

# Managed Long-Term Care Audit Guide Family Care, Family Care Partnership and Program of All-inclusive Care for the Elderly (PACE) Managed Care Organizations

This document is applicable to managed care organizations (MCOs) contracted with the Department of Health Services (DHS) to operate Family Care (FC), Family Care Partnership (FCP), and Program of All-inclusive Care for the Elderly (PACE).

**Funding: Medical Assistance, CFDA number 93.778; however, the department does not consider this program to be federal financial assistance and OMB Circular A-133 is not applicable.**

## Background

Family Care, Family Care Partnership, and PACE managed long-term care (LTC) programs improve coordination of long-term care services by creating a single flexible benefit for services. MCOs operating FC are contracted to cover specific LTC services and are funded by Medicaid. MCOs operating FCP and PACE are contracted to cover specific acute and primary (A and P) services in addition to LTC services and are funded by Medicaid and Medicare. FCP and PACE programs must be operated under a licensed health maintenance organization (HMO). The Office of the Commissioner of Insurance (OCI) must permit the FC LTC program MCOs, unless operated under a licensed HMO. A list of the required services offered by contracted MCOs is available in the description of the LTC benefit package in the FC, FCP and PACE contracts.

(<https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm>)

MCOs receive per member per month (PMPM) payment based on an actuarially sound methodology for each enrollee to manage the care for all MCO recipients who are living in their own homes, community-based residential settings, or nursing facilities. MCOs will:

- Develop and manage a comprehensive network of services and supports and deliver some services directly through MCO staff.
- Conduct a comprehensive assessment of the individual's needs, abilities, preferences and values with the member, family, and/or guardian. The care management team—consisting of at least a social service coordinator and registered nurse, the member, and informal supports—jointly participates in completing a comprehensive assessment that looks at areas such as activities of daily living, physical health, nutrition, autonomy and self-determination, communication, and mental health and cognition.
- Design a care plan in partnership with the member, based on information gathered during the comprehensive assessment and tailored to the individual's needs, preferences, and outcomes.
- Be responsible for the quality of care and services members receive, and for continually improving the quality of care and services.

Unless indicated otherwise, all compliance requirements in this section reflect the FC, FCP, and PACE contracts between DHS and the MCOs. The auditor should refer to the actual contract and any supplementary materials when assessing how a requirement applies to a particular MCO.

**Auditor qualifications:** FC, FCP, and PACE are risk-based managed care programs. The independent certified public accountant (CPA) audit team should include members with health insurance or managed care audit experience.

**Sending the audit report to DHS:** The auditor should refer to the MCO FC, FCP, or PACE contract with DHS for the annual independent CPA audit report submission requirements.

## **Risk assessment**

DHS considers the FC, FCP, and PACE programs to be high risk for the purposes of planning the annual independent audit by an external CPA audit firm for the decisions around testing, sample size, materiality, and individually significant items.

## **Compliance requirements and required audit procedures**

### ***1. General accounting requirements***

**Compliance Requirement:** The FC, FCP, and PACE contracts require the MCOs to maintain a full accrual accounting system in accordance with Generally Accepted Accounting Principles (GAAP). Audited financial statements must be presented on a GAAP basis. FCP and PACE programs must also meet the HMO reporting requirements of a statutory presentation for submission to the OCI.

**Audit Procedures:** Standard audit procedures and sampling of accounting transactions should be completed in order to determine compliance with GAAP including:

- Review of accounting policies and procedures to ensure consistency.
- Interview the chief financial officer (CFO) or responsible financial person to ensure they have a thorough understanding of GAAP as it relates to a risk-based, capitated, managed care contract.

**Compliance Requirement:** The FC, FCP, and PACE contracts require the MCO to maintain an internal control environment sufficient to ensure the reliability and integrity of financial information, compliance with laws and regulations, and safeguarding of the assets.

**Audit Procedures:** Review the policies and procedures and conduct relevant staff interviews in order to evaluate and document the auditor's understanding of the internal control environment. Include a report on the internal control environment in the final audit report as described in the DHS contract.

