Australian Government
Department of Health and Aged Care

Compliance Monitoring and Support Framework

Hearing Services Program

Hearing Services Program

Contents

Chapter 1 – Framework overview

Objective and purpose

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

The Compliance Monitoring and Support 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:

- ensure client safety and quality hearing outcomes for clients
- provide support to providers by assisting them to comply with the program requirements
- maintain program integrity
- ensure appropriate financial management of the public monies that support the program and
- safeguard Commonwealth records including sensitive client personal and health information.

We contract service providers to deliver high quality services to program clients and retrospectively reimburse them for services that comply with program requirements. Legislation and contracts govern the program. In addition to compliance checks that are part of the accreditation process, we monitor program compliance in several ways. These include:

- self-assessment
- complaints investigations
- claim reviews
- audits.

The framework

The framework describes the:

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

We make the framework available to all providers online and a hyperlink is included in the program's electronic accreditation kit. A range of supports are available (Chapter 3).

Revisions

We developed an initial framework in 2013, following a 2012 review of program audit and compliance. We updated it in 2017 following a review of:

- lessons learnt from ongoing audit and compliance activities
- provider feedback following audit processes
- emerging trends, government policies and priorities.

We completed a further review and update in 2020 following a thematic review of program legislation and regulation and the release of the Hearing Services Program (Voucher) Instrument 2019. Minor edits were completed om 2022 with the consolidation of the Hearing Rehabilitation Outcomes into the Schedule of Service Items and Fees.

In early 2024, further minor edits were completed to introduce the new provider check-ins, qualified practitioner checks, removal of historical references, and inclusion of the staggered recovered and payment plan options.

We developed the framework in line with the following guidelines and protocols:

- the Australian National Audit Office's (ANAO) better practice guides. These guides help Commonwealth government agencies improve the quality and consistency of their administration of public service obligations and activities
- the Australian Standard for Risk Management, AS/NZS ISO 310002018
- the Guidelines for Auditing Management Systems, AS/NZS ISO 19011 2018
- 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 and contractual requirements

For the purposes of this document, we refer to these legislative and contractual requirements as the program requirements:

- *Hearing Services Administration Act 1997*
- Hearing Services Program (Voucher) Instrument 2019
- Australian Hearing Services Act 1991
- Australian Hearing Services (Declared Hearing Services) Determination 2019
- Service provider contract
- Schedule of Service Items and Fees including program standards:
    - Minimum Hearing Loss Threshold (MHLT) Guidelines
    - Eligibility Criteria for Refitting (ECR)

The Australian Government has a responsibility to assure the Australian community that:

- providers deliver high quality and safe services to clients of the program through meeting the program requirements
- we spend public funds according to the legislative framework supporting the program.

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*
- *Hearing Services Administration Act 1997*.

Section 16 (a) of the *PGPA Act 2013* requires us to establish and maintain an appropriate system of risk oversight and management.

Under section 16 of the *Hearing Services Administration Act 1997* (Conditions of accreditation), the Minister for Health and Aged Care 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:

> *'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' clauses (2)*
> *'Each condition of the accreditation of the contracted service provider is taken to be a condition of the engagement' clause (3)*

To deliver program services, providers must be accredited and have a contract with the Commonwealth. This contract specifies that all providers must comply with the:

- Act
- instrument
- contract
- schedule of service items and fees.

Clause 16 of the contract outlines the audit provisions and 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.

We monitor program compliance throughout the course of a provider's relationship with the program, from accreditation through service delivery and closure. We implement responses to risks and non-compliance 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 must maintain compliance with the program requirements. A range of supports are available to help providers understand what they need to do. Most providers maintain compliance and where we identify non-compliance are willing to address the issues promptly and effectively. Where we require further compliance action, the focus of these actions is to help the provider 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 we actively identify, evaluate and monitor risks. We assess risks based on their likelihood and potential consequences. We implement compliance activities to control risks.

Adopt a proportionate approach to non-compliance

This means, in the event that we identify non-compliance, we will:

- assess the information available
- implement a reasonable response based on our legislative requirements, the severity of the issues identified and the provider's willingness to comply.

Be transparent

We publish documents such as this framework to give providers a clear understanding of the approach to program compliance. In dealing with individual providers, we clearly articulate and document audit findings. As we generally do not conduct on-site audits, we do this via teleconferences with providers to:

- discuss outcomes
- provide an audit report
- give providers the opportunity to respond.

Be accountable

Compliance activities are consistent with:

- legislation
- the contract
- the schedule of service items and fees
- program standards
- program policies and procedures.

Decisions are appropriately and accurately documented and escalated or referred as necessary.

Respond in a timely manner

In all cases we undertake audits and compliance activities in a timely way. The time will vary depending on the type of audit, the complexity of issues identified and provider responses.

Act consistently

Ensure a consistent approach across the program, including how we apply procedures and actions.

Be fair

Focus on being impartial and objective, ensuring that if we identify any non-compliance, we give the provider an opportunity to respond.

Contacting clients

We may contact clients, or their guardians, as part of compliance monitoring, to seek information that may help us investigate a complaint or conduct our audit. For example, we may need to confirm that a client has received reimbursement for any incorrect payments they have made to a provider.

Hearing Services Program support

Providers must have policies, processes and systems to ensure compliance with program requirements. The contract may require provides to have:

- an internal audit or review policy
- supervision of non-qualified practitioners policy

- medical referral policy
- client transfer policy
- complaints policy
- guides and training for staff.

