Australian Government

Department of Health

Contracted Service Provider

Compliance Monitoring and Support Framework

Hearing Services Program

May 2020

Table of Contents

Glossary of TermsTerm	Definition/Details
accreditation	The process to determine an entity's ability to meet the requirements set out in the *Hearing Services Program (Voucher) Instrument 2019*, considered necessary to deliver hearing services to clients of the Hearing Services Program.
Accreditation Scheme	The Accreditation Scheme (the scheme) is currently outlined under *Part 4* of *Hearing Services Program (Voucher) Instrument 2019*, which sets out the requirements for applicants and empowers the Minister for Health to make decisions to accredit hearing services providers.
the Act	*Hearing Services Administration Act 1997*, which is the overarching legislative instrument for the Hearing Services Program.
audit	"…systematic, independent and documented process for obtaining audit evidence and evaluating it objectively to determine the extent to which the audit criteria are fulfilled".[1]
client	A person who is eligible for the Hearing Services Program.
complaint	An expression of dissatisfaction with any aspect of the Hearing Services Program. Please refer to the Hearing Services Program Complaints Policy.
compliance action	Action taken to address potential or identified non-compliance with program requirements.
condition	An additional requirement or restriction placed on a contracted service provider, usually in response to identified non-compliance.
the Contract	Service Provider Contract establishes the requirements under which contracted service providers are required to deliver services through the Hearing Services Program.
CSPN	Contracted Service Provider Notice. Electronic notices giving program updates and clarifications.
e-Claim	An online claim for services lodged by a contracted services provider, via Practice Management Software, to the Hearing Services Online portal.
ECR	Eligibility Criteria for Refitting, which lists criteria to support the refitting of a hearing device/s through the program, and the required supporting documentation.
eligible person	A person who meets the eligibility criteria for the Hearing Services Program, set out in *Hearing Services Program (Voucher) Instrument 2019*.
the Framework	This Compliance Monitoring and Support Framework, which outlines the program's approach to monitoring compliance with the program requirements.
fully subsidised device	Fully subsidised devices approved by the Hearing Services Program. Costs for these devices are fully covered by the program (previously known as 'free-to-client').
HSO	Hearing Services Online. The online portal for clients and providers, which providers are able to access a secure area to manage their clients, sites and practitioners.
MHLT	Minimum Hearing Loss Threshold. The Hearing Services Program requires clients being fitted with a hearing device to meet a minimum 3 Frequency Average Hearing Loss Threshold of greater than 23dB (3FAHL > 23dB), measured at 0.5, 1 and 2 kHz. The Minimum Hearing Loss Threshold (MHLT) Guidelines list exemption criteria which must be met before fitting a program client who has mild hearing loss (equal to or below 23dB).
MP	Medical Practitioner eg. general practitioner, Ear, Nose & Throat (ENT) specialist etc.
partially subsidised device	Partially subsidised devices approved by the Hearing Services Program. Costs for these devices are partially covered by the program (previously known as 'top-ups').
the program	The Hearing Services Program, as established by the *Hearing Services Administration Act 1997*.

[1] AS/NZS ISO 190112014, Guidelines for auditing management systems

Glossary of TermsTerm	Definition/Details
program requirements (mandated requirements)	The requirements of the program as set out in • *Hearing Services Administration Act 1997* (the Act) • Hearing Services Program (Voucher) Instrument 2019 (the instrument) • Australian Hearing Services Act 1991 • Australian Hearing Services (Declared Hearing Services) Determination 2019 • Service Provider Contract (the Contract) • Schedule of Service Items • Schedule of Fees • Hearing Rehabilitation Outcomes (HROs) • Minimum Hearing Loss Threshold (MHLT) Guidelines • Eligibility Criteria for Refitting (ECR)
provider	Contracted service provider. A hearing services provider who has been contracted to deliver services through the Hearing Services Program.
risk	The effect of uncertainty on the outcomes and objectives of the program[2].
risk control	Measures to modify risk, including process, policy, device, practice or other actions[3].
RSS	Rich Site Summary. An automated notification systems used to alert stakeholders to changes to the website and the release of CSPNs.
SAT	Self-Assessment Tool. A mandatory, annual, compliance self-assessment questionnaire required from all providers.
Schedule of Fees	The Schedule of Fees lists the fee paid by the Commonwealth to providers for each service item and hearing device category.
Schedule of Service Items	The Schedule of Service Items provides information, service requirements, claiming conditions and evidence requirements for claiming for services available to program clients through the program.
standards	Refers to the Hearing Rehabilitation Outcomes (HROs), Minimum Hearing Loss Threshold (MHLT) Guidelines and the Eligibility Criteria for Refitting (ECR). New program standards may be issued by the Commonwealth.
suspension	A direction to stop providing all, or specified services to clients. This may occur if there has been a serious breach of the Contract.
termination	The cancellation of a provider's Contract to deliver hearing services through the program.
voucher	An authority (paper or electronic) issued enabling eligible clients to received services through the program.

[2] AS/NZS ISO 310002009 Risk Management – Principles and guidelines, p1
[3] AS/NZS ISO 310002009 Risk Management – Principles and guidelines, p6

Chapter 1 Framework Overview

Objective and Purpose

The Australian Government Hearing Services Program (the program) provides hearing services, and a range of fully and partially subsidised hearing devices, to eligible Australians to manage their hearing loss and improve their engagement with the community. This includes continued support to hearing research that focuses on ways to reduce the impact of hearing loss, and the incidence and consequence of avoidable hearing loss.

The Compliance Monitoring and Support Framework (the Framework) aims to provide a realistic, transparent and consistent approach to monitoring program compliance.

The objectives of the program's Framework and compliance activities are to

1. ensure client safety and quality hearing outcomes for clients
2. provide support to providers by assisting them to comply with the program requirements
3. maintain program integrity
4. ensure appropriate financial management of the public monies that support the program and
5. safeguard Commonwealth records.

By becoming accredited with the program, contracted service providers (providers) are able to deliver high quality services to program clients. They are then required to comply with the program's legislation, the current Service Provider Contract (the Contract), the Schedule of Service Items and Schedule of Fees, and three program Standards (the Hearing Rehabilitation Outcomes (HROs), the Minimum Hearing Loss Threshold Guidelines (MHLT) and the Eligibility Criteria for Refitting (ECR). In addition to compliance checks that are part of the accreditation process, program compliance is monitored in several ways including self-assessment, complaints investigations, claim reviews and audits.

The Framework

The Framework describes

- the objectives and legislated and contractual requirements for compliance monitoring (Chapters 1 and 2)
- the principles that underpin the approach to audit and compliance of providers (Chapter 3)
- the risk assessment methodology used to determine audit and compliance priorities and approaches (Chapters 4 and 5)
- the role that provider self-assessment plays in compliance monitoring (Chapter 6)
- the types of audit activities that may be undertaken (Chapter 7)
- the circumstances in which various types of compliance action may be taken (Chapter 8) and
- the continuous improvement processes (Chapter 9), including opportunities for providers to give feedback about the Framework and the program's compliance monitoring activities.

