice, the following actions will be taken:

1. Initial Violation: For a first time violation of the 40% rule, issue a notice of compliance. This is the initial notification of the violation to come into compliance in before the next monthly authorization cycle.

2. Second Violation: For a second time violation of the 40% rule, issue a notice of compliance, and refuse to issue any new authorizations to this provider, including backdated authorizations. Agencies should also offer Technical Assistance to the provider.

3. Third Violation: For a third time violation of the 40% rule, issue a notice of compliance, and refuse to issue any new authorizations to this provider, including backdated authorizations. Notify the licensor to issue a citation. Agencies should also offer Technical Assistance to the provider.

4. Fourth Violation: For a fourth time violation of the 40% rule, issue a notice of compliance, and refuse to issue any new authorizations to this provider for six (6) months, including backdated authorizations. Notify BPI of the issue and potential permanent suspension (provider IPV). Agencies should also offer Technical Assistance to the provider.

5. Fifth/Final Violation: Notify BPI of the offense and proceed with a recommendation for permanent suspension.

4.9.2 Referrals

Referrals are a formal request for an investigation for fraud for both clients and providers. Agencies must develop procedures for how referrals are received, processed, and substantiated.

Note: Please send all fraud referrals through the appropriate channels (for example, the Fraud Mailbox). Do not send referrals directly to BPI staff. This will assist BPI with the tracking of processed referrals.

4.9.2.1 Tracking Referrals

The Department and local agencies are responsible for establishing a tracking method for all provider based referrals that includes the source, the allegation, background information, and the resulting action. Technical Assistance on the process of tracking referrals is available from the BPI (DCFBPITArequest@wisconsin.gov).

4.9.3 Red Flags

4.9.3.1 Red Flag Reports

Red Flag Reports are automatically generated reports available in WebI that identify whether providers are violating a set list of criteria. The Red Flag Reports flag providers that have either violated a policy or where there is reasonable suspicion of fraudulent activity. The findings from these reports are then utilized to generate possible referrals.

Provider Red Flag Reports include (but are not limited to):

1. Unusual Payment Timing Report
2. Payment Grouping Report
3. Provider Over Capacity Report
4. Child Mobility Report
5. Reimbursement per Slot Report
6. Licensing Provider Red Flag Report

4.9.3.2 Red Flags for Site Visits

Any red flags identified during a site visit conducted by any agency or Department staff should be reported to the relevant agency's local fraud investigator or BPI. Local agency agencies may develop their own red flags to add to this list that would result in a referral either to their internal fraud investigator or to the BPI. Below is a list of recommended red flags for site visits:

- Overcapacity
- Inaccurate SISO's
    - Meaning more children signed in than are present at the facility
    - Utilization is high but few or no children are present each time the provider is monitored
    - Times for SISO's seem to be rounded
    - Parent signatures entered prior to the end of the week (If parent signatures are required on the SISOs)
    - SISO's are missing or incomplete
- Siblings leaving at different times or at suspicious in and out times
- Three attempted unannounced visits (unable to access facility)
- Operating Outside of Regulated Hours
- Possession of MyWIChildCare EBT Cards, PINs, or any representation of these items

4.9.4 Data Tracking Requirements

Agencies are required to maintain counts of the total number of provider referral and the number of provider referrals opened for investigation. This information may be requested each year in the Agency Fraud Plan.

4.10 Provider Investigations

If resources are available, local agencies may conduct provider investigations or forward a referral to BPI via the Fraud Mailbox. If an agency requires assistance with an investigation, they may request Technical Assistance via the TA Mailbox. A BPI auditor/mentor may be assigned to assist with the completion of the investigation.

4.10.1 Local Agency Provider Investigation Tools

This section briefly details the various tools and required procedures that local agency investigations may utilize during a provider investigation. The tools listed in this section are not all encompassing.

4.10.1.1 Unannounced Site Visit

The Department, local agencies and licensing/certification specialists have the authority to visit and inspect any child care center at any time during licensed/certified hours of operation. By accessing and observing the facility, the agency can:

- Assess ratio and capacity
- Assess accurate recordkeeping.
- Determine whether the care of children is taking place
- Determine whether the care that is occurring is consistent with the provider's payment/billing records (through 2017)
- Determine whether there are any other indicators of suspicious activity

During a site visit, the investigator should review the original Sign-In/Sign-Out (SISO) sheets and, at the agency's discretion, and can remove up to three (3) years of the

records since the child's last date of attendance for auditing purposes. It is recommended that 52 weeks of records are removed. If records are removed, the local agency must leave a Removal of Records Receipt with the provider stating the date range of the records taken. When removing original records, the provider should be given an opportunity to make copies of the records if they have an onsite photocopier and copies can be made within a feasible timeframe. If copies were not made on site, the local agency or its contractor should make copies of the records and send them to the provider within 10 days of the visit.

During the visit, the investigator should offer Technical Assistance (TA) regarding best practices and should articulate any necessary policy clarifications. The TA is provided on a case by case basis, and is provider-specific to any errors that the auditor may identify while at the location. Any TA offered should be documented.

Investigators may also interview the provider during the site visit. Suggested interview questions include (but are not limited to):

- How many children attend the center, and how often?
- How many children are private pay?
- Are there any children in the home under the age of 7? (only for CERT/LFAM providers)
- Where do the children enter and leave the facility?
- Is transportation provided? Do you bill for transportation?
- Do you have any employees?
    - If yes, what are their names and shifts?
    - Do they have children that attend this facility?
- Do you have any volunteers?
- Do you participate in the food program?
- How is attendance recorded? (Not applicable after MyWIChildCare implementation)
- Who bills the Wisconsin Shares program? (Not applicable after MyWIChildCare implementation)

Once the investigator has completed the interview and received a copy of the SISOs, they will provide a property receipt (or Removal of Records receipt) and vacate the premises. Once they return to the office, they should complete an Incident Report summarizing the visit.