The program has a range of supports and risk controls in place to:

- effectively manage program compliance risks
- ensure application of the above principles
- help providers to maintain compliance.

We provide 3 different types of program support: education and information, systems support and compliance checks.

Education and information

Web content

The program's web content gives providers access to a broad range of program information including:

- accreditation guidelines
- eligibility criteria
- legislation
- service and claiming requirements
- compliance support.

Provider notices

We publish regular notices to inform and update providers about key changes or issues that occur with the program. Providers must keep up to date with notices and make their staff aware of the information we provide.

Hearing Services contact centre

The program contact centre (1800 500 726) offers advice and information regarding all aspects of the program. Where required, the contact centre may refer calls to specific program staff who can best respond to that enquiry.

Email support

The program email address is hearing@health.gov.au. Enquiries, complaints, and support for clients and providers are received through this email address. Emails are referred to specific program staff who can best respond to the issue in the email.

Systems support

Hearing Services Online (HSO) portal

The HSO portal allows providers to:

- manage clients
- manage site and practitioner information
- 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.

Providers must be aware of the service and claiming requirements of the program when issuing vouchers and delivering and claiming for services. The portal incorporates key business rules that review claims for payment in accordance with the schedule of service items and fees. While HSO checks some rules when the claim is submitted, providers must ensure that, when delivering the service, the requirements for the service have been met.

Compliance checks

Accreditation compliance

We assess a provider's application for accreditation under the program according to the accreditation scheme requirements. 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.

Post accreditation check-in

Following accreditation, providers will have a 6-month compliance check-in to review and support ongoing compliance with the program requirements. During the check-in they will be asked to provide copies of their policies, procedures and templates to ensure they comply with program requirements. The program will work with providers to address any issues identified.

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.

Qualified practitioner checks

We regularly check qualified practitioners hold the required membership levels with a recognised practitioner professional body and that the QP details including provider links are accurate. For example, providers may be asked to supply copies of PPB membership certificates.

Claim reviews

We regularly review claiming data to ensure providers are submitting claims according to program requirements. For example, we identify claims that do not comply with the schedule of service items and fees, including:

- those with incorrect dates of service
- binaural claims when the client has one device
- duplicate claims.

Audits

An audit is a review of compliance with all or targeted components of the program requirements. We do not intend for them to be punitive. They identify areas of non-compliance so action can be taken to prevent reoccurrences. By working with us, most providers can correct non-compliance. We give providers an opportunity to address any issues identified by an audit. They can then outline a plan to fix the areas of non-compliance, including reviewing their internal processes and systems to ensure compliance in the future. However, more serious compliance actions may be taken without further notice if there:

- are risks to client safety or program integrity
- is evidence of fraud (refer to Chapter 4).

You will receive a guide about the process with your audit or claims review notification letter.

Providers should use the outcomes of compliance checks to review and update their policies, procedures and systems to meet the program requirements.

Chapter 4 – Risk-based approach to compliance monitoring and actions

We monitor compliance through a range 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.

Providers rectify non-compliance through compliance actions. The level of compliance monitoring and support will vary depending on the:

- levels of risk and non-compliance identified
- provider's willingness and capacity 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.

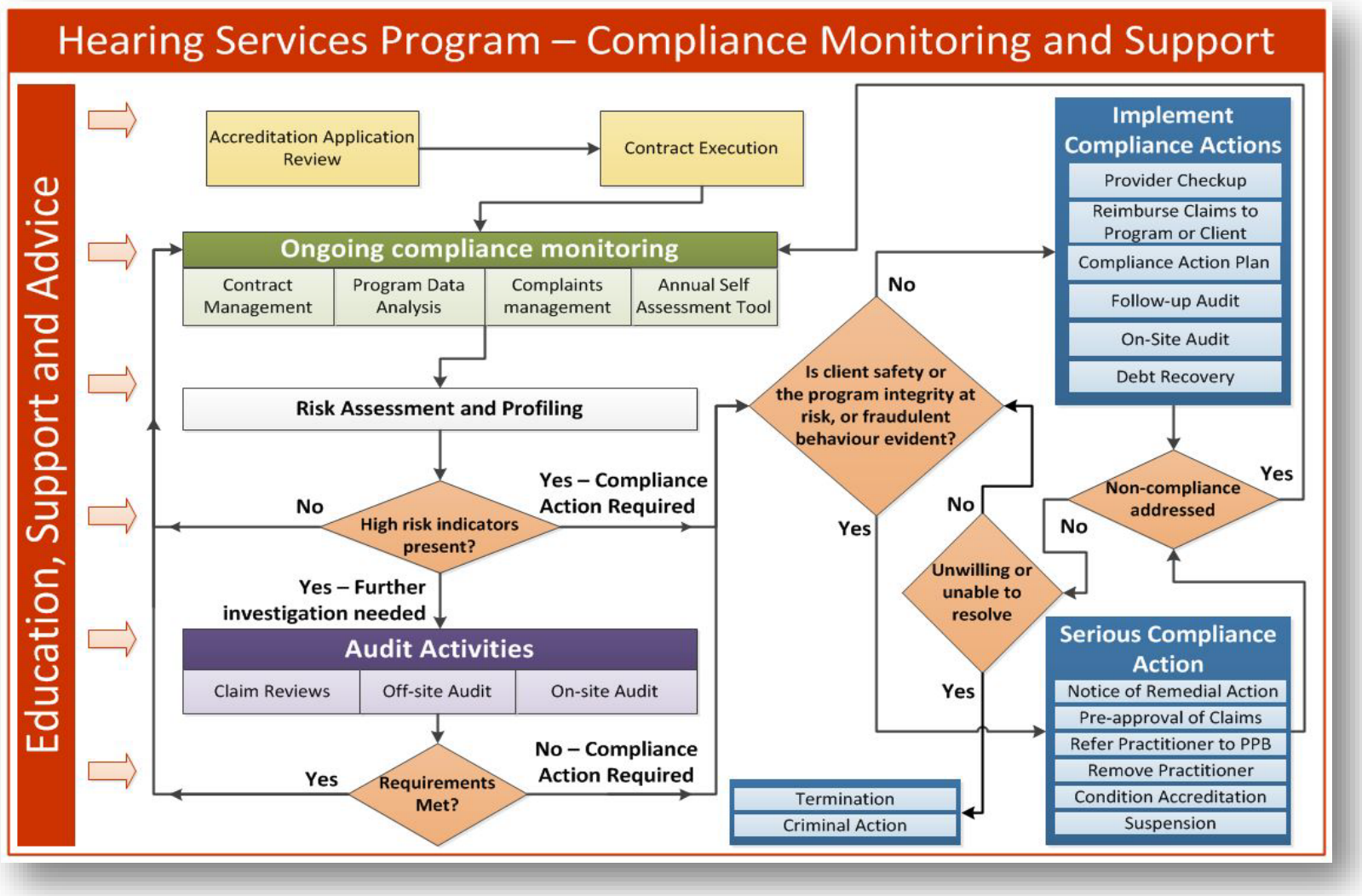
In accordance with the compliance principles and supports outlined in Chapter 3, the key elements of the compliance monitoring and support framework are:

- 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 help identify 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
    - 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. This allows providers to undertake unscheduled activities 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 we give to the provider
    - we give providers an opportunity to address the identified issues and to outline a plan of how they have addressed or will address the issues
- provider reimbursement of unsubstantiated or invalid claims to the Commonwealth. Providers must reimburse the Commonwealth for any payments they have received for services not delivered according to the program requirements (refer clause 13 of the contract)
- provider reimbursement of unsubstantiated or incorrect payments received from clients. Providers must reimburse the client for any payments the client made for services where the payment was not compliant with program requirements (refer subsection 51(2) of the instrument)
- we may take more serious compliance actions, as described in Chapter 8 (Diagram 3), when client safety or program integrity are at high risk, or when there is evidence of fraud.

The following chapters discuss each of these framework elements in more detail.

Diagram 1 – Hearing Services Program compliance monitoring and support framework overview



Chapter 5 – Program risk identification, assessment and management

The program identifies, assesses and manages risk through:

- 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
- deciding which compliance measures the department and providers will put in place to reduce the likelihood of the risk occurring 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 most providers are willing to comply with program requirements, we use a risk-based approach to monitoring program compliance. This means we can:

- 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
- deliver action plans to address the greatest risks.

Program risk management focuses on 4 key areas:

- **Client safety** – risks to client health and wellbeing. For example, failure to refer clients for appropriate medical and further audiological evaluation or delivering services using non-qualified practitioners.
- **Service delivery** – services not provided according to program requirements. For example:
  - ambient noise or equipment calibration certification not being up to date
  - providing services outside the voucher period
  - providers charging the client for services available to them through the program.
- **Program integrity** – risks to the integrity and quality of the program. For example:
  - misrepresenting the program

    - a provider promoting itself as a sole or endorsed provider to the program
    - a provider that is not appropriately insured exposes the Commonwealth to potential litigation.
- **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 and fees
    - are not compliant with the PGPA Act 2013
    - are fraudulent.

We review a wide range of data and information sources to assess the likelihood of these risks occurring, including:

- HSO data
- claiming data
- complaints from clients, health or hearing professionals
- contract management issues
- previous compliance actions, including audit outcomes
- outcomes of the annual self-assessment process
- internal or external tip-offs and notifications.

We determine the focus of the compliance monitoring activities, including which providers are selected for audit by:

- assessing this data and information against the program risks
- identifying patterns of high-risk behaviour.

Chapter 6 – Provider self-assessment

The self-assessment tool (SAT) is an online questionnaire 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 they're meeting the program requirements
- 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 we specify. We give providers 6 weeks to complete the SAT online. We usually release the SAT in the last quarter of a calendar year and providers complete it through a secure online survey tool – Citizen Space.

We may ask new providers to complete a SAT as part of their first audit if they have not previously completed one.

We will schedule a formal audit for providers that do not submit or satisfactorily complete their SAT by the required deadline.

We use responses to the SAT as one of several sources of information informing our 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".*[1]

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

Auditors

Qualified program staff generally conduct audits, however in some exceptional circumstances qualified personnel outside the program may conduct audits. All staff conducting audits have completed accredited audit and compliance training to ensure they have the necessary knowledge and skills. This is in line with the guidelines outlined in AS/NZS ISO 19011:2018.

Auditors must identify any conflict of interest before undertaking an audit and must comply with the department's conflict of interest policy. The auditor must declare any material conflict of interest using a Declaration of Interests form. The auditor and their supervisor must document and undertake actions to manage the conflict. Auditors should abstain from undertaking any audit where a material conflict of interest exists. We also expect auditors to comply with the Australian Public Service Code of Conduct[2].