The Framework is made available to all providers through the program website and a hyperlink is included in the program's electronic Accreditation Kit. A range of supports are available (refer Chapter 3 Compliance Monitoring Principles and Provider Support).

An initial Framework was developed in 2013 following a 2012 review of program audit and compliance. It was updated in 2017 following a review of lessons learnt from ongoing audit and compliance activities, provider feedback following audit processes, and emerging trends, government policies and priorities. A further review and update was completed in 2020 following a thematic review of program legislation, quasi legislation and regulation. This included the consolidation of the *Hearing Services (Participants in the Voucher System Determination) 1997*, the *Hearing Services Voucher Rules 1997*, the *Hearing Services (Eligible Persons) Determination 1997*, the *Hearing Services Rules of Conduct 2012* and the *Hearing Service Providers Accreditation*

Scheme 1997 into the *Hearing Services Program (Voucher) Instrument 2019*. The Service Provider Contract was rewritten.

The Framework was developed in accordance with the following guidelines and protocols

- the Australian National Audit Office's (ANAO) better practice guides. These guides are designed to assist Commonwealth government agencies to improve the quality and consistency of their administration of public service obligations and activities (guides can be located at ANAO Website - Better Practice Guides)
- the Australian Standard for Risk Management, AS/NZS ISO 310002009
- the Guidelines for Auditing Management Systems, AS/NZS ISO 19011 2014 and
- the *Public Governance, Performance and Accountability Act 2013* (the PGPA Act) which provides guidance on the use and management of public resources by the Commonwealth.

Chapter 2 Legislation & Contractual Requirements

- *Hearing Services Administration Act 1997* (the Act)
- *Hearing Services Program (Voucher) Instrument 2019* (the instrument)
- *Australian Hearing Services Act 1991*
- *Australian Hearing Services (Declared Hearing Services) Determination 2019*
- Service Provider Contract (the Contract)
- Schedule of Service Items and Schedule of Fees
  and three program standards:
  - Hearing Rehabilitation Outcomes (HROs)
  - Minimum Hearing Loss Threshold (MHLT) Guidelines
  - Eligibility Criteria for Refitting (ECR)

For the purposes of this document, these legislative and contractual requirements are collectively described as the program requirements. The Australian Government has a responsibility to provide assurance to the Australian community that providers are delivering high quality and safe services to clients of the program through meeting the program requirements.

Legislative Authority to Monitor Risks and Compliance

Authority to monitor risk and compliance is established by several legal instruments including the *Public Governance, Performance and Accountability (PGPA) Act 2013*, and the *Hearing Services Administration Act 1997*.

Section 16 (a) of the *PGPA Act 2013* requires that the accountable authority of a Commonwealth entity establishes and maintains an appropriate system of risk oversight and management.

Under section 16 of the *Hearing Services Administration Act 1997* (Conditions of accreditation), the Minister is empowered to accredit an entity subject to one or more conditions specified in the *Hearing Services Program (Voucher) Instrument 2019*. This section also empowers the Minister to make a decision to cancel the accreditation of an entity if the entity contravenes a condition of accreditation. Section 20 of the Act (Contracted service providers) states at clauses (2) and (3)

> "The terms and conditions of engagement are to be set out in a written agreement between the Minister (on behalf of the Commonwealth) and the contracted service provider. The terms and conditions must be consistent with the Accreditation Scheme and the Rules of Conduct" and
>
> "Each condition of the accreditation of the contracted service provider is taken to be a condition of the engagement."

Following accreditation, providers enter into a written contract with the Commonwealth. This contract specifies that all providers must comply with the Act, the Instrument, the Contract, and the Schedule of Service Items and Fees.

Clause 16 of the Contract provides a list of the audit activities and the actions that a provider must take to support these activities, and outlines the Commonwealth's access to sites and records.

Clause 16.1 of the Contract stipulates that the Commonwealth may audit any matters it considers relevant to the performance of the provider's obligations under the Contract.

Program compliance is monitored throughout the course of a provider's relationship with the program, from accreditation through service delivery and closure. Responses to risks and non-compliance are implemented using a risk-based approach (refer Chapters 4 and 5).

Chapter 3 Compliance Monitoring Principles and Provider Support

As a provider of services under the program you are obligated to maintain compliance with the program requirements. A range of supports are available to assist providers to understand what they need to do. The majority of providers maintain compliance and where non-compliance is identified are willing to address the issues promptly and effectively. Where further compliance action is required, the focus of these actions is on supporting the provider to improve compliance.

Compliance Principles

The approach to audit and compliance is guided by the following principles

- **apply a risk-based framework to decision-making**. This means that risks are actively identified, evaluated and monitored. Risks are assessed on their likelihood and potential consequences. Compliance activities are implemented to control risks
- **adopt a proportionate approach to non-compliance**. This means, in the event that non-compliance is identified, the information available will be assessed and a reasonable response will be implemented based on the severity of the issues identified and the provider's willingness to comply
- **be transparent**. Documents such as this Framework are published to give providers a clear understanding of the approach to program compliance. In dealing with individual providers, audit findings are clearly articulated and documented. As we generally do not conduct on-site audits, this is done via teleconferences with providers to discuss outcomes, the provision of an Audit Report, and giving providers opportunities to respond
- **be accountable**. Compliance activities are consistent with legislation, the Contract, the Schedule of Service Items and Fees, the program standards, and program policies and procedures. Decisions are appropriately and accurately documented, and escalated/referred as necessary
- **respond in a timely manner**. In all cases audits and compliance activities will be undertaken in a timely way, noting that time will vary dependent on the type of audit, the complexity of issues identified and provider responses
- **act consistently**. Ensure a consistent approach across the program, including how procedures and actions are applied and
- **be fair.** Focus on being impartial and objective, ensuring that if any non-compliance is identified, the provider will be given an opportunity to respond.

Contacting Clients

Clients are not routinely contacted as part of compliance monitoring. In exceptional circumstances, clients may be contacted to seek information that may assist the investigation of a complaint or for audit purposes (for example to confirm that a client has received reimbursement for any incorrect payments they have made to a provider).

Hearing Services Program Support

Providers are required to have policies, processes and systems to ensure compliance with program requirements. These may include an Internal Audit/Review Policy, Supervision of Non-qualified Practitioners Policy, Medical Referral Policy, Client Transfer Policy, and Complaints Policy, along with guides and training for staff.

To effectively manage program compliance risks, ensure application of the above principles, and assist providers to maintain compliance, the program has a range of supports and risk controls in place. Program supports can be categorised in three ways education and information, systems support and compliance checks.