Agencies should develop their own Incident Report forms. Incident Reports should include the following information:

- Date and Time of the visit
- Provider Number
- Facility Name
- Brief description of all events that transpired during the visit, including:
    - The agency staff that participated in the visit
    - The date range of the attendance records requested

- When the agency staff arrived, and who answered the door
- The number of children in attendance
- Employees in attendance
- Hours of Operation
- How many children attend and at what times
- How attendance is entered
- Whether transportation is provided
- Licensee's work hours at the facility.

Note: When conducting an on-site visit, the local agency or their contractor must treat the provider with courtesy and respect. Identification should always be presented prior to entering the facility.

Note: During a site visit, local agency and state staff may encounter various concerns. If a provider is found to be strongly under the influence of either alcohol or drugs or appears to be impaired, the state or local agency staff member should contact their local police, utilizing the non-emergency line to report this information. If there are additional concerns regarding the children's safety, this information should also be sent to the provider's licensing/certification specialist.

4.10.1.2 Requesting Information

Investigators may request any additional information they believe may be beneficial for the case. This includes: requesting punch in and out times ("punch times"), conducting surveillance or monitoring visits, or holding parent interviews.

Punch times may be utilized to determine whether or not the parents were in their approved activity during the time period that the child is listed as in care. This assists in the determination of whether or not a client overpayment should be issued. Additionally, punch times may be used to verify the provider's work hours if they have outside employment. This assists in determining whether or not the center was open when they were billing. For instance, (prior to MyWIChildCare implementation) look to see if the provider was signed in on the SISO as caring for children, when they were punched in at work, etc.

4.10.1.3 Surveillance

Local agencies or their contractors may conduct surveillance on the provider's facility.

4.10.1.4 Monitoring Visits

Local agencies have the authority to conduct monitoring visits at any point during the investigation. During a monitoring visit, staff may collect additional records, and verify if TA is being utilized. This can be used as evidence in the concluding report. If any serious licensing violations are discovered, these must be forwarded to BECR or the facility's licensor or certifier.

Note: For contact information for BECR, please visit the Child Care Resources page: https://dcf.wisconsin.gov/childcare/resources.

4.10.1.5 Parent Interviews

Local agencies have the authority to conduct parent interviews. Parent interviews are occasionally utilized to determine whether or not the provider is reporting false information, and whether or not collusion is occurring. These may be conducted in person, in writing, or over the phone. It is strongly recommended that these interviews are recorded. Because Wisconsin is a one party consent state, investigators may record an interview without notifying or receiving consent from the subject (§ 968.29, Wisconsin Statutes).

4.10.2 Required Documentation

Several documents are required to be issued to providers following investigations.

4.10.2.1 Provider Explanation Letter

The Provider Explanation Letter (also referred to as the 7M letter) is sent out if a violation is identified during an investigation or audit. The 7M Letter provides details regarding the violated policy(ies), and requests the provider respond or provide an explanation for the violations within 30 days. The providers response may be verbal (an arranged meeting or via telephone), or in writing. It is encouraged that the providers provide an explanation in person (also known as a provider meeting). The 7M letter is sent via regular and certified mail.

If a provider has not responded within 25 days of the letter, the investigator should attempt to contact the provider again to encourage submission of an explanation. Explanation is not required, but is strongly encouraged.

4.10.2.2 Technical Assistance Letter

Local agencies should thoroughly document any TA provided to providers. An effective way is through the use of a TA letter. This letter documents any errors discovered and the recommended solution provided by the agency staff. It is highly recommended that this letter be signed and returned to the agency.

4.10.3 YoungStar Investigation Referrals

The BPI conducts provider YoungStar Investigations. If an agency encounters a situation where they believe a provider does not have an accurate YoungStar rating Registry, submit a fraud referral to the BPI Fraud Mailbox.

Indicators of YoungStar fraud include (but are not limited to):

1. During a site visit, teachers on the Registry are not in attendance
2. The teacher listed as the primary is not providing the majority of care
3. Teachers do not have the required certificates, etc. to be ranked as high as they are
4. Director and/or teacher does not have wages reported from the center
5. Director and/or teacher has wages reported from outside employment during the time they are registered as providing care on The Registry

Note: For additional information on the YoungStar rating Registry, please visit http://www.the-registry.org/.

Note: If a YoungStar investigation is opened and a YoungStar overpayment is determined, this will also be entered in the Recommendation, and must be approved by BELP.

Note: If YoungStar makes an error that would cause a negative impact to a provider in a given month such as a rating not completed in time, DCF has the ability to rate the provider on a case-by-case basis under minimal extenuating circumstances. Contact BPI for assistance with these cases.

4.10.4 Data Tracking Requirements

Agencies are required to maintain counts of the total number of provider investigations opened each year, and the total number of each outcome for a provider investigation: including closed no action, closed with agency error, closed with provider error, closed with provider stipulation, closed with provider permanent suspensions, and the overpayment amounts for each category. This information may be requested each year in the Agency Fraud Plan.

4.11 Sanctions

There are several forms of sanctions for providers, including overpayments, provider errors, permanent suspension (IPVs), and criminal prosecution. Each of these is discussed briefly below.

Under the authority of DCF 201.04(5)(c) any of the following actions may be taken against a provider who submits false, misleading, or irregular information to an agency or the Department, or if the provider failed to comply with the terms of the program in § 49.155, Wisconsin Statutes, or DCF 201, and the provider fails to provide to the satisfaction of the Department an explanation for the noncompliance.