## ***2. Capitation receivable and payable***

**Compliance Requirement:** The reliability of the financial statements is largely dependent on the accuracy of the MCO's accounting methodologies and estimates for its Medicaid and Medicare capitation revenue. Furthermore, management of these revenue sources is complex and critical to the solvency of the MCO. The MCO must develop adequate processes, procedures, and systems to accurately record the collection of capitation for each eligible and enrolled member in a timely fashion. In addition, the MCO must understand basic program eligibility requirements to coordinate enrollment efforts, recognize capitation revenue as it is receivable, record unearned revenue resulting from enrollment and disenrollment date differences and member cost share adjustments, write off capitation revenue as necessary, and follow up on open, but unresolved, enrollment and resulting capitation issues. The MCO must have a process to accurately reconcile and follow up on monthly enrollment and capitation reports generated by the Medicaid program Forward Health interChange system, against the active membership identified and maintained in the MCO internal data system. An MCO operating FCP and/or PACE programs must also have a process to accurately reconcile and follow up on monthly Medicare enrollment and capitation generated by the Centers for Medicare and Medicaid Services (CMS).

### **Audit Procedures:**

- Review and evaluate the MCO's process for ongoing reconciliation of its records to the state reports and data systems to ensure that enrolled members are served and members no longer enrolled do not continue to receive service unless a specific decision to continue serving was made by the MCO and documented in a transition plan to ensure continuity of care.
- Review the detailed capitation receivable and/or payable report by member and month generated from a database the MCO is using to reconcile membership and capitation. Sample the report records to determine if:
  - 1) The policies related to eligibility are consistently applied.
  - 2) The MCO has taken the appropriate action in accordance with state and MCO policies to resolve date of enrollment discrepancies, which may result in a delayed capitation payment, a payment at an incorrect level of care (LOC), a payment with an incorrect cost share deduction, or a payment that the MCO is not entitled to and recorded as unearned revenue.
  - 3) The capitation amount claimed as receivable or payable corresponds to the contracted rate at the appropriate LOC as identified in the state capitation reports.
  - 4) Retroactive adjustments recorded as receivable or payable correspond to the MCO contract and supported by calculations and other documentation.
- Trace a sample of members claimed as receivable from the prior year report to the remittance payment report to verify receipt.
- Determine the reasonableness of the prior year capitation receivable and payable by comparing the prior year estimated receivable and payable to a report of capitation received and deposited and capitation reports demonstrating recoupments for the

prior year capitation payable in the audit year for prior year dates of service.

- Trace a sample of members claimed as receivable and payable for the current audit year to subsequent payment remittance reports to verify receipt and/or recoupment.
- Determine the reasonableness of retro adjustments receivable and payable by reviewing MCO calculations and other supporting documentation.
- Evaluate adequacy of follow-up by the MCO on open issues and reasonableness of ongoing status as a receivable or payable.

### ***3. Member receivable***

**Compliance Requirement:** The MCO is responsible for monitoring, invoicing, and collecting the member's monthly cost-share as determined by county income maintenance (IM) staff and the member's monthly room and board.

#### **Audit Procedures:**

- Review and evaluate the policy and procedures used for invoicing, collecting, and reconciling cost share and room and board.
- Compare member cost share requirements from the monthly Cost Share Report and the capitation report against amounts invoiced and collected on the accounts receivable ledger to ensure the accuracy of the collections and stated receivable. Review documentation to explain variances and related follow-up that may be due to timing, error, etc.
- Compare the room and board receivable against source documentation to calculate member-specific room and board with amounts invoiced and collected to ensure the accuracy of the stated receivable. Review documentation to explain variances and related follow-up that may be due to timing, error, etc.
- Review the aging and balances of outstanding accounts to evaluate the probability of actual collections as it relates to the receivable estimate and allowance for uncollectible accounts.
- Review non-payment of cost share greater than 60 days and compliance with policy and procedure for non-payment of cost share. (Non-payment of cost share affects a member's financial eligibility for participation in the FC, FCP, or PACE programs; see MCO contract for more information).
- Review detailed payable and receivable reports by member including accounts with credit balances. Review the process for issuing refunds for credit balances. Select a sample and test outstanding balances against the policy and procedure ensuring accounts with credit balances are included in the sample.
- Review member receipts posted after year-end to determine the accuracy of the member receivable estimate.