Education and Information

Hearing Services Program Website. The website, www.hearingservices.gov.au, gives providers access to a broad range of program information including accreditation guidelines, eligibility criteria, legislation, service and claiming requirements and compliance support.

Contracted Service Provider Notices (CSPNs). Regular CSPNs are released to inform and update providers about key changes or issues that occur with the program. All providers are required to keep up to date with CSPNs and other notices and to ensure their staff are made aware of the information being provided.

Rich Site Summary (RSS) Feed. An RSS Feed is available to providers to ensure they can keep up to date with changes to the website and are alerted whenever a formal notice is released, including CSPNs. Providers can learn more about how to register for RSS feeds on the program website.

Hearing Services Program Information Line. The Hearing Services Program Information Line – 1800 500 726 offers advice and information regarding all aspects of the program. Where required, calls may be referred to specific people who can best assist with that enquiry.

Systems Support

Hearing Services Online (HSO) Portal. The HSO portal is available to providers to assist them in managing their client, site and practitioner information, and to submit claims for payment.

The HSO portal allows real-time eligibility checking to ensure clients are eligible to receive services under the program. Client service and claiming history is also available.

The portal incorporates business rules that review claims for payment in accordance with the Schedule of Service Items and Fees. Providers are required to be aware of the service and claiming requirements of the program.

Compliance Checks

Accreditation Compliance. A provider's application for accreditation under the program will be assessed in accordance with the requirements of the Accreditation Scheme. Where the application demonstrates a lack of understanding about the program, the applicant is contacted so that this can be rectified. When the decision to accredit a provider is made, they will receive further information to support their capacity to comply with the program requirements.

Self-Assessment. The annual provider self-assessment (SAT) gives providers an opportunity to review their compliance with the program requirements. This is a compulsory online questionnaire and is one of the sources of information that informs our risk-based compliance monitoring.

Claim Reviews. Claiming data is regularly reviewed to ensure claims are being submitted in accordance with the program requirements. For example, identify claims that do not comply with the Schedule of Service Items and Fees, including claims that had been submitted with incorrect dates of service or binaural claims having been paid when the client is monaurally fitted.

Audits. An audit is a review of compliance with all or targeted components of the program requirements. Audits are not intended to be punitive. They identify areas of non-compliance so action can be taken to prevent reoccurrences. By working with providers, most non-compliance can be rectified. Providers will generally be given an opportunity to address any issues identified by an audit and will have an opportunity to outline a plan to rectify the areas of non-compliance, including reviewing their internal processes and systems to ensure compliance in the future. However, if there are risks to client safety or program integrity, or there is evidence of fraud, more serious compliance actions may be taken without further notice (refer to Chapter 4).

The outcomes of compliance checks can be used by providers to review and update their policies, procedures and systems to meet the program requirements.

Chapter 4 Risk-based Approach to Compliance Monitoring and Actions

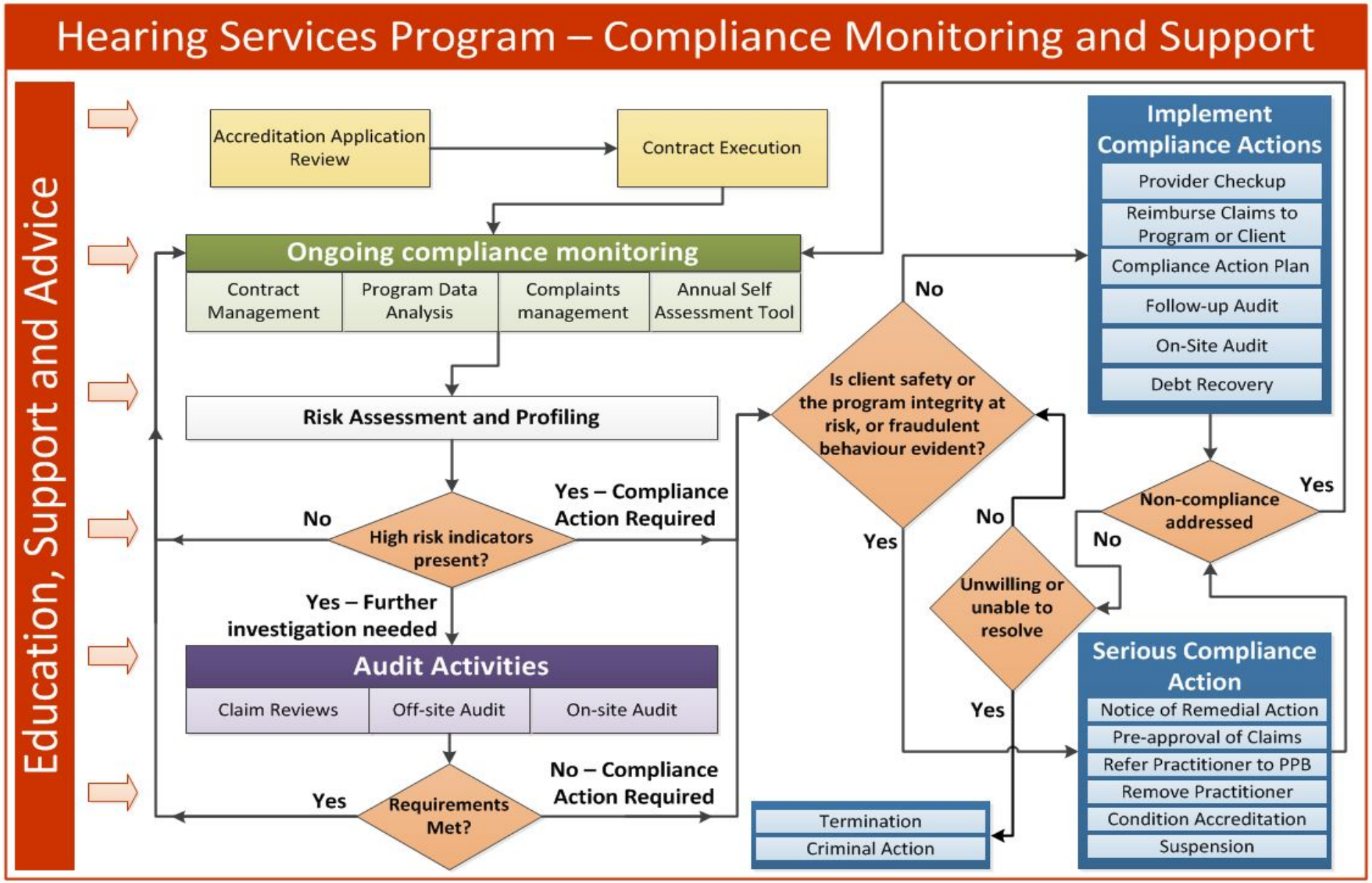
Compliance is monitored through a continuum of activities including

- provider accreditation and contracting
- complaints management
- provider self-assessments
- program data analysis
- claim reviews and audit activities
- graduated compliance actions and
- regular monitoring and review of the risk approach to compliance monitoring.