1. Refuse to issue new child care authorizations to a provider for a period of time not to exceed six (6) months.
2. Revoke existing child care authorizations to the provider.
3. Recoup and/or recover overpayments under par. DCF 201.04(5)(e) or DCF 201.04(5)(ed), or recover overpayments
4. Impose forfeiture on the provider under DCF 201.04(5)(cg).

Additional sanctions include:

1. Overpayments: assessed whenever a provider received a higher benefit amount due to an Administrative Error, Provider Error, or permanent suspension.
2. Stipulation: A written notice that explains the required conditions for remaining in the Wisconsin Shares program, including any hearing rights. This is usually awarded in lieu of a permanent suspension, and may be associated with a refusal to grant new child care authorizations to a provider for six (6) months

3. Permanent Suspension/Intentional Program Violation: issued when a provider has intentionally violated Wisconsin Shares policy. These may be assessed with or without an overpayment. If an IPV is awarded, the provider is permanently suspended from the Wisconsin Shares program. This will result in the revocation of existing child care authorizations to the provider.

4.11.1 Overpayments

The Department, local agencies and tribes shall take all reasonable steps necessary to recover any overpayment made due to administrative error, provider error, or intentional program violation, DCF 201.04(5)(a)1. when the provider was not eligible for the amount of subsidy paid. All calculated overpayments resulting from an investigation and attendance record review, regardless of the dollar amount, shall be established in CSAW. For provider overpayments, the negative adjustment amounts shall be entered in CSAW for each affected week and authorization. Once entered in CSAW, a notice will be generated and sent out that weekend. Recoupment of any negative adjustments will begin two weeks later.

Overpayments are issued when a provider received a higher payment amount than they were eligible to receive. Provider overpayments may be as a result of an administrative error, provider error, or permanent suspension.

Providers are liable for all overpayments described in this section, unless otherwise identified.

Note: BPI has authority to issue overpayments and sanctions to child care providers as written in 49.155(7b) and 49.155(7m), Stats., and DCF 201.04(5), 250.04(1), 250.05(4), 251.04(1), and 251.05(4).

4.11.1.1 Overpayment Calculations

To determine the overpayment amount for a provider, three items must be verified or determined:

1. Determine Overpayment Period.
2. Verify funds have not already been covered from the client for the same time period.

4.11.1.1.1 Overpayment Period

The overpayment period be established with a begin and end date. The overpayment begin date for providers will be the first date of the error through the either the last day of the error, or defined by the audit range.

Claims for incorrect payments due to an intentional program violation or provider error, may be established for up to six (6) years prior to the notification date of the overpayment, also known as the date of discovery.

The overpayment period for an administrative error claim ends with the month the error last occurred and extends back 12 months or when the error first became effective, whichever is most recent. The overpayment period for an administrative error overpayment cannot begin more than 12 months prior to the notification date of the overpayment (§ 893.43, Wisconsin Statutes).

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

4.11.1.1.1.1 Correcting an Overpayment

Recoupment begins two weeks after a negative adjustment is entered in CSAW for a provider. Negative adjustments can be corrected in CSAW prior to recovery. Once recoupment begins, the worker cannot change the negative adjustment. If a worker needs to change the amount after recoupment has begun, please contact BPI via the Technical Assistance mailbox.

As of June 2017, recoupment will no longer be possible. Any provider negative adjustments entered in CSAW will be referred to BV for recovery.

4.11.1.1.1.2 Entering an Overpayment

If it is an overpayment from a time period **prior to** MyWIChildCare implementation for your agency, enter it in CSAW using the current procedure.

If it is a provider overpayment **after** MyWIChildCare implementation:

1. If the overpayment is for **YoungStar, Accreditation, or a Provider Price** correction, the calculation should be completed in PLBC. No additional steps need to be taken by the agency after the calculation has been completed in PLBC.
   Note: Agencies cannot calculate overpayments for YoungStar and Accreditation overpayments. Please contact the Bureau of Program Integrity (DCFBPITArequest@wisconsin.gov) for assistance with the calculation in PLBC.
2. **For any other provider overpayments**: Calculate the overpayment off system and enter the amount in the Ad Hoc Functionality in EBT CSAW. No additional steps need to be taken after the entry has been made in the Ad Hoc Functionality in EBT CSAW.

4.11.1.1.2 Verify Funds

To verify funds have not already been recovered from the client for the same time period, the worker must search the client's case in BV. If no overpayment has been issued to the client for the date period in question, an overpayment may be assessed for the provider.

4.11.1.2 Overpayment Classifications

4.11.1.2.1 Administrative Errors

Administrative Errors (also referred to as agency errors) are defined as an overpayment that was a result of agency entered information that was incorrect. There are several types of Administrative Errors that may be assessed: those that affect eligibility and those that affect authorizations.

Note: If a provider overpayment occurs that is an administrative error for YoungStar, the overpayment will be recouped at 10% from future YoungStar issuances to a continuing provider.

Provider administrative errors may include (but are not limited to):

1. Incorrect Entry of Provider Information
2. Incorrect Entry of Provider Billing Information (Prior to MyWIChildCare Implementation)

4.11.1.2.1.1 Incorrect Entry of Provider Information

This error may occur when a worker enters a provider's information incorrectly. This may include accreditation, provider price, YoungStar rating, etc. Correct the information in PLBC for impacted (past or current) months and in EBT CSAW for future months. If the correction calculates an overpayment, enter the overpayment in CSAW.

4.11.1.2.1.2 Incorrect Entry of Provider Billing Information

This error may have occurred under the previous payment structure (the structure up until MyWIChildCare implementation). In this case, an agency worker may have entered the provider's ARFs into CCPI incorrectly, resulting in either an under or overpayment. If the correction calculates an overpayment, enter the overpayment in CSAW.