Types of audits

We schedule provider audits following analysis of risk assessment criteria and data analysis. We categorise audits by type, scope and method.

In accordance with the risk-based approach, most audits are a result of risk profiling and assessments (refer Chapter 5) and we target those providers deemed to be higher risk. Targeted audits also result from specific signals such as unusual claiming patterns detected in data analysis, complaints or tip-offs. However, to support our quality assurance and to monitor the efficacy of the audit process, we also do random audits. We identify and select

[1] AS/NZS ISO 19011:2018 Guidelines for auditing management systems
[2] http//www.apsc.gov.au/publications-and-media/current-publications/aps-values-and-code-of-conduct-in-practice

sites and clients for these audits by applying a random number generator to an alphabetical listing of sites and clients. We compare the findings from this cohort of audits to those from 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 we identify serious noncompliance, we may expand the scope during the audit. If this occurs, we notify providers of the reasons for the expanded audit.

General audits

Most audits are general audits. We examine a provider's compliance with all the program requirements including both service management documentation and procedures and audits of client records.

Limited scope audits

A limited scope audit may involve one or more of the limited scope audit types described below (for example, we may select a provider for both an MHLT and refit requirements audit). Limited audits focus on specific risks or requirements of the program including:

- **Replacements audit** – determining if the provider has met the requirements to support the replacement.
- **Refit audit** – determining if clients refitted with new devices through the program met the eligibility criteria for refitting (ECR).
- **Minimum Hearing Loss Threshold (MHLT) audit** – determining if the client has met the MHLT requirements before fitting of a hearing device.
- **Specialist client audit** – ensuring that services provided to complex clients comply with the program.
- **Partially subsidised device audit** – ensuring that services meet the program requirements for the provision of partially subsidised devices.
- **Other limited scope audits** – checking other specific program requirements we identify from:
    - the review of claiming data
    - specific risk signals such as a substantial complaint about a provider.

Follow-up audits

As a result of a previous audit, we may require providers 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 providers have addressed non-compliance.

Claim review audits

We routinely audit claiming data held in the HSO portal. We do these reviews 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 invalid claims, for example:

- voucher status
- service availability
- duplicate claims
- claiming binaural services after monaural fittings
- .

Audit method

There are two audit methods, off-site or on-site. Program auditors complete most provider audits 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. It also gives the provider an opportunity to respond, before we issue the audit report. The provider may also respond in writing following receipt of the audit report. With their audit notification letter, we also give providers an audit guide that gives more information about the process.

Off-site

Program auditors complete most provider audits off-site and require providers to give selected client files for review. Usually, the auditor selects 20 client files from a provider's client list, based on data analysis. Sometimes, they may request more, or less, client files.

Auditors also conduct all claim review audits off-site.

On-site

An auditor may conduct an on-site audit, in limited cases, where they deem it necessary. For example, if there are client safety risk indicators or an off-site audit revealed issues needing further investigation. On-site audits will involve program auditors visiting the identified sites to undertake the audit on the premises. Depending on the scope of the audit, this can include some or all client files. We expect providers to ensure that staff are available to provide requested information.