Non-compliance is rectified through compliance actions. The level of compliance monitoring and support will vary depending on the levels of risk and non-compliance identified, and the provider's willingness to comply with program requirements.

An overview of the compliance monitoring processes is outlined in Diagram 1 Hearing Services Program Compliance Monitoring and Support Framework Overview.

Diagram 1 Hearing Services Program Compliance Monitoring and Support Framework Overview



In accordance with the compliance principles and supports outlined in Chapter 3, the key elements of the Compliance Monitoring and Support Framework are

- **a risk-based approach to monitoring compliance** focusing resources on the highest priority risks and issues identified using program data, including claiming patterns
- **enabling providers to self-assess their compliance** using the annual Self-Assessment Tool (SAT) to assist in the identification of any areas of non-compliance with the program requirements. Provider self-assessment provides a timely, structured opportunity for providers to review the program requirements, critically examine their own systems and processes, and take action to address any areas of non-compliance
- **reviewing and managing complaints** about providers and their delivery of program services
- **analysis of program data and risk indicators**
- development of a **risk-based schedule of audit activity** which includes flexibility so that unscheduled activities may be undertaken to address new or changed regulatory risks as they are identified
- **routine and regular reviews of historic claims data and patterns**, with providers given an opportunity to review any irregularities identified from the claim reviews
- **targeting of monitoring activities**, such as audits, to address high risk areas
- **reporting of risk-based audits and audit findings in an Audit Report** which is given to the provider
- providers are given **an opportunity to address the identified issues** and to outline a plan of how the issues have been or will be addressed
- **provider reimbursement of unsubstantiated or invalid claims to the Commonwealth.** Any payments made to providers for services not delivered in accordance with the program requirements must be reimbursed to the Commonwealth (refer clause13 of the Contract)
- **provider reimbursement of unsubstantiated or incorrect payments received from clients.** Any payments collected from clients for services not delivered in accordance with the program requirements, must be reimbursed to the client(refer subsection 51(2) of the instrument) and
- **more serious compliance actions**, as described in Chapter 8 (Diagram 3), may be involved when client safety or program integrity are at high risk or when there is evidence of fraud.

Each of these elements of the Framework is discussed in detail in the following Chapters.

Chapter 5 Program risk identification, assessment and management

Program objectives (Chapter 1) are achieved with the support of risk identification, assessment and management. This involves

- examining an organisation's practices to identify the risks that may threaten achievement of the objectives by causing an adverse outcome
- evaluating the likelihood and consequences of risks to assess their seriousness and
- deciding which compliance measures should be put in place to reduce the likelihood of the risk occurring and/or reduce the consequences should the risk occur.

Hearing Services Program Risk Assessment

Non-compliance with the program requirements poses risks to program objectives, including risk to the achievement of optimal client outcomes and to program integrity. As the program's resources are finite and the majority of providers are willing to comply with the program requirements, a risk-based approach to monitoring program compliance is employed to

- identify the main risks to clients and the program
- identify the type and frequency of compliance monitoring activities appropriate in individual cases, consistent with available resources and an acceptable level of residual risk and
- deliver action plans to address the greatest risks.

Program risk management focuses on four key areas

1. **Client Safety** – risks to client health. For example, failure to refer clients for appropriate medical and further audiological evaluation, or services being delivered by non-qualified practitioners.
2. **Service delivery** – services not provided in accordance with the program requirements. For example, ambient noise and/or equipment calibration certification are not up to date, services are provided outside the voucher period, or providers obtain payment from client for services available to the client through the program.
3. **Program Integrity** – risks to the integrity and quality of the program. For example, misrepresenting the program, the provider promoting itself as a sole or endorsed provider to the program, or exposing the Commonwealth to potential litigation by the provider not being appropriately insured.
4. **Financial Issues** – risks associated with the mismanagement of program funding. For example, payments that do not meet the conditions for payment outlined in the Schedule of Service Items, which are not compliant with the PGPA Act 2013, or are fraudulent.

To assess the likelihood of these risks being realised, a wide range of data and information sources are reviewed including

1. Hearing Services Online data.
2. Claiming data.
3. Complaints from clients or health/hearing professionals.
4. Contract management issues.
5. Previous compliance actions, including audit outcomes.
6. Outcomes of the annual self-assessment process.

Assessment of this data and information against the program risks, and identification of patterns of high risk behaviour, helps to determine the focus of the compliance monitoring activities, including which providers are selected for audit.

Chapter 6 Provider Self-assessment

In response to earlier reviews of the program's compliance activities, and to support the shift to risk-based auditing, in 2012 the program introduced the provider Self-Assessment Tool (the SAT). The SAT is an online questionnaire, in checklist format, which requires providers to review and confirm their compliance with the program requirements.

The purpose of the SAT is to

- encourage providers to review their own practices and processes to ensure the program requirements are being met and
- support and encourage providers to develop an improvement plan to rectify any gaps they identify.

Self-Assessment Process

Clause 16.8 of the Contract requires providers to complete and submit an annual SAT by the date specified by the Commonwealth. Providers are given six to eight weeks to complete the SAT online. The SAT is usually released in September each year and is completed through a secure online survey tool - Citizen Space.

New providers may also be asked to complete a SAT as part of their first audit if they have not previously completed one.

Providers that do not submit or satisfactorily complete their SAT by the required deadline will be scheduled for a formal audit.

Responses to the SAT are used as one of several sources of information informing risk assessment process. The SAT asks for details of unreported breaches, and any action providers have taken or planned to address these areas of non-compliance. There may be follow-up compliance monitoring activities.

Chapter 7 Audit

An audit is a

> *"…systematic, independent and documented process for obtaining **audit evidence** and evaluating it objectively to determine the extent to which the **audit criteria** are fulfilled".*[4]

Audits enable us to check whether a provider has appropriate systems, processes and governance arrangements in place and are meeting the program requirements.

Auditors

Generally audits are conducted by program staff, however in some exceptional circumstances audits may be conducted by qualified personnel outside the program. All staff conducting audits have completed accredited audit and compliance training to ensure they have the necessary knowledge and skills, in accordance with the guidelines outlined in AS/NZS ISO 190112014.

Auditors must identify any Conflict of Interest prior to undertaking an audit and must comply with the Department's Conflict of Interest policy. Any material conflict of interest must be declared on a Declaration of Interests form and the auditor and their supervisor must document and undertake whatever action is required to manage the conflict. Auditors should abstain from undertaking any audit where a material conflict of interest exists.

Auditors are also expected to comply with the Australian Public Service Code of Conduct[5].