4.11.1.2.2 Provider Error(s)

Provider Errors are unintentional or inadvertent errors made by a provider where they reported incorrect information (such as billing incorrectly), failed to report information, or violated any Wisconsin Shares, licensing, certification, or YoungStar policies. The Department or local agency shall take all reasonable steps necessary to recover from a provider any overpayments made for child care services for which the provider was not eligible for.

Through 2017, the following Provider Errors will remain for any remaining provider investigations. Many of these overpayments refer to the previous payment structure (from the state to the provider). However, many of these will remain under the MyWIChildCare initiative.

Provider Errors include (but are not limited to):

- Over Billing/Reporting
- Providing Care at an Unauthorized Location
- Overcapacity

- Billing Outside of Regulated Hours
- Contradictory Records
- Provider Reporting Incorrect Information
- Displaying Incorrect Information on a YoungStar The Registry Profile

Note: If a provider overpayment occurs that is a provider error for YoungStar, the overpayment will be recouped at 25% from future YoungStar issuances to a continuing provider.

4.11.1.2.2.1 Over Billing/Reporting

This is assessed when a provider received reimbursement based on attendance records that billed for more hours than a child was in attendance. Evidence supporting this error includes: childr(en) are not listed on the SISOs, or billing when there was no access to the facility documented by Department or agency staff.

This error is only possible for cases that were under the payment system prior to MyWIChildCare. This type of overpayment can be made for up to six (6) years after the implementation of MyWIChildCare.

Example: According to the provider's SISO, Jenny Jones arrived at 7:25 a.m. on February 17 and left at 3:55 p.m. However, when Jenny's hours were reported on the standard ARF, the provider billed her as arriving at 7:00 a.m. and leaving at 4:00 p.m. The total overpayment would be for 25 minutes from the morning, because rounding rules instruct the provider to report Jenny as arriving at 7:30 a.m. on the ARF.

Example: A provider billed for John Smith attending 40 hours the week of August 10; however, no attendance records were available when the Department made the onsite visit. 35 hours are considered a full time authorization; therefore, a 35-hour overpayment would be established.

4.11.1.2.2.2 Providing Care at an Unauthorized Location

This overpayment is assessed when a provider received reimbursement for care provided at a location other than the location for which the authorization was issued. Providers who claim attendance for children at a location that is not authorized and/or regulated are out of compliance with their regulation for the time period in which this care occurred and an overpayment shall be established. The funds will not be re-issued to the correct provider location.

Example: Tim Thomas has an authorization for a child care provider at location 001; however, on October 28 7 hours of care is provided at location 002. The overpayment shall be established for the full 7 hours since Tim's authorization was not for location 002.

4.11.1.2.2.3 Overcapacity

This overpayment is assessed when a provider received reimbursement for care when the provider was in violation of the limits on the maximum number of children in care. Providers that are out of compliance with their regulation are subject to overpayments for the period in which they were out of compliance, as they are not considered properly

regulated during that period. A full overpayment will be assessed for every child for the time in which the facility was overcapacity.

Example: Mary Jones is a licensed family provider with a capacity of 8 children. On April 12, she had 10 children in care between 3 p.m. and 5 p.m. Six of those children were authorized and reported as attending from 8:00 a.m. to 5:00 p.m. and four school-aged children attended from 3 p.m. to 8 p.m. An overpayment would be calculated for all Wisconsin Shares children that were in care from 3 p.m. to 5 p.m., which is the time during which the provider had more than eight (8) children and therefore was overcapacity.

4.11.1.2.2.4 Billing Outside of Regulated Hours

This overpayment is assessed when a provider was in violation of the terms of the provider's license, such as the age of children served by the center and hours, days, and months of operation of the center. Providers who claim attendance for children during times that they are not regulated or at a location that is not authorized/regulated, are out of compliance with their regulation for the time period in which the care occurred. Payment for attendance outside of regulation results in an overpayment for all subsidized children during the period the provider was out of compliance.

Example: Sue Jones is licensed to provide care from 6 a.m. to 6 p.m. Her sister, Mary Jones, works from 3:00 p.m. to 11 p.m. and Sue is paid for the care she provides to Mary's children from 2:30 p.m. to 11:30 p.m. In calculating the overpayment, consider the hours from 6:01 p.m. to 11:30 p.m. (5 ½ hours) to be overpayment hours. This should also be reported to her licensor.

Note: This will only be possible for cases that were under the payment system prior to MyWIChildCare. This type of overpayment can be made for up to three years after the implementation of MyWIChildCare in your region.

4.11.1.2.2.5 Contradictory Records

An overpayment may be assessed when the attendance/classroom/tracking records demonstrate contradictions, such as: the times on the records for specific children overlap, gaps in care, or make it unclear where the child actually was, or whether they were in care.

The following are representative examples of these instances (but are not limited to):

- Discrepancy between receipts and SISOs
- No Access to SISOs: The provider refused or failed to have SISOs available when the Department requested to review them
- Overbilling: The provider billed the parents for more hours than children actually attended
- Billing with no name on SISO: The provider billed for children who did not appear on the SISOs for the week
- Billing with no hours on SISO: The provider billed for children whose names appeared on the SISOs but were marked as absent or had zero hours of attendance on the attendance records for the week

- Missing SISO Times: The provider billed for children who were missing a sign in or out time
- Parent Schedule Discrepancies: The provider is billing for time when the parent was not in their approved activity
- Provider is anticipating children's schedules and/or rounding times, rather than recording the actual arrival and departure time of the children
- Parent signatures do not match from week to week or are different from parent's records

4.11.1.2.2.6 Provider Reported Incorrect Information

A provider reported to an authorization worker the incorrect provider price or accreditation information (only applicable for out–of-state providers), and this incorrect price affected the amount of subsidy funds received. To determine that this is a provider error rather than an administrative error, the provider price reported would most likely have to be submitted in writing.