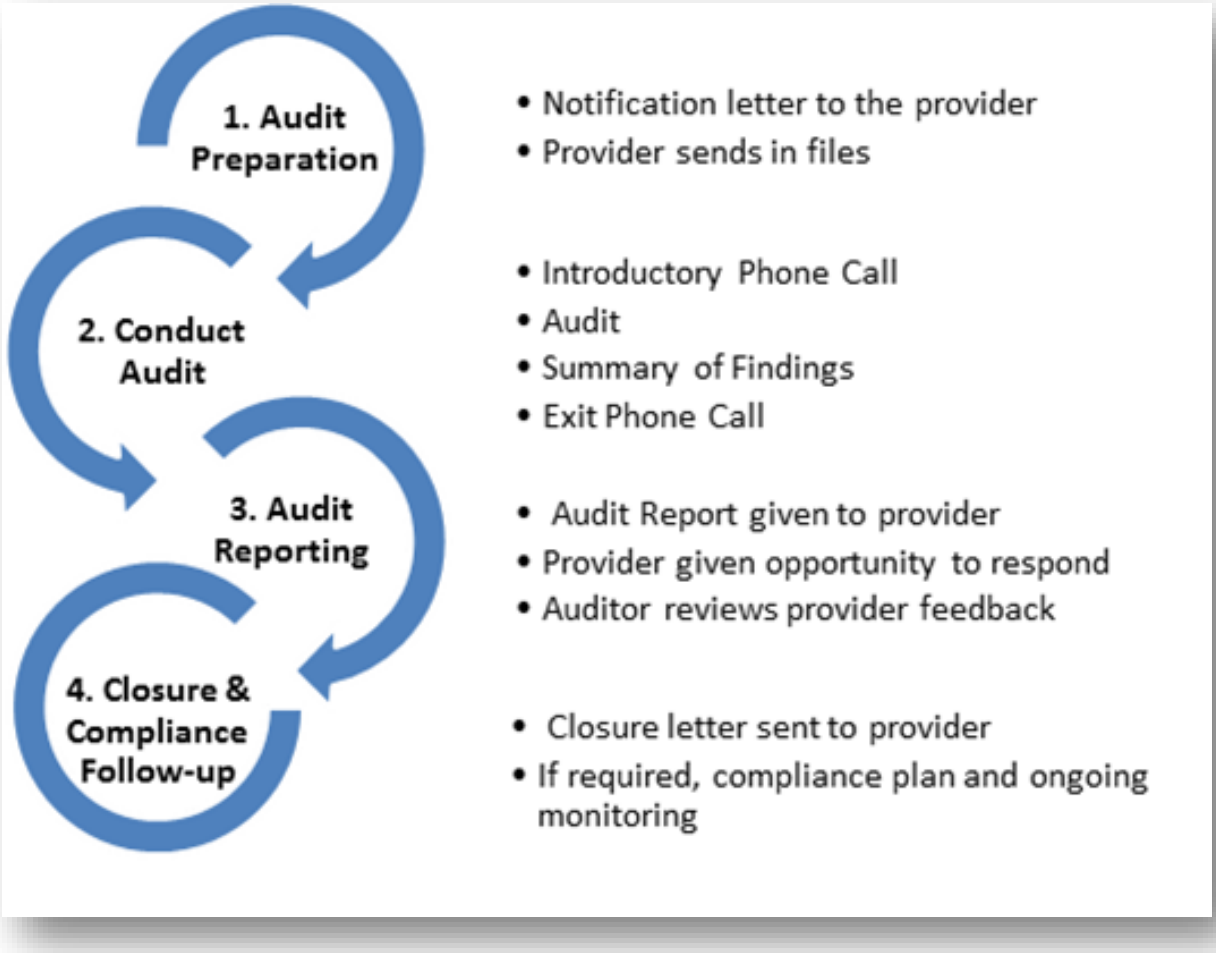
Audit stages and timeframes

Timeframes for audits vary depending on the complexity and scope of the audit. Generally, audits take about 3 to 4 months from the date of notification of an audit through to audit closure. They can take longer if the provider needs additional time to review and respond or there are a large number of claims per client to review.

An audit is undertaken in 4 stages as outlined in Diagram 2 – prepare, conduct, report and close.

Where closure depends on the provider's commitment to compliance actions, there will be follow-up after the audit.

Diagram 2 – Stages of a program audit



Stage 1 – Audit preparation

We give notice to the provider's registered address in the portal. The period of advance notice given depends on the audit scope and the reasons we have selected the provider for audit. In most cases, providers are given ten working days' notice of an audit. We may conduct short notice audits if the identified program risks suggest that this is appropriate. In these cases, there is a minimum notice period of 24 hours.

When we notify a provider 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 providers must submit and the due date for submission. We require providers to upload documents to a secure folder on the department's server. We provide instructions for accessing the server and uploading files with the notification letter.

Stage 2 – Conduct audit

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

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

Stage 3 – Audit reporting

Following the exit teleconference, the provider will receive an audit report. Auditors aim to provide the report to the provider within 20 working days of reviewing the summary of files with the provider. This depends on:

- timely provision of all the required documentation
- the provider's availability to participate in the exit teleconference (refer the contract, clause 16.2).

The audit report will show whether the provider has met the program requirements, and what areas they need to address.

Requirements met

If the audit indicates that providers are meeting program requirements, the auditor will specify this in the audit report. The auditor will send the report with an email notifying the provider that no further action is required.

Requirements not met

If the audit indicates that the provider has not met the program requirements, the audit report will present:

- the **audit** findings, identifying the areas of non-compliance. The auditor will ask the provider to advise what actions they have, or will, take to ensure compliance with program requirements in future
- any unsubstantiated or invalid claims made against the program. Unless the provider can substantiate these claims, they must reimburse the Commonwealth or the client (refer the contract, cause 13 and subsection 51(2) of the instrument)
- the compliance **actions** the provider must take (refer Chapter 8).

Once the auditor has sent an audit report, providers have 10 business days to respond. The provider's response must include information on how they have addressed, or propose to address, the issues identified, including timeframes.

Stage 4 – Audit closure

When the auditor is satisfied with the provider's response, and any actions taken, they close the audit. The provider will receive a closure letter. Where the areas of non-compliance are not fully addressed, the auditor will document and monitor compliance action after closure (refer Chapter 8).

We encourage providers to give feedback about our audit process, to support our continuous improvement. They can provide feedback directly to the auditor in writing or anonymously through an online survey. The auditor provides instructions on how to complete the survey 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 providers take appropriate action 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

Diagram 3 (compliance monitoring and compliance actions pyramid) outlines the range of compliance options the program may implement and Table 1 (explanatory notes) further expands on these. The types of compliance actions required depends on:

- the nature of the non-compliance
- non-compliance severity and frequency
- the provider's willingness and capacity to comply and 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. The level of compliance monitoring and action will be higher where:

- there is an unwillingness to comply
- a provider needs significant support to comply.

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. We will contact the provider, in writing or by phone, to discuss the issues and options to address the non-compliance. This approach can deliver positive results and we may not require further compliance action if the provider demonstrates:

- an understanding of the problem
- a willingness to act.

To reduce the risk of non-compliance providers can utilise any of the program supports outlined in the framework (refer Chapter 3).

Common compliance actions we apply include requiring the provider to:

- participate in a compliance action plan
- amend policies, procedures and templates
- undertake staff training and development
- reimburse invalid claims or incorrect client payments.

Compliance action plans

Where we identify more serious non-compliance that the provider cannot easily rectify or that require follow-up, we will implement a compliance action plan. The plan will give the provider time to address the issues identified. The plan can include more than one compliance action. The plan will:

- outline the required compliance actions the provider must take to address the non-compliance
- include conditions and timeframes for the delivery of compliance actions.