Types of Audits

Provider audits are scheduled following analysis of risk assessment criteria and data analysis. The audits are categorised by type, scope and method. There are two provider audit types

Targeted: the majority of audits are based on risk profiling and assessments (refer Chapter 5) and are targeted at those providers deemed to be higher risk. Targeted audits also result from specific signals such as unusual claiming patterns detected in data analysis, or complaints or tip-offs.

Random: to support our quality assurance and to monitor the efficacy of the audit process, 10% of provider audits are selected randomly from providers not identified through the targeted audit processes. Sites and clients selected for random audits are identified using a random number generator applied to the alphabetical listing of sites and clients.

The findings from this cohort of audits are compared to those from the targeted audits. This information improves our capability to assess and identify higher risk providers.

Audit Scope

The scope of an individual audit will vary depending on the issues identified. If serious non-compliance is identified the scope may be expanded during the audit. If this occurs, providers will be notified of the reasons for the expanded audit.

Audit scope is classified as either general, limited, follow-up audit or claim review.

[4] AS/NZS ISO 190112014, Guidelines for auditing management systems
[5] http//www.apsc.gov.au/publications-and-media/current-publications/aps-values-and-code-of-conduct-in-practice

General Audits: most audits are general audits which examine a provider's compliance with all the program requirements. All random audits will be general audits. In most cases, a provider's first audit will be a general audit.

Limited Scope Audits: a limited scope audit may involve one or more of the limited scope audit types described below (for example, a provider may be selected for a MHLT and refit requirements audit). Limited audits focus on specific risks or requirements of the program including

> **Minimum Hearing Loss Threshold (MHLT) Audit:** determining if the MHLT requirements have been met prior to the fitting of a hearing device.
>
> **Refit Audit:** determining if the Eligibility Criteria for Refitting (ECR) have been met for program clients who were refitted with new devices through the program.
>
> **Complex Client Audit:** ensuring that services provided to complex clients are compliant with the program, including complex client notifications and provision of information about the services they may receive from Hearing Australia.
>
> **Partially Subsidised Device Audit:** ensuring that the program requirements for the provision of partially subsidised devices have been met.
>
> **Other Limited Audit:** other specific program requirements identified from the review of claiming data or from specific risk signals such as a substantial complaint about a provider.

Follow-up Audits: as a result of a previous audit, providers may be required to participate in a follow-up audit. This is likely to occur 12 months after the initial audit and may be a general or a targeted audit, depending on the issues identified previously. These audits help to ensure non-compliance has been addressed.

Claim Review Audits: audits of claiming data held in HSO are routinely undertaken. These reviews are done on a much broader scale than either general or limited audits. You will not receive advance notice of a claim review as we do not initially require you to submit any information. Claim reviews involve checking a client's claim history against the program requirements, in particular the Schedule of Service Items and Fees, and the program standards. Claim reviews focus on detecting incorrect claims, for example duplicate claims, binaural services being claimed after monaural fittings, and an alternative listening device (ALD) fitting on a voucher with an existing fitting.

Audit Method

There are two audit methods, off-site or on-site. The majority of provider audits are completed by program auditors off-site, via a desk-based review of selected client files and provider records. The number of files selected for an audit will vary, depending on the scope and risks identified.

The auditor will invite the provider or their representative to participate in an introductory and an exit meeting to discuss the audit. The introductory meeting allows the provider to ask any questions about the audit process. The exit meeting includes discussion of any concerns noted by the auditors and gives the provider an opportunity to respond, prior to the issue of the Audit Report. The provider may also respond in writing following receipt of the Audit Report.

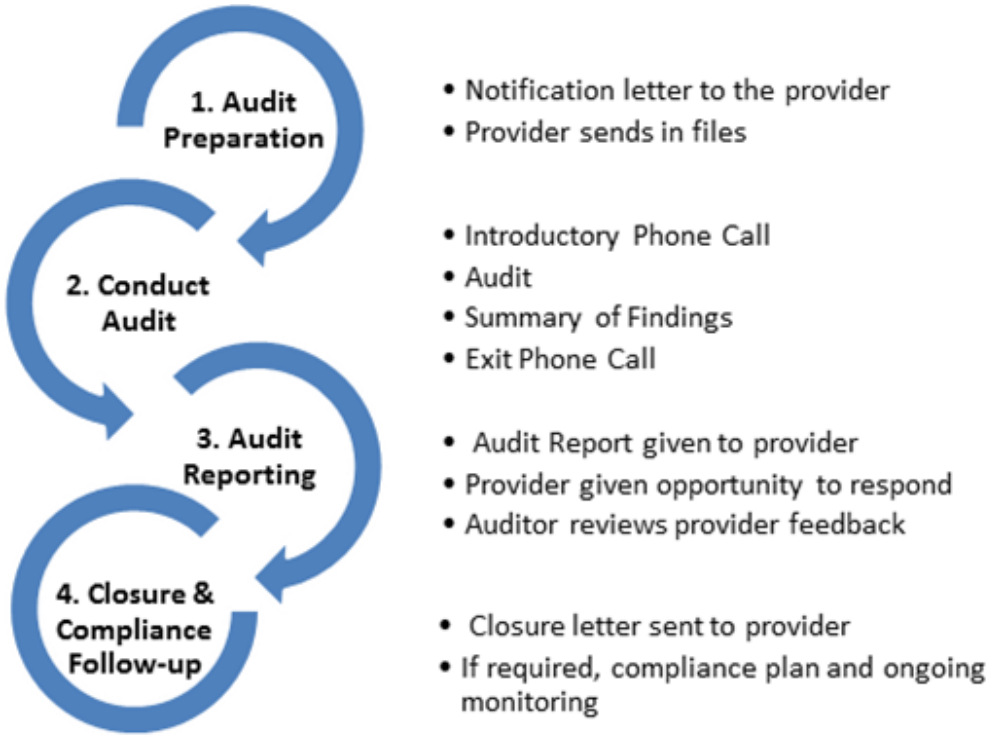
Off-site: generally provider audits are conducted off-site and the provider is required to give selected client files for review. Usually 20 client files are selected from a provider's client list, based on data analysis, although more or less client files may be requested. All claim review audits are also conducted off-site.

On-site: in limited cases, where deemed necessary, an on-site audit may be conducted. For example, if there are client safety risk indicators or an off-site audit revealed issues that require further investigation. On-site audits will involve program auditors visiting the identified site/s to undertake the audit on the premises. In accordance with the scope of the audit, this can include some or all client files. Providers are expected to ensure that staff are available to provide requested information.

Audit Stages and Timeframes

Timeframes for audits vary depending on the complexity and scope of the audit. Generally audits take approximately three months from the date of notification of an audit through to audit closure. An audit is undertaken in four stages prepare, conduct, report and close as outlined in Diagram 2. Where closure is contingent on commitment to compliance actions, there will be follow-up after the audit.