Example: Provider 123 submits their provider prices to their local agency in writing in September. They report charging $300 a week for 0-1 years old, $250 for ages 1- 3 years old, and $200 for 4-12 years old. However, in November the provider reports that they submitted the inaccurate pricing accidentally. They actually charge $325 a week for the age group 0-1 year olds. The agency must enter this correction in PLBC for all of the previous months, in this case September, October and November. If PLBC results in an overpayment, this should be entered in CSAW as a provider overpayment.

4.11.1.2.2.7 Displaying Incorrect Information on the YoungStar Program The Registry Profile

This occurs when a provider intentionally misrepresents information on their YoungStar Program Registry Profile that impacts the YoungStar rating. This may include: displaying the incorrect director, teachers, facility location, ownership, or teacher Registry Career Levels. If an egregious inaccuracy or if the inaccuracy was intentional, this may be classified as an IPV (4.11.3).

YoungStar adjustments will be made directly to providers on a monthly basis. If a provider receives a YoungStar adjustment for which they were not eligible, an overpayment will be assessed. This overpayment will be recouped from future issuances for 3 star or higher rated facilities. For 2 star or lower facilities, this amount must be entered in the BV system.

Contact BPI with the information. BPI will:

1. Locate the Provider in the PLBC Module and correct the YoungStar rating.
2. Calculate the overpayment:
    a. If the facility is a 3 Star or higher rated facility, the overpayment will be recouped from future issuances.
    b. If the facility is two stars or lower, this amount must be entered in to the BV system.

c. The overpayment must take into consideration the 90-day grace period in which providers have the ability to report the change and find a new staff member to maintain their current Star Rating.

3. Move the provider through the Quick Collect process.

Example: ABC Day Care has a lead teacher with a profile registry of 9. This teacher's rating makes the facility a 4 Star facility. The teacher leaves ABC Day Care on August 10. The Director intentionally does not report this to the agency in order to preserve their 4 Star rating. The Bureau of Program Integrity discovers this in January. The overpayment begin date will be November 10, through the last day of January, because of the 90 day grace period, and the rating will be updated for future months.

Example: Sandy's Child Care loses a staff person on October 4. When the rating batch occurs on October 15 occurs, a pending 4 Star rating is generated for the program. On January 15, if the rating batch runs and still shows the program at 4 Star, the YoungStar Technical Consultant will activate the October 15 4 Star pending rating. No overpayment will be issued and the Wisconsin Shares payments will become reflective of the 4 Star beginning February 1.

4.11.2 Stipulations

Stipulations are issued to providers by senior auditors at BPI following the formal investigation process, or if requested by an agency investigator. A stipulation is issued to a provider in lieu of a permanent suspension in cases that meet the criteria for a permanent suspension, but the providers are receptive of the corrections, and there is evidence that the provider will come into compliance in the future. Stipulations may also be awarded to cases where there is not enough evidence to support a permanent suspension. If a stipulation is issued, an audit should be conducted six months later. This allows the Department to offer additional Technical Assistance, and assist in maintaining the Department's mandate for having accessible, high-quality child care centers. An overpayment should still be taken for any overpayments attached to the stipulation.

4.11.3 Permanent Suspension

Providers may be permanently suspended (also referred to as a provider IPV) when they *intentionally* make a false or misleading statement, misrepresent or withhold facts, or commit any act that constitutes a violation of state or federal law for the purpose of using, presenting, transferring, acquiring, receiving, possessing, or trafficking benefits.

Permanent suspensions are determined by the Department and/or local agency, and approved by Division administrators. Providers may be suspended for any of the following actions (but are not limited to):

- Numerous Wisconsin Shares violations are uncovered
- Egregious overpayments are uncovered
- The provider had a previous stipulation

- Possessing and/or utilizing parent's MyWIChildCare cards, account numbers, and/or PINs to issue payment to themselves, or any representation of these items
- Cashing benefits or providing "kickbacks" to parents

If an agency believes that a permanent suspension is warranted, they must submit the case to BPI for review via the Technical Assistance Mailbox. The agency should provide a brief summary of reasons for the permanent suspension.

Once received, a BPI team member will contact the requestor for additional assistance. The agency worker will have to complete a recommendation document that will be provided by BPI. All requested permanent suspensions will be heard at the bi-weekly permanent suspension meeting.

4.11.3.1 Permanent Suspension Meeting

If an investigator recommends a permanent suspension, a meeting must be held with the lead investigator/auditor, BPI Supervisors, OLC, and DECE administration. The investigator must defend why they are recommending permanent suspension, and defend the accuracy of the overpayment period, the overpayment amount, and the egregiousness of the violations. The assembled body will then approve or deny the permanent suspension. If the Division approves the suspension, the provider will never be allowed to participate in Wisconsin Shares again (as a provider) and will receive an overpayment to recover any misappropriated funds. If a permanent suspension is granted, a notice will be sent within 48 hours or within two (2) business days. The following week, any overpayments attached to the suspension must be entered in CSAW and coded as IV.

4.11.4 Provider Appeal Process

Providers have the opportunity to appeal two decisions. They may appeal: 1) the overpayment amount and 2) the issuance of a permanent suspension (IPV) (if applicable). The provider must submit the appeal request in writing and indicate which decision they wish to appeal. The appeal processes for the overpayment amount and the permanent suspension (IPV) issuance are described in detail below.
When an enforcement action is taken against a provider such as the determination of an overpayment or a suspension from the Wisconsin Shares program, the provider will receive an enforcement notice from the Department or local agency. This action is appealable within 30 days from the date of the enforcement notice. If the provider appeals the enforcement action, they are instructed to send a letter of appeal to the Division of Hearings and Appeals (DHA) with a copy of the enforcement notice. Requests for a hearing sent to anyone other than DHA do not constitute a proper request. For an active provider, CSAW will continue to recover an overpayment during the appeal process by reducing each issuance up to 50%.