### ***4. Incurred but not reported provider claims (IBNR)***

**Compliance Requirements:** The reliability of the financial statements is largely dependent on the accuracy of the MCO's accounting methodologies and estimates for the incurred but not reported (IBNR) provider claims. MCOs must develop and monitor the methodology based on their actual claims payments data. More than one method should be

developed to assist in estimating IBNR as accurately as possible. A single methodology may be accurate in any given year, but anomalies can occur that will cause an estimate to be materially under or over projected. Furthermore, monitoring of the methodology is necessary to facilitate process refinement as systems and procedures change and to facilitate disclosure of material variances from estimated IBNR, in particular those related to prior year estimates.

#### **Audit Procedures:**

- MCOs may include claims entered into an in-house claims system not yet paid as part of IBNR. In addition, MCOs that contract for third party administrator (TPA) claims processing may have an amount due to the TPA for claims processed and paid by the TPA. Verify this payable to the source document(s) and check the IBNR calculation to ensure that these payables have not been “double counted” as accounts payable and included in the IBNR estimate.
- Verify the exclusion of care management services, internally provided or contracted, from the IBNR model and estimate. Targeted case management services contracted and paid for by the MCO are an exception to this exclusion.
- Review prior year IBNR methodology and estimate by comparing the prior year IBNR by month to claims paid (by date of service) by month, using the MCO lag report or other process in place. The auditor should verify the over/under prior year estimate and ensure it is disclosed on the MCO financial statement in the notes to the financial statements or as a separate line item on the revenue and expense statement.
- Review the current year IBNR estimate against paid claims reports by date of service in the lag report. The auditor should analyze the accuracy of the IBNR estimates to provide confidence in the methodologies used to establish the year-end IBNR estimate.
- Compare monthly paid report against bank statements to validate paid claims reports used in IBNR development.
- Review the current and prior year IBNR to assess the reasonableness of the method utilized by the MCO to estimate and subsequently adjust its IBNR. DHS has recommended that the MCOs use additional detailed methodologies, such as percent of completion by service category by month, PMPMs by service category by month, PMPMs by regional service category, and/or service authorization to paid claims by service category by month.

#### **5. Capacity for financial solvency and stability**

The contract between the permitted FC MCO, not operated by a licensed HMO, and DHS includes provisions for demonstrating that the MCO has the capacity to assume the financial risks associated with that contract. The financial solvency requirements for permitted MCOs are found in the DHS contract with the MCO and defined in Wis. Stat. ch. 648 and Wis. Admin. Code ch. Ins 57, under the authority of the OCI. The MCO’s financial capacity consists of three components: working capital, restricted reserve, and solvency protection. MCOs operating the FC LTC program under a licensed HMO or operating the FCP and PACE programs that must operate under a licensed HMO are not

subject to the requirements of this section. HMOs must meet the OCI requirements for licensed health insurers.

### **Working Capital**

**Compliance Requirements:** The purpose of the working capital is to provide ongoing liquid assets to manage routine fluctuations in revenue and expenses that will occur in the day-to-day normal course of business operations.

Working capital is the difference between current assets and current liabilities. A permitted MCO's working capital shall not be less than the requirement outlined in the DHS contract for the relevant audit period.

### **Audit Procedures:**

- Verify the cash balance to the bank statement
- Verify the classification of assets and liabilities as "current" by reviewing source documents for prepaid expenses, other assets not reviewed elsewhere, and other liabilities not reviewed elsewhere.
- Substantiate the current assets and liabilities by reviewing appropriate source documentation. Determine whether the balance sheet assets and liabilities are appropriately classified according to GAAP.
- Compare the calculated working capital to the FC contractual requirements.

### **Restricted Reserve**

**Compliance Requirements:** The purpose of the restricted reserve is to provide continuity of care for enrolled members, accountability to taxpayers, and effective program administration. The restricted reserve provides additional liquid assets to underwrite the risk of financial volatility due to unusual, unbudgeted program expenditures.

The MCO shall establish and maintain a separately identifiable investment reserve account with a financial institution to meet the restricted reserve requirements of the contract. Deposits to and withdrawals from the restricted reserve are to be clearly identifiable within the account and the accounting system and supported by documentation. Documentation of approval for disbursements in compliance with the DHS FC contract should be provided by the MCO.

The calculation for the required minimum balance for the contract year is defined in the DHS FC contract.