Diagram 2 Stages of a Program Audit



Stage 1 Audit Preparation

Notice is given in writing, to the Contract Holder's registered address. The period of advance notice given depends on the audit scope and the reasons the provider has been selected for audit. In most cases, providers are given ten working days' notice of an audit. Short notice audits may be conducted if the identified program risks suggest that this is appropriate. In these cases, there is a minimum notice period of 24 hours.

When a provider is notified that an audit will occur, information provided will include the type, scope and method of audit. The notification letter will also outline the documents that must be submitted and the due date for submission. Documents will be required to be scanned and uploaded to a secure folder on the department's server. Instructions for accessing the server and uploading files are provided with the notification letter.

Stage 2 Conduct Audit

Once the requested files and documentation have been received, the auditor will check the documents are complete and legible. The auditor will then hold an audit introduction teleconference with the provider to confirm the start of the audit, giving the provider an opportunity to ask questions about the process. During the audit, the auditor will

- review the client files provided for compliance with the program requirements
- contact the provider for additional information or seek clarification as necessary
- where required, request that more files or other documents be provided
- provide a summary of audit findings for consideration and review and
- request the provider participate in an audit exit teleconference. This will provide an opportunity to discuss any of the issues identified by the auditor and is a final opportunity to provide any additional documentation/evidence.

Stage 3 Audit Reporting

Following the exit teleconference, the provider will receive an Audit Report. Auditors aim to provide the Audit Report to the provider within 20 working days of receiving the files. This is dependent on timely provision of all the required documentation and the provider's availability to participate in the exit teleconference (refer the Contract, Clause 16.2).

The Audit Report will show whether or not the program requirements were met.

Requirements Met if the audit indicates that program requirements are being met, this will be specified in the Audit Report. The report will be sent with an email notifying the provider that no further action is required.

Requirements Not Met if the audit indicates that program requirements have not been met, the Audit Report will present

- the **audit findings**, outlining the areas where non-compliance was identified. The provider will be asked to advise what actions they have, or will, take to ensure compliance with program requirements in future
- any **unsubstantiated and/or invalid claims** made against the program. Unless these claims are able to be substantiated, the provider will be required to reimburse the Commonwealth and/or the client (refer the Contract, Clause 13 and subsection 51(2) of the instrument) and
- the **compliance actions** required by the provider (refer Chapter 8).

Once an Audit Report has been sent, providers have ten working days to respond. The provider's response must include information on how the provider has addressed or proposes to address the issues identified, including timeframes.

Stage 4 Audit Closure

When the auditor is satisfied with the response and any actions taken, the audit is closed. The provider will receive a closure letter. Where the areas of non-compliance are not fully addressed, follow-up compliance action will be documented and monitored post closure (refer Chapter 8).

Providers are encouraged to give feedback about our audit process, to support our continuous improvement. Feedback can be given directly to the auditor in writing or provided anonymously through an online survey. Instructions on how to complete the survey are included in the closure letter.

Chapter 8 Compliance actions

Ensuring compliance with the program requirements is key to overall client safety, the integrity of the program and safeguarding the expenditure of public money. Audits and other activities such as reviewing complaints, data analysis or claim reviews identify non-compliance with the program. However, it is the compliance response that ensures appropriate action is taken to address the non-compliance and therefore reduce the risk to the program. Compliance actions are strategies put in place to ensure providers address identified non-compliance with the program requirements. Providers may be subject to multiple concurrent compliance actions and responses, depending on the issues identified through compliance monitoring.

Types of Compliance Action

The range of compliance options that may be implemented are outlined in Diagram 3 (Compliance Monitoring and Compliance Actions Pyramid) and Table 1 (explanatory notes). The types of compliance actions required will depend on the nature of the non-compliance, its severity and frequency, and the provider's willingness to comply and to address the issues. Where a provider is willing to comply and needs minimal support, the level of compliance monitoring or compliance action needed is low. However, where there is an unwillingness to comply and/or a provider needs significant support to comply, the level of compliance monitoring and action will be high.

Program Response to Non-compliance

After identifying non-compliance, the first step is to give the provider an opportunity to respond and outline how they propose to address the non-compliance. The provider will be contacted in writing or by phone to discuss the issues and options to address the non-compliance. If the provider demonstrates an understanding of the problem and a willingness to act, this approach can deliver positive results and no further compliance action may be required. To reduce the risk of non-compliance providers can utilise any of the program supports outlined in the Framework (refer Chapter 3).

Commonly applied compliance actions include requiring the provider to

- develop a Compliance Action Plan and/or
- reimburse incorrect claims.

Compliance Action Plans

Where non-compliance is identified and is not easily rectified by the provider, a Compliance Action Plan (the plan) will be implemented. The plan will give the provider time to address the issues identified. More than one compliance action can be included in a plan. The plan will outline the required compliance actions the provider must take to address the non-compliances, and include conditions and timeframes for the delivery of compliance actions. Plans will generally require the provider to outline the steps they will take to ensure their staff will be made aware of the non-compliance and their strategies to prevent the non-compliance reoccurring. An example plan is included at Attachment A to this Framework.

Reimbursement of Incorrect Claims

Reimbursement of invalid or unsubstantiated claims payments for services claimed through the program must be made in accordance with the program requirements. Invalid claims are claims that do not comply with the program requirements. Unsubstantiated claims are claims for which there is insufficient evidence to show that the service was provided.

Clause 13.1 of the Contract states
"Where the Service Provider has received payment of Scheduled Fees under clause 12.1 from the Commonwealth for Services that were not provided in accordance with the Act, this Contract or the Schedule of Service Items and Fees, the Service Provider will be liable to reimburse the Commonwealth the amount of the payment."

Invalid or unsubstantiated claims are recovered from future payments by the Commonwealth to the provider. If the repayment is not made, a debt will be created to the Commonwealth and under clauses 23 and 24 of the Act, and debt recovery action will commence.

Examples where a provider would be required to reimburse the Commonwealth include
- services provided prior to the client's voucher start date (the instrument (section 14))
- fitting a client who had minimal hearing loss without meeting the MHLT Guidelines (the instrument (section 47)) and the ECR
- client review services provided within 12 months of a fitting (Schedule of Service Items)
- binaural services claimed for monaurally fitted clients (Schedule of Service Items) and/or
- services provided by a provisional practitioner without appropriate supervision (the Contract (clauses 8.1(b) and 12.2) and the instrument (section 38(c)).

It is very important that client files accurately document all services provided and contain evidence that service requirements were met.

Serious Compliance Action

The main focus is to work with providers to reduce the need for serious compliance action, however in some circumstances compliance objectives cannot be met through education or by assisting providers to comply. For example, there could be circumstances which may make a provider no longer suitable to provide hearing services to program clients. These may include where a provider
- has contravened a condition of their accreditation
- has a history, or there is evidence of, systemic non-compliance
- is acting in a fraudulent way
- has failed to ensure services are delivered by qualified/adequately trained personnel
- has failed to respond (or failed to respond appropriately) to attempts to assist the provider to return to compliance and/or
- is unable to address their non-compliance.