Plans will generally require the provider to outline:

- the steps they will take to make sure their staff are aware of the non-compliance
- their strategies to prevent the non-compliance reoccurring.

An example plan is included at Attachment A.

Reimbursements

Reimbursement of invalid or unsubstantiated claims

Services claimed through the program must comply with the program requirements, otherwise they are invalid. 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."*

Generally, the Commonwealth recovers invalid or unsubstantiated claims from future payments to the provider. In some situations, we may issue a provider an invoice to repay the funds directly. Debt recovery action will commence if the provider does not reimburse the funds by the due date, or we cannot deduct them from future claims.

Examples where we would require a provider to reimburse the Commonwealth include:

- services provided when the client did not have a valid voucher at the date of fitting or service
- no evidence available to substantiate the services met program requirements as outlined in the schedule of service items and fees
- fitting a client who had minimal hearing loss without meeting the MHLT Guidelines (the instrument (section 47))
- refitting a client without meeting one of the eligibility criteria for refitting
- replacements of devices without obtaining beforehand either a
    - correctly completed statutory declaration
    - manufacturer or supplier damaged beyond repair letter
- binaural services claimed for monaurally fitted clients (schedule of service items and fees)
- maintenance claims when the client had not agreed to maintenance
- services provided by a practitioner not meeting the program requirements for practitioners (the contract (clauses 8.1 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 providers met service requirements.

The department will consider requests from providers to stagger the processing of recoveries in the portal. If recoveries are being managed by invoice, providers can request a formal payment plan which may be approved by the department. You will be provided details of how to request staggered recoveries or a payment plan as part of the audit or claims review process.

Reimbursement of client payments

Generally, services and devices supplied to clients are fully subsidised by the department. However, in some circumstances clients can be asked to make a payment (Hearing Services Program (Voucher) Instrument 2019 – Part 7. Providers may be required to refund client

payments if the payment was not compliant with the program's legislation or contract (section 51(2) Hearing Services Program (Voucher) Instrument 2019).

Serious compliance action

The focus is to work with providers to reduce the need for serious compliance action. However, in some circumstances providers cannot meet compliance objectives despite 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:

- contravenes a condition of their accreditation
- shows a history, or evidence of, systemic non-compliance
- acts in a fraudulent way
- fails to ensure that qualified or adequately trained personnel deliver services
- fails to respond (or fails to respond appropriately) to attempts to assist the provider to return to compliance
- cannot address their non-compliance.

In these circumstances the program may take additional compliance action against a provider, including:

- 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 and accreditation
- suspending the provider from delivering services to program clients until they address the issues
- terminating the provider's contract
- taking criminal action against the provider.

Diagram 3 – Hearing Services Program compliance monitoring and compliance actions pyramid