Any income or gains generated by the restricted reserve funds are to remain within the account until the balance reaches the required minimum balance. The MCO may only make disbursements from the restricted reserve account as set forth in the DHS FC contract. The MCO must provide an investment report for the restricted reserve account as part of the required financial reporting submitted to DHS.

**Audit Procedures:**

- Verify the balance of the restricted reserve account reported on the year-end MCO balance sheet to the supporting investment statement.
- Compare the required risk reserve amount communicated in the MCO's permit issued by the OCI and in the DHS annual fiscal review memo to the actual risk reserve amount and note the adequacy or deficiency.
- Verify that earnings generated by the restricted reserves remain in the restricted reserve account as demonstrated on the balance sheet and supported by the investment report statement of earnings.
- Determine whether the MCO obtained prior approval from DHS for any restricted reserve account disbursements in accordance with DHS contract requirements.

**Solvency Reserve**

**Compliance Requirements:** The solvency fund provides for continuity of services and smooth transition of members from the existing MCO to another entity as described in the MCO contract, or in the event the existing MCO becomes irreversibly insolvent. The MCO must maintain the amount as set forth in the MCO contract in an account designated by DHS and held by the Department of Administration (DOA).

- The MCO solvency fund balance must be reported on the MCO's balance sheet.
- Income generated by the funds will be recognized by the MCO and remain within the account until the MCO meets the required minimum balance as set forth in the MCO contract.
- Income or gains generated by the solvency fund beyond the minimum balance may be used as set forth in the OCI statute and MCO contract.

**Audit Procedures:**

- If the solvency fund requirements are not fully funded the auditor should review documentation of funding plans as approved by the OCI.
- Compare the amount recorded on the balance sheet to the balance confirmation received from DOA.
- Trace any investment earnings reported on the income statement to the investment statement.

**6. Capitation revenue**

**Compliance Requirements:** In full consideration of services in the benefit package rendered by the MCO for each enrolled member, DHS pays the MCO an actuarially determined monthly capitation payment as a PMPM rate specified in the MCO-specific contract terms, capitation rate section of the FC, FCP, and PACE contracts. DHS converts the monthly capitation to a daily rate for members with a partial month enrollment. Capitation revenue should be recognized and reflected on the Revenue and Expense Statement on an accrual basis according to GAAP.

**Audit Procedures:**

- Verify total capitation accounted for as received against the State 820 reports

regardless of date of service (see section 2, capitation receivable).

- Verify total capitation payments are accounted for in the MCO's general ledger system and/or against the MCO's total capitation receipt system/database. Note that each MCO has different systems/databases in place to track capitation received for each member and each should be able to generate a report of capitation received by member, which should then tie to the general ledger as the supporting detail.
- Verify the calculation of accrued capitation revenue to the capitation revenue reported on the Revenue and Expense Statement. The verification work paper for accrued capitation revenue should reflect this calculation.

## ***7. Care management services***

**Compliance Requirements:** Care management service expense can be based on a calculated internal allocation process and/or as a service purchased from a contracted vendor(s). Care management services are material program expenditures that DHS actuaries include in the service component of the capitation rate-setting process. DHS annually approves the care management unit rate to be used for encounter reporting and the MCO must request a prospective change from the initial approved rate. Care management services in this section do not include care management state plan services authorized in the member service plan.

### **Audit Procedures:**

- Review allocations, methodologies, and supporting documentation of the care management staff of internal care management rates, including wages, benefits, direct, and indirect/allocated expenses to determine the reasonableness against the rate approved by DHS for the audit year. The MCOs are required to submit direct costs and allocated costs to develop a proposed care management rate for approval as part of the annual certification process. MCOs may use a cost center or department for care management in the accounting system.
- Verify administrative overhead allocations are included in the expense reported in the income statement as developed in the approved rate and submitted to the state service encounter reporting system.
- Trace the approved rates for submission of the internal care management services to the MCO's file for encounter reporting submission to the state.
- Trace the total internal care management cost supporting documentation to source documents such as payroll records and review the system rate for reasonableness.
- Trace payments for contracted care management providers to the MCO's contracted rate and source claim documents submitted for payment. Review the rate against the DHS-approved rate if identified in the DHS fiscal review memo for the contract year.
- Verify that care management services are accounted for on an incurred basis. Review the accounting records to assure that associated payables for contracted and internally provided care management services are properly captured and accrued.
- Review the MCO's process for monthly encounter to financial reconciliation for care management services.