In these circumstances the contractual and legislative rights and responsibilities guide the action taken. Actions include
- requiring pre-approval of claims or claims placed on hold
- referring a practitioner to their Practitioner Professional Body
- requiring a provider to cease using a practitioner to deliver services to program clients
- applying conditions to the provider's contract
- suspending the provider from delivering services to program clients until issues are addressed
- terminating the provider's contract and/or
- taking criminal action against the provider.

Diagram 3 Hearing Services Program Compliance Monitoring and Compliance Actions Pyramid

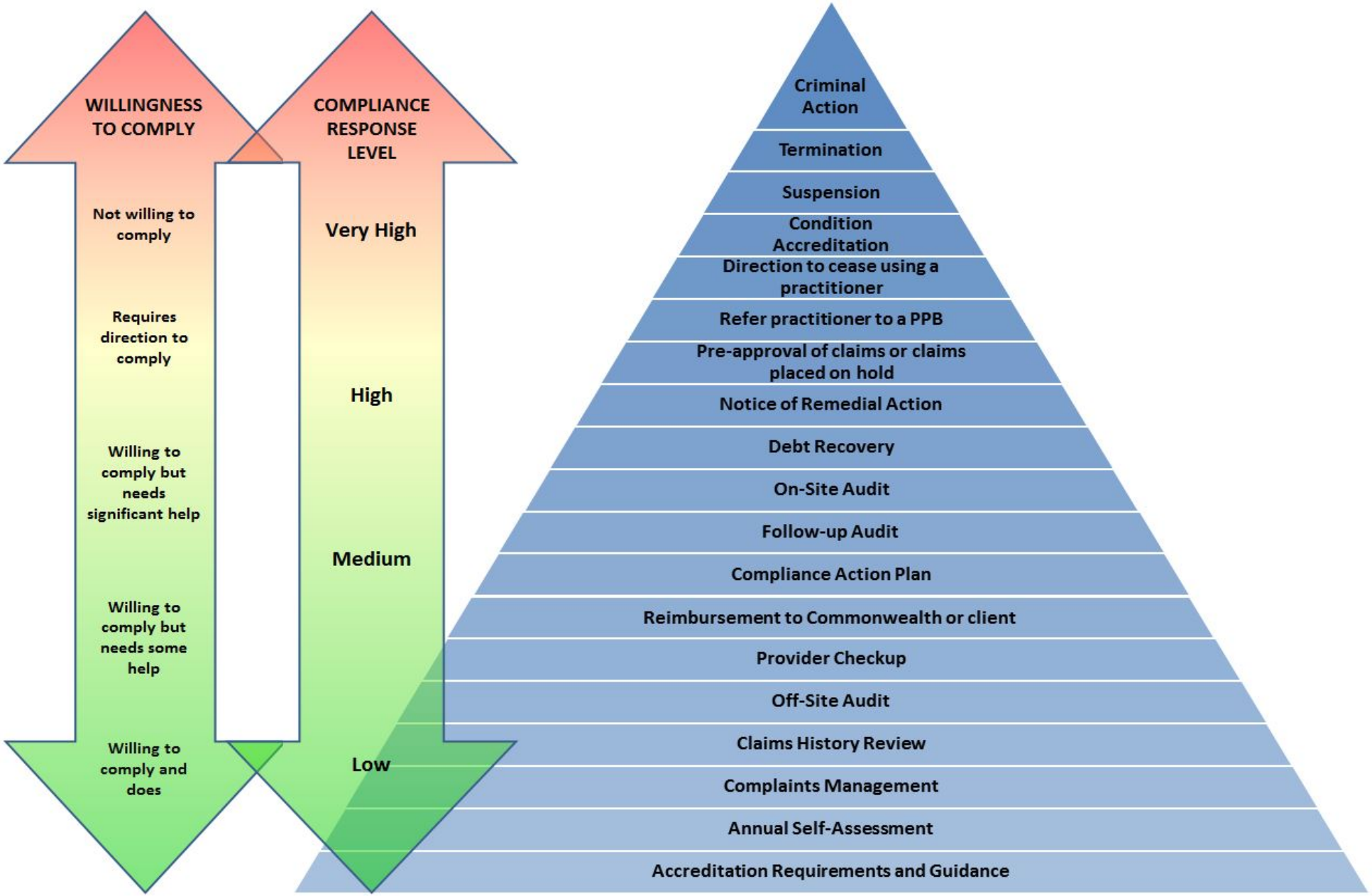


Table 1 Compliance Activities and Actions Explained

Compliance Action	Details
Accreditation Requirements and Guidance	To deliver services as part of the program, providers are required to be accredited and contracted with the Department of Health. The accreditation process requires that providers demonstrate their compliance with a range of factors including professional qualifications, site and equipment standards, and insurance. Where the application demonstrates a lack of understanding about the program, the applicant is contacted so that this can be rectified. When the decision to accredit a provider is made, they will receive further information to support their capacity to comply with the program.
Annual Self-Assessment	Providers are required by the Contract (clause 16.8), to complete an annual Self-Assessment Tool (SAT). The SAT is an opportunity for providers to reflect on the practices and processes they use to ensure continued compliance with contractual and legislative obligations. The SAT requires providers to certify that they have the necessary procedures and policies in place to ensure compliance with program requirements.
Complaints Management	When a complaint is received it is reviewed and investigated as necessary. Any recommendations are notified to the relevant parties. Depending on the outcome of the investigation, there may be recommendations for an audit and/or other compliance actions.
Claim Review	Claiming data is regularly reviewed to ensure claims are being submitted in accordance with the program requirements, including the Schedule of Service Items and Fees. Where incorrect claims are identified providers are given an opportunity to justify the claim. If the claim cannot be justified providers will be required to reimburse the payment.
Off-site Audit	Risk-based audits of providers may be triggered by unusual claiming patterns, complaints, excessive recoveries or rejections, incomplete SATs or breaches identified on consecutive SATs. When a provider is identified for an off-site audit, a review of a selected number of client files will be undertaken and the provider will be required to submit copies of the files for audit. The majority of audits undertaken by the program are off-site audits. In some cases, for example if there is evidence of systemic non-compliance or further investigation is needed, the scope of the audit can be expanded to cover additional sites and/or clients.
Reimbursement to Commonwealth or client	As specified by the Contract (clause 13), where payments are made to providers for services that were not provided in accordance with the program requirements, the provider must reimburse the Commonwealth. Incorrect payments are deducted from future Commonwealth payments, or they become a debt due to the Commonwealth and debt recovery action may be taken. In specific circumstances (subsection 51(2) of the instrument) a provider may be required to refund a payment received from a client.
Compliance Action Plan	If issues are identified through the annual self-assessment, audits, complaints process or other sources, providers may be required to develop and complete a Compliance Action Plan to address the issues identified. Follow-up via check-ups and/or follow-up audits may occur.