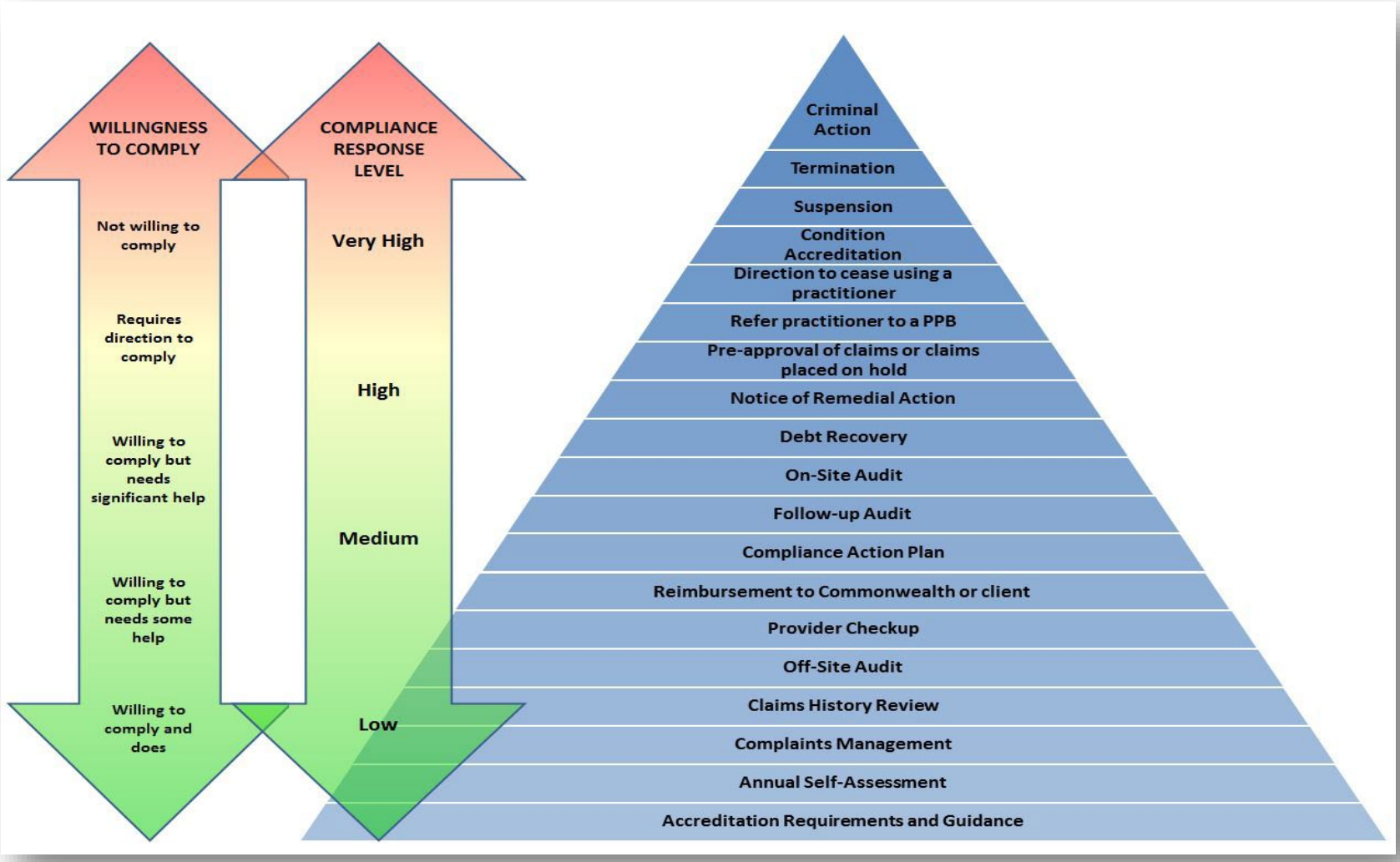


Table 1 Compliance Activities and Actions Explained

Compliance action	Details
Accreditation requirements and guidance	To deliver services as part of the program, we require providers to be accredited and contracted with the Department of Health and Aged Care. 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, we contact the applicant to rectify this. When we make the decision to accredit a provider, they will receive further information to help them comply with the program.
Annual self-assessment	Clause 16.8 of the contract requires providers 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 we receive a complaint, we review and investigate as necessary. We notify relevant parties of any recommendations. Depending on the outcome of the investigation, we may recommend an audit or other compliance actions.
Claim review	We regularly review claiming data to ensure providers are submitting claims according to the program requirements, including the schedule of service items and fees. Where we identify invalid claims, we give providers an opportunity to justify the claim. If the provider cannot justify the claim, they must reimburse the payment.
Off-site audit	Unusual claiming patterns, complaints, excessive recoveries or rejections, incomplete SATs or breaches identified on consecutive SATs may trigger a risk-based audit of a provider. When we identify a provider for an off-site audit, we review a selected number of client files and require the provider to submit copies of the files for audit. Most audits we undertake are off-site audits. In some cases, we may expand the scope of the audit to cover additional sites or clients. For example, if there is evidence of systemic non-compliance or we need to investigate further.
Reimbursement to Commonwealth or client	Clause 13 of the contract specifies that providers must reimburse the Commonwealth for payments they received for services that did not meet the program requirements. We deduct these payments from future Commonwealth payments, or they become a debt due to the Commonwealth and we may take debt recovery action. In specific circumstances (subsection 51(2) of the instrument) we may require a provider 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, we may require providers to develop and complete a compliance action plan to address the issues identified. Follow-up via check-ups or follow-up audits may occur.
Provider check-up	When we initiate compliance actions, we may require providers to participate in a provider check-up. They must outline their progress towards completing the compliance actions and review any evidence of ongoing non-compliance. This can occur any time after we

Compliance action	Details
	require a compliance action but is usually within 6 to 12 months depending on the seriousness of the issues. We monitor more serious issues of non-compliance through a follow-up or on-site audit, or other compliance actions.
Follow-up audit	If an audit identifies serious areas of non-compliance, we do a follow-up audit to confirm providers have addressed the issues. This usually occurs 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 we identify a serious complaint or breach, we may do an on-site audit to fully investigate the issue. This will involve Commonwealth officers attending the premises to investigate files, policies and procedures.
Debt recovery	A provider must reimburse an invalid claim (see clause 13 of the contract). If they do not do this, the Hearing Services Administration Act 1997 allows the Commonwealth to recover the debt.
Notice of remedial action	If providers do not resolve serious issues 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 we identify serious systemic non-compliance, we may require providers to seek pre-approval before submitting claims, or we may put claims on hold. This will involve a review of the evidence supporting the claim or requiring the provider to complete actions before we approve payment.
Refer practitioner to a PPB	To investigate and monitor compliance with the instrument, the Minister for Health and Aged Care, or their delegate, can refer, or obtain information about, a practitioner to or from a practitioner professional body (section 40).
Direction to cease using a practitioner	Clause 8.2 of the contract may require a provider to cease using a specified practitioner to deliver program.
Conditions applied to the contract	We may apply conditions to a provider's contract where there is serious non-compliance. This may limit the services they can provide to program clients. We may place specific restrictions or additional requirements on providers either permanently or for a fixed period.
Suspension	As outlined by the clause 25 of the contract, the Commonwealth may issue a suspension notice. If we issue a suspension notice, 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 or the provider entirely.
Termination	Where the provider fails to satisfy any of its obligations under the contract, the Commonwealth may terminate the contract (see clause 28). The provider will no longer be able to deliver services through the program and may have their accreditation revoked. We may terminate the contract if, for example:

Compliance action	Details
	practices reveal that the program or its clients are at significant risk we have given the provider the opportunity to address non-compliance, but they have been unable or unwilling to do so we identified fraudulent behaviour following a period of suspension of services where it is unlikely the provide can address the issues. Before suspending or terminating a contract, we will give providers an opportunity to explain why we should not suspend or terminate their contract. We give providers 28 days to respond but may shorten this time period if the risk to clients or the program warrants it. This is within the discretion of the program. We will review the response and make a decision regarding whether to proceed with the proposed action.
Criminal action	Where there are serious breaches of a criminal nature, including fraudulent claims, we notify relevant authorities who may initiate legal action.