- Verify the care management services are excluded from the IBNR calculation.

### **8. Financial statement and data certification**

**Compliance Requirements:** The FC, FCP, and PACE contracts include federal requirement 42 CFR 438.600, which requires MCOs to ensure that data submitted to the state is accurate, complete and truthful to the best of their knowledge by signing and submitting:

- Data Certification Form with each accepted batch of encounter data; and
- Certification Form with each submitted financial statement.

#### **Audit Procedures:**

- Interview the staff person responsible for signing the attestation to ensure that adequate controls and verification of the data files and financial statements exist to support their attestation. Auditor review should identify:
  - 1) How the reporting is verified as accurate, complete, and truthful.
  - 2) The person responsible for the data file review and the frequency of review.
  - 3) The checks and balances are in place to ensure data accuracy, completeness, and truthfulness.
- Review the reconciliation of data from the MCO information system(s) used to transfer the data to the state encounter reporting system, to the general ledger accounts. The data may originate from multiple systems to include MCO and TPA systems. The reconciliation should include:
  - 1) Member revenues for cost share revenue and room and board.
  - 2) Member services, including provider payments and refunds.
  - 3) Care management services.

### **9. Claims**

**Compliance Requirements:** The MCO is responsible for ensuring that paid claims are for authorized services provided to eligible and enrolled members, to contracted providers at the contracted rate for each contracted program. MCOs should have a claim audit function to identify fraudulent claims, payments to Medicaid suspended providers, or claims processing errors.

#### **Audit Procedures:**

- Review the MCO's policies and procedures for the internal audit function to protect against fraudulent service or suspended provider claims and claims processing errors.
- Verify system controls that limit staff access to change contracted providers, service authorizations, and provider rates. Evaluate the MCO's audit of documentation and authorization for approved changes. Review process for documentation and updates due to staff position changes.
- Verify that submitted claims for each contracted program are for authorized services provided to eligible and enrolled members by contracted providers at the contracted rate.

- 1) Review MCO process for verification of service provision.
- 2) Select a sample of at least 70 LTC records from the MCO's long-term care (LTC) service claims processing and at least fifteen (15) additional claims of A&P services for a minimum sample of at least 85 records for MCOs contracted to provide acute and primary (A&P) services in addition to the LTC benefit package. Select a second sample of at least 60 self-directed supports (SDS) service claims. A separate sample and report must be completed for each contracted LTC program. Evaluate claims processing against the provider contracted rate, authorization, and other validation criteria to ensure accuracy and timeliness of claims processing against the MCO policy and procedure and DHS contract requirements. Validate against source documents for member eligibility, provider contract, contracted services and rates, authorizations, explanation of benefits (EOBs), cancelled checks, adjustments, denials, and refunds.
- 3) Sampling should use a combination of traditional random sampling and through auditor selection to ensure the sample includes claims from all broad categories of service. Categories of service for the LTC service claims sample should include the categories identified in the DHS financial reporting template such as residential, institutional, home care (personal care and supportive home care), vocational, transportation, therapies, adaptive equipment, adult day activities, and other LTC services. Audits of MCOs operating FCP and PACE programs should also include the A&P categories of service such as inpatient hospital, outpatient hospital, other acute and primary services.
- 4) Document the results of the sample testing in the DHS Claims Audit Report template for Audits of Managed Long-term Care MCOs at <https://www.dhs.wisconsin.gov/familycare/mcos/fiscal.htm> and submit them to DHS with the annual audit report.
  - Evaluate follow-up with providers, claims appeals, refunds, and other documentation related to claim sample.

Email questions regarding this document or the audit requirements for Managed LTC MCOs to [DHSLTCFiscalOversight@dhs.wisconsin.gov](mailto:DHSLTCFiscalOversight@dhs.wisconsin.gov).



**WISCONSIN DEPARTMENT**  
*of* **HEALTH SERVICES**

Division of Medicaid Services  
P-00466 (11/2025)

[www.dhs.wisconsin.gov](http://www.dhs.wisconsin.gov)