DHA will notify DCF OLC or the local agency human services staff of all appealed enforcement actions by sending an acknowledgment of receipt of appeal as well as a copy of the appeal letter. DHA assigns an administrative law judge (ALJ) to the case

and DCF assigns an attorney to represent the Department. DHA will also send a notice to the provider and their attorney, if they are represented, that an ALJ has been assigned to the appeal.

Each local agency is responsible for ensuring program integrity in the Wisconsin Shares program. The contract between the local agencies and the Department requires the local agencies to provide legal representation as necessary at all hearings. Corporation counsel is strongly urged to provide representation at all provider hearings. DCF OLC is available to provide training and technical support.

4.11.4.1 Pre-Hearing Conference Call
See Section 4.5.7.3.1 for policy and procedure.

4.11.4.2 Witness Lists
See Section 4.5.7.3.2 for policy and procedure.

4.11.4.3 Exchange of Exhibits
The DCF OLC or local agency legal staff is responsible for submitting all exhibits that will be used in the hearing to the ALJ and opposing party. The exhibits for a provider hearing should include documents, such as:

- For a licensed provider- the licensing application, license and transmittal/cover letter from the regional licensing staff
- For a certified provider- the certification application, certified provider number, and transmittal/cover letter from the certifying agency such as a local agency that authorized the certification.
- Copy of overpayment or suspension letter.
- Any amendments to the Department's or local agency's original overpayment calculation.
- Relevant notices of violation (294) from Bureau of Early Care Regulation (BECR).
- Removal of Records Receipt (from the onsite visit) signed by the investigator and provider.
- Non-compliance statements (such as no access visits) or incident reports from BECR.
- SISO sheets and attendance report forms (ARF) for the overpayment period.
- In/out mode report from CCPI, if applicable.
- A spreadsheet of representative weeks of the overpayment calculation (legal staff should work with the lead investigator to understand the calculations).
- Total negative adjustment (overpayment) amount.
- If emails are included, redact any information regarding other providers.
- Signed ARF and CCPI language that the provider attests to the accuracy of the information submitted for billing (maintain for three years).
- Summaries of parent interviews conducted.
- The index and overpayment calculation information from the Child Care Chapter 4 manual.

- *DCF Provider Newsletter* (formerly *Sharing the News*).
- Copy of signed YoungStar contract.
- Anything else relevant to the investigation.

4.11.4.4 Hearing
See Section 4.5.7.3.4 for policy and procedure.

4.11.4.5 Proposed Decision
After the hearing is held, the ALJ may request either oral or written closing arguments. Within 30 days, the ALJ will draft a proposed decision and submit it to DCF or the local agency, and the provider or their attorney (if they are represented). At that time, both parties have an opportunity to submit objections to the ALJ's proposed decision.

4.11.4.6 Final Decision
The Department or local agency designee will review objections submitted by both parties and draft the final decision. The final decision may simply adopt the proposed decision. The final decision will be issued to all involved parties in the case. The provider may appeal the decision within 30 calendar days to Circuit Court, or petition for a rehearing within 20 calendar days if the provider can show a material mistake of law or fact or if the provider has discovered new evidence that was unavailable at the time of the hearing.

4.11.4.7 Dismissal
See Section 4.5.7.3.6 for policy and procedure.

4.11.4.8 Remand
See Section 4.5.7.3.7 for policy and procedure.

4.11.4.9 Stipulation
At various stages during the appeal process, the parties may reach a resolution to their differences. In that case, a stipulation is drafted by the Department's lead attorney or local agency legal staff. The conditions of the stipulation must be approved by the Bureau of Program Integrity Bureau Director or by the designated appropriate local agency official.

4.11.5 Data Tracking Requirements
Agencies are required to maintain data and total counts of the following information:

- Total number of Administrative Errors
- Total number of Provider Errors
- Total number of Provider Permanent Suspensions (IPVs) requested and approved
- Total amount of overpayment for each sanction type
- Total number of provider appeals for overpayments and permanent suspensions (IPV)
- Total number of provider remands
- Total number of provider remands not completed within the 10-day grace period

This information will be requested each year in the Agency Fraud Plan.

4.12 Collections

Once a sanction and a monetary overpayment are established, it is necessary to cooperate with the PACU to retrieve the state and federal monies that were deemed inappropriate for the parent or provider to have received.

Note: DCF has authority for all collection actions described in this section through Wisconsin Statutes §49.155(7m), 49.85.; and DCF 201.04(5)(b), 201.04(5)(c), 201.04(5)(e), 201.04(5)(ed), 201.04(5)(eh) , 201.04(5)(ep),and 201.04(5)(et).

4.12.1 Recovery of Provider Overpayments

All overpayments made to a child care provider, whether the overpayment is due to administrative error, provider error, or a provider permanent suspension, must be collected. The Department or local agency calculates the overpayment and establishes it in CSAW, which will generate a Child Care Payment Adjustment Notice of Decision. The notice is mailed to the last known address in CSAW and informs the provider of the overpayment, child(ren)'s names and attendance date(s) that caused the overpayment, the reason for the overpayment, and the provider's appeal rights.

The provider may also receive an individualized Notice of Overpayment, mailed to the last known address in CSAW, from the Department or local agency that established the overpayment. This letter should be generated on local agency letterhead and include the amount of the overpayment, which DCF 201.04(5)(b),and 201.04(5)(c), administrative rules were violated to create the overpayment, and the process for the provider to appeal the overpayment. If the local agency sends a manual notice of overpayment, it should be sent at the same time as the system-generated notice, so that the time period to appeal is the same.