Compliance Action	Details
Provider Check-up	When compliance actions are initiated, providers may be required to participate in a provider check-up. This will require them to outline their progress towards completing the compliance actions and to review if there is evidence of any ongoing non-compliance. This can occur any time after a compliance action has been required, usually six to twelve months depending on the seriousness of the issues. More serious issues of non-compliance will be monitored through a follow-up or on-site audit, or other compliance actions.
Follow-up Audit	If an audit identifies serious areas of non-compliance, a follow-up audit will be undertaken to confirm the issues have been addressed. This is likely to occur 12 months after the initial audit and may be a general or a targeted audit, depending on the areas of non-compliance.
On-Site Audit	If a serious complaint or breach is identified, an on-site audit may be undertaken to fully investigate the issue. This will involve Commonwealth Officers attending the premise/s to investigate files, policies and procedures.
Debt Recovery	Where an incorrect claim has not been reimbursed as required by the Contract (Clause 13), the Commonwealth can seek to recover the debt as specified by the *Hearing Services Administration Act 1997*.
Notice of Remedial Action	If serious issues are not able to be resolved and non-compliance continues, the Commonwealth may issue the provider with a Notice of Remedial Action. As specified by the Contract (clauses 15.4 and 42), the provider must accept any request or direction in relation to services provided under the Contract.
Pre-approval of claims or claims placed on hold	Where serious systemic non-compliance is identified, providers may be required to seek pre-approval before submitting claims, or claims may be put on hold. This will involve a review of the evidence supporting the claim or requiring actions to be completed before approving payment.
Refer practitioner to a PPB	The instrument (section 40) authorises the Minister or their delegate to refer, or obtain information about, a practitioner to/from a practitioner professional body for the purposes of investigating and monitoring compliance with the instrument.
Direction to cease using a practitioner	A provider may be required to cease using a specified practitioner to deliver program services as outlined by the Contract (clause 8.2).
Conditions applied to the Contract	Serious non-compliance can result in conditions being applied to a provider's Contract, limiting the services they can provide to program clients.
Suspension	As outlined by the Contract (clause 25), the Commonwealth may issue a Suspension Notice. If a suspension notice is issued, the provider must stop providing the specified services to program clients until otherwise notified by the Commonwealth. Suspension Notices may apply to specific sites or services.

Compliance Action	Details
Termination	Where the provider fails to satisfy any of its obligations under the Contract, the Commonwealth may terminate the Contract (refer Clause 28). The provider will no longer be able to deliver services through the program and may have their accreditation revoked. Termination of the Contract may occur if, for example • practices were revealed that place the program and/or its clients at significant risk • the provider has been unable or unwilling to address non-compliance, despite being given the opportunity • fraudulent behaviour was identified and/or • following a period of suspension of services where it is unlikely the issues can be addressed. Prior to suspending or terminating a Contract, providers will be given an opportunity to explain why the Contract should not be suspended or terminated. Providers are given 28 days to respond, but this time period may be shortened if the risk to clients or the program demands a shorter response time. This is within the discretion of the program. The response will be reviewed and a decision made regarding whether to proceed with the proposed action.
Criminal Action	Where there are serious breaches of a criminal nature, including fraudulent claims, relevant authorities will be notified. Legal action may be initiated.

Chapter 9 Monitoring, reviewing and improving this Framework

We are committed to continuously reviewing and improving the effectiveness of the Framework.

Provider Feedback

Complements, complaints and feedback about our approach to compliance monitoring and management, including the Framework are welcome. You may contribute by

- completing a feedback survey following their audit experience (a link to the online survey is supplied in the audit closure letter)
- providing comments in the allocated section of the annual SAT questionnaire
- emailing hearing@health.gov.au. (please mark Attention Compliance Support Team)
- ringing the Hearing Services Program Information Line (9.00am - 5.00pm EST, Monday - Friday on 1800 500 726 or TTY 1800 500 496)
- writing to Hearing Policy and Compliance Section, Hearing Services Program, Department of Health, MDP 113, GPO Box 9848, Canberra City ACT 2601

Publication of the Outcomes of Compliance Monitoring

The program produces regular Lessons Learnt Reports highlighting common areas of non-compliance and providing advice on compliance achievement. All information is de-identified.

Regular CSPNs are released about issues identified during audit and compliance monitoring.

Program information, notices and updates are available on the website hearingservices.gov.au. Providers are required to register for the RSS Feed to ensure they are automatically kept up to date with the release of new information.

Attachment A: Sample Compliance Action Plan

Action Required	Due Date
1. Update Templates **a. Maintenance Agreement template** Provide an updated Maintenance Agreement template which includes the program requirements. **b. Refit Criteria** Provide an updated checklist for refitting program clients to show the correct refit criteria and evidence (Eligibility to Refit Criteria). **c. Quotation Template** Provide an updated device quote template in accordance with program requirements.	
2. Update Policies and Procedures Provide policies and procedures to ensure future compliance with program requirements, including **a. Referral Policy** to correctly definite non-routine clients **b. Supervision of Non-Qualified Practitioners Policy** to show how you will ensure appropriate supervision of non-qualified personnel**.** **c. Eligibility Checking Procedures** to ensure client eligibility is checked prior to service delivery. **d. Implementation** Outline how you will ensure your personnel are aware of the updated policies and procedures.	
3. Reimburse the Commonwealth As invalid and/or unsubstantiated claims were identified you are required to reimburse the Commonwealth $xx.xx. Details of the reimbursements required are outlined in the list of reimbursements provided. Instructions on how to initiate these reimbursements through the portal are available in the HSO User Guide. You are required to process the reimbursements in the portal within 10 working days from the date of this letter. Once processed, the amounts will be deducted from your next payment from the Commonwealth. Please notify me when you have processed the reimbursement/s.	10 working days from receipt of letter
4. Reimburse Client Refund $xx.xx to Client Name for the client payment for services that were available to them under the program. Please ensure you retain evidence of this refund on the client file and provide the evidence when completed.	28 days from the receipt of this letter

Compliance will be monitored by

Action Required	Due Date
1. Document Review Reviewing the updated templates, policies and procedures.	Following receipt of documents.
2. Confirm Repayment to the Client Contacting the client to confirm the repayment was made to them as required.	
3. Confirm Repayments to the Program Checking that claims have been reimbursed to the Commonwealth.	
4. Claim Review Reviewing all claims submitted for 3 months from the date of the Compliance Action Plan, to ensure policies and procedures have been implemented.	Over the next 3 months.
5. Provider Check-up Contact the provider in three months to discuss progress on achieving the compliance actions.	
6. Follow-Up Audit Conducting a follow-up audit of the site in 12 months.	