Chapter 9 – Monitoring, reviewing and improving this framework

We continuously review and improve the effectiveness of the framework.

Provider feedback

Compliments, 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 (we provide a link to the online survey 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 contact centre (9.00am - 5.00pm EST, Monday - Friday on 1800 500 726 or TTY 1800 500 496)
- writing to the Hearing Policy and Compliance Section, Hearing Services Program, Department of Health and Aged Care, 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.

We publish regular provider notices about issues identified during audit and compliance monitoring.

Program information, notices and updates are available on the website.

Attachment A – Sample compliance action plan

Action required	Due date
Update templates a. Maintenance agreement template – provide an updated maintenance agreement template which includes the program requirements. b. Quotation template – provide an updated device quote template in line with program requirements.	10 business days from receipt of this letter
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 you check client eligibility before delivering services. d. Implementation – outline how you will make your personnel aware of the policy and procedure updates.	20 business days from receipt of this letter
Reimburse the Commonwealth – we identified invalid or unsubstantiated claims totalling $xx.xx for which you must reimburse the Commonwealth. We have outlined details of the reimbursements required in the list provided. Instructions on how to initiate these reimbursements through the portal are available in the Processing a recovery guide. You must process the reimbursements in the portal within 10 business days from the date of this letter. Once processed, we will deduct the amounts from your next payment from the Commonwealth. Please notify me when you have processed the reimbursements.	10 business days from receipt of letter
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 keep evidence of this refund on the client file and provide the evidence when completed.	28 days from the receipt of this letter

We monitor compliance by:

Actions to be taken by the department	Due Date
Document review – reviewing the updated templates, policies and procedures.	Following receipt of documents.
Confirm repayment to the client – contacting the client to confirm the repayment was made to them as required.	As required
Confirm repayments to the program – checking that providers have reimbursed claims to the Commonwealth.	Within 10 business days of repayment confirmation
Claim review – reviewing all claims submitted for 3 months from the date of the compliance action plan, to ensure providers have implemented the policies and procedures.	Over the next 3 months.
Provider check-up – contact the provider in 3 months to discuss progress on achieving the compliance actions.	
Follow-up audit – conducting a follow-up audit of the site in 12 months.	

Glossary

Term	Definition
Accreditation	The process to determine an entity's ability to meet the requirements set out in the Hearing Services Program (Voucher) Instrument 2019.
Accreditation scheme	Part 4 of Hearing Services Program (Voucher) Instrument 2019 outlines the Accreditation Scheme. The scheme sets out the requirements for applicants and empowers the Minister for Health and Aged Care 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, documented process for obtaining records, statements of fact or other relevant information and assessing them objectively to determine the extent to which specified requirements are fulfilled." AS/NZS ISO 190112014, Guidelines for auditing management systems.
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	The service provider contract establishes the requirements under which contracted service providers must deliver services through the Hearing Services Program.
e-claim	An online claim for services lodged by a contracted services provider, via practice management software, to the program's online portal.
ECR	Eligibility criteria for refitting, which lists criteria to support the refitting of hearing devices through the program, and the required supporting documentation. Contained in the Schedule of Services Items and Fees.
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	Previously known as 'free-to-client', costs for fully subsidised devices are fully covered by the program.
HSO	Hearing Services Online. The online portal for clients and providers, where providers can access a secure area to manage their clients, sites and practitioners.

Term	Definition
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 or equal to 23.3dB (3FAHL >= 23.3dB), 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 23.3dB). Contained in the Schedule of Services Items and Fees.
MP	Medical practitioner e.g. general practitioner, Ear, Nose & Throat (ENT) specialist etc.
Partially subsidised device	Previously known as 'top-ups', costs for partially subsidised devices are partially covered by the program.
The program	The Hearing Services Program, as established by the Hearing Services Administration Act 1997.
Program requirements (mandated requirements)	The requirements of the program as set out in Hearing Services Administration Act 1997 Hearing Services Program (Voucher) Instrument 2019 Australian Hearing Services (Declared Hearing Services) Determination 2019 Service Provider Contract Schedule of Service Items and Fees Minimum Hearing Loss Threshold (MHLT) Guidelines Eligibility Criteria for Refitting (ECR)
Provider	A hearing services provider who we contract to deliver services through the Hearing Services Program.
Provider notices	Electronic notices giving program updates and clarifications.
Risk control	Measures to modify risk, including process, policy, device, practice or other actions. (AS/NZS ISO 31000:2018 Risk Management – Principles and guidelines, p1)
SAT	Self-assessment tool. A mandatory, annual, compliance self-assessment questionnaire all providers must complete.
Schedule of Fees	The Schedule of Fees (contained within the Schedule of Service Items and Fees) lists the fee paid by the Commonwealth to providers for each service item and hearing device category.
Schedule of Service Items and Fees	The Schedule of Service Items and Fees provides information, service requirements, claiming conditions and evidence requirements for claiming for services available to program clients, and the fees paid through the program.
Standards	Refers to the Minimum Hearing Loss Threshold (MHLT) Guidelines and the Eligibility Criteria for Refitting (ECR). The Commonwealth may issue new program standards.
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.

Term	Definition
Voucher	An electronic authorisation that enables eligible clients to receive services through the program.

health.gov.au/hearing-services

All information in this publication is correct as at 27 February 2024