Recovery of an overpayment will occur in one of the following ways:

1. Voluntary Repayment Agreement
2. Referred to the benefit recovery (BV) system in CARES through the Quick Collect Process.

This procedure stands for both inactive Wisconsin Shares providers, as well as those permanently suspended from the Wisconsin Shares program.

4.12.1.1 Voluntary Repayment

The Voluntary Repayment Process occurs when a provider agrees of their own accord to return funds to the Wisconsin Shares program. This may occur due to a provider believing they have been overpaid or due to an authorization to the incorrect provider. If the provider agrees to the Voluntary Repayment, the provider must complete the Voluntary Repayment Agreement and return it to the Department or local agency. The form may be mailed to the provider, and returned via email, scan or fax. This form must be scanned in to the ECF. The Department will then contact FIS to initiate the Voluntary Repayment process. The funds will be debited from the provider's bank account

registered with FIS and returned to the state. It is vital that the funds are in the account when the debit is processed. If funds are not available, the Department will receive a failure notice. The Department will then force the provider through the Quick Collect process.

If a provider would like to submit a manual check rather than use the Voluntary Repayment process, they may do so. Agencies must still enter a negative adjustment in CSAW in order for the check to be processed by PACU.

4.12.1.2 Overpayment Reconciliation Process

When a provider has been suspended from the Wisconsin Shares program and has received a final decision on the suspension and overpayment or has passed the 30 days to appeal a suspension and overpayment, the provider is reconciled in CSAW. The reconciliation process is completed to finalize the suspension and/or overpayment.

DCF manages reconciliations for all providers. When an overpayment has been established in CSAW, the Department looks for any held payments for care provided prior to the suspension date. If there are “pre-suspension” held payments, these are applied to the established and upheld overpayment, reducing the overpayment amount that the provider owes.

The Department also indicates in CSAW that the provider has been permanently suspended, which then refers the provider to the Benefit Recovery (BV) system in CARES to begin recovery of the remaining overpayment.

4.12.1.3 Personal Liability for Overpayment

If the provider is a corporation or limited liability company (LLC), the Department will first attempt to collect the overpayment from that corporation or limited liability company. However, 49.155(7m)(b) Wisconsin Statutes allows the Department to recoup overpayments from some officers, directors or employees of a child care provider that is a corporation, and some members, managers, or employees of a child care provider that is a limited liability company. These people may be found personally liable for overpayments if the business, corporation, or limited liability company is unable to repay the Department.

4.12.2 Collections Process

4.12.2.1 Referring a Provider to Benefit Recovery (BV)

Once an overpayment has been established for a child care provider, they are referred to the benefit recovery (BV) system in CARES by BPI and sent to the Department’s Public Assistance Collection Unit (PACU) for further repayment and collection action, if applicable.

Once the overpayment has been calculated and the negative adjustment is established in CSAW, a claim is created on the BVCO (Claims for Child Care Provider) screen.

4.12.2.2 BVPP – Provider Repayment Agreement (RPA)

A payment arrangement can be made by contacting the local agency or Public Assistance Collection Unit (PACU) to negotiate a repayment amount, if the balance cannot be paid in three (3) years or 36 months. The minimum payment accepted by PACU is $20 per month per liable person. Failure to return a RPA or to make a payment arrangement will result in delinquency and further collections actions.

Benefit Recovery Provider Repayment Agreement (BVPP) screen in CARES is used to record all returned provider RPAs. All providers for whom an overpayment has been established are required to complete and sign a repayment agreement. If the overpayment is under $500, monthly installments of at least $50 per month must be paid. If the overpayment is over $500, equal monthly installments in an amount sufficient to pay the balance in full within three (3) years or 36 months must be paid.

If multiple persons are jointly and severally liable for an overpayment, each will receive a separate RPA; however, an individual and their spouse may both sign one RPA. Each liable individual is responsible for the debt until it is repaid in full; therefore, if one liable individual misses a payment or becomes delinquent, the other individual is still responsible for the debt.

All payments and outstanding repayment agreements must be returned to the local agency no later than the 25 of the month. Repayment summary notices are automatically generated when a monthly payment is made. A provider will receive a repayment summary notice for all payments recorded in CSAW. The notice provides the current balance and serves as a reminder to make the next month's payment.

4.12.2.3 Dunning Notices

If a provider fails to return a repayment agreement, fails to make a payment, or pays too little, a Dunning Notice will be generated. A Dunning Notice is a past due notice that informs the provider that they are required to pay the balance of the debt and failure to complete and return a repayment agreement could result in delinquency and further collections actions.

If a provider receives three (3) Dunning Notices over the life of the debt, CARES determines the provider to be delinquent and the debt is referred to the Central Recoveries Enhanced System (CRES) collection system for additional collection action including levy, warrant/lien and Department of Revenue (DOR) state tax intercept.

If a provider is delinquent on a current overpayment, and he/she receives another overpayment, the second overpayment is automatically considered delinquent, without the provider receiving any additional Dunning Notices.

4.12.2.4 Provider Payments

4.12.2.4.1 Manual Provider Payments

Providers can submit manual repayments (e.g. submits a check) to the PACU for an established overpayment. If a local agency receives this check, please send it to the PACU for processing.

Additionally, manual checks may be submitted if a provider believes they have been overpaid and would like to return funds. First pursue a Voluntary Repayment (4.12.1.1), however if they insist upon a check, an overpayment will have to be established in the amount of the manual check, and then the check can be processed by PACU.

4.12.3 Delinquency Collections Process

4.12.3.1 Referring a Provider for Delinquency

At the end of the first business day of each month, a cycle will run that looks at the prior month's claim creations, repayment agreements (RPAs), and received payments.

- If a new claim was entered, CARES will automatically generate an RPA to each person liable for the debt.

- If an RPA exists, CARES will look on BVPA to see if a returned RPA was entered.
    - If it was, the system will look for payments received during that time period. All payment amounts must total at least the installment amount on BVPA. If all payments for the previous month do not add up to at least the total installment amount, CARES generates a Dunning Notice.
    - If it was not entered on BVPA or if a repayment was not equal to the monthly amount or an amount agreed upon in the RPA, CARES generates a Dunning Notice.

- If a repayment agreement has not been entered on BVPA, but a payment has been made, CARES will generate a Dunning Notice. If a client alerts the worker to this situation, the worker can reset the Dunning Notices, if the payment satisfies the amount in the repayment agreement; otherwise, no action is necessary by the worker.

If a provider receives three (3) Dunning Notices over the life of the debt, BPI determines the provider to be delinquent and the provider is referred to CRES for additional collection action including levy, warrant/lien and DOR for state tax intercept. The referral date is noted on BVPA as "Referred to CRES."

4.12.3.2 Delinquency Collections Actions

There are several ways that a provider may be considered delinquent:

1. The provider has not submitted payments, or has not met the payment amount required by the repayment agreement, for three (3) months.
2. The provider has received three (3) or more Dunning Notices over the life of a debt.
3. The provider receives an additional overpayment while delinquent on a current overpayment, the second overpayment is also automatically considered delinquent.

If a provider is found delinquent, a Levy, Warrant/Lien, or DOR State Tax Intercept may occur.

4.12.3.2.1 Levy
See Section 4.6.2.2 for policy and procedure.

4.12.3.2.2 Warrant/Lien
See Section 4.6.2.3 for policy and procedure.

4.12.3.2.3 DOR State Tax Intercept
See Section 4.6.2.4 for policy and procedure.

4.12.3.3 Delinquency Collections Appeal Process
In provider overpayment cases, the local agency that established the overpayment is responsible for handling the delinquency collection appeal process for levy, warrant/lien, and DOR tax intercept.

The PACU will receive all requests for collection-related appeals and will forward the Request for Summary to the local agency. The agency must complete the Request for Summary and return it to DHA. DHA will then process the appeal and notify the agency of the scheduled hearing date and time.

The required documents for these hearings include:
- Calculation of the overpayment
- Original overpayment notice that includes the provider's hearing rights
- The decision from any prior hearing(s)
- Three (3) Dunning Notices from the benefit recovery (BV) system
- Signed repayment agreement (RPA), if applicable
- Delinquency collection notice(s)- notice prior to levy, levy notice, DOR certification notice to tax refunds or credits, and notice of warrant docketed
- Any other supporting documentation that will support the reason for the overpayment

The PACU will provide the agency with copies of the appropriate delinquency collection action notices, which include levy notices, warrant notices and tax offset notices. If you have not received the documentation prior to the hearing, please contact PACU at 1-800-943-9499 or dwspacu@wisconsin.gov.

The ALJ should limit collections hearings to questions of procedure, prior payment and/or mistaken debtor identity; however, under certain circumstances the ALJ may decide to review the underlying merits of the overpayment. Therefore, the agency must be prepared to defend the original overpayment determination as well as the collection action. If the ALJ expands the inquiry into the underlying reason for the overpayment, please alert the DCF OLC.

4.12.4 Retention of Records

The Department and local agencies are responsible for retaining all records, including letters and notices sent by the agency, for a minimum of three (3) years after an overpayment claim reaches a zero balance or a minimum of three (3) years after the debt is written off.

4.13 Confidentiality and Routine Disclosure

Agencies must 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 governmental 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. If you have any questions about confidentiality provisions, please contact your corporation counsel or the DCF OLC.

No person may use or disclose information concerning applicants and recipients of a public assistance program for any purpose not connected with the administration of the programs.

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.

Note: This is established under s. 49.83, Stats.

3.14 Contact Information

Issue	Specific	Who to Contact	Information
For Technical Assistance:	Eligibility or Authorization Questions *Note: Please first contact your BRO coordinator with your question prior to contacting the Child Care Subsidy and Technical Assistance Line.*	BRO Coordinator Child Care Subsidy and Technical Assistance Line	Bureau of Regional Operations (BRO) Coordinators http://dcf.wisconsin.gov/files/regionaloperations/pdf/contactlist.pdf Child Care Subsidy and Technical Assistance Line: 1. ChildCare@wisconsin.gov 2. (608) 422 - 7200
	Collection Questions	PACU	1. PACU helpline: (800) 943 - 9499 2. PACU Assistance Mailbox: dwspacu@wisconsin.gov
	Legal Questions	OLC	DCFCalLegal@wisconsin.gov
	Investigation or Sanction Questions	BPI	DCFBPITArequest@wisconsin.gov
	YoungStar Questions	YoungStar	youngstar@wisconsin.gov
For Fraud Reporting:	For Milwaukee County	MECA	Parent referrals only: 1. MECA fraud hotline: (414) 289 - 5799 2. MECA fraud mailbox: DCFMBMECACCFRAUD@wisconsin.gov
	For the Entirety of the State	Bureau of Program Integrity (BPI)	For Clients and Providers: 1. The DCF fraud mailbox: dcfmbchildcarefraud@wisconsin.gov 2. The DCF fraud hotline: (877) 302 - 3728 3. Submit the Report Child Care Fraud Form 4. Writing to: Department of Children and Families Bureau of Program Integrity PO Box 8916 Madison, WI 53708-8916