Waiver Provider Standards Manual

State of Hawaii
Department of Health
Developmental Disabilities Division

3.7 Fiscal Accountability

Fiscal Audit is a CMS Requirement

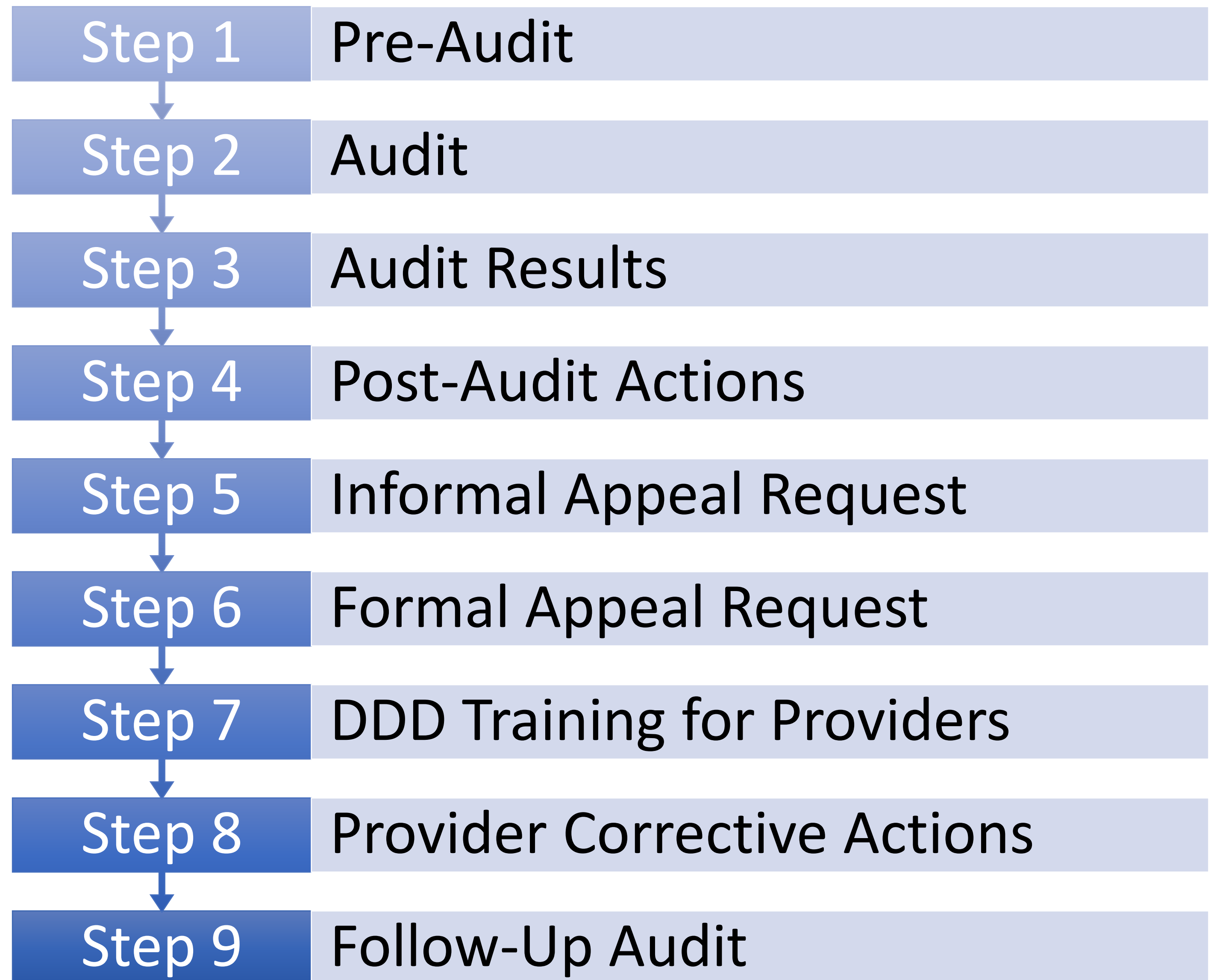
THE CENTERS FOR MEDICARE AND MEDICAID SERVICES REQUIRES POST-PAYMENT REVIEWS TO ENSURE FINANCIAL ACCOUNTABILITY.

FINANCIAL ACCOUNTABILITY IS ONE OF THE SIX (6) MANDATORY ASSURANCES THAT THE STATE MUST DEMONSTRATE COMPLIANCE.

AN ANNUAL FISCAL AUDIT IS CONDUCTED TO ENSURE COMPLIANCE.

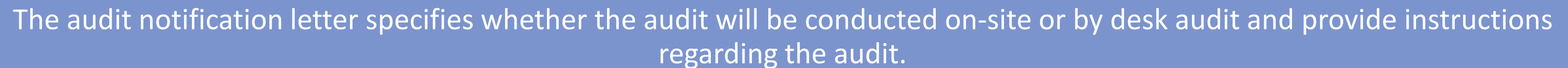
STATES MUST CONDUCT ANNUAL FISCAL AUDIT AND REGULAR REPORTING TO CMS TO ENSURE THAT THE AUTHORIZED SERVICES ARE DELIVERED, CODED, AND PAID FOR IN ACCORDANCE WITH THE REIMBURSEMENT METHODOLOGY SPECIFIED IN APPROVED WAIVER.

Fiscal Audit Process



Step 1: Pre-Audit

Pre-Audit



The Provider will send the name and telephone number of a contact person for the audit, as well as a secured email address to the Auditor prior to the audit date.

Fiscal Audit Checklist Sample

Department of Health
Developmental Disabilities Division
Fiscal Audit Checklist

Provider Name: ____________________ Participant Name: ____________________

Fiscal Audit Date: ____________________ Fiscal Audit Period: ____________________

Waiver Service: ____________________ Direct Support Worker: ____________________

Please utilize the following checklist to ensure sufficient documentation is presented and ready for inspection by the DDD Fiscal Section. (Please refer to the Waiver Standards Manual - 3.7 Fiscal Accountability for documentation requirements.) Copies of all supporting documents must be submitted to the DDD Fiscal Section by 3:00 pm on the day of the fiscal audit.

1.0	**Individualized Service Plan (ISP) (ISP must cover the fiscal audit period. More than one ISP may be needed.)**	
1.1	❑	Participant Name
1.2	❑	Authorized Service(s), Level, Ratio, and Units
1.3	❑	Authorized Start and End Date of Waiver Service(s)
2.0	**Participant Attendance Log (Service documentation must contain seven (7) data elements.)**	
2.1	❑	Participant Name
2.2	❑	Date(s) of Service Provided
2.3	❑	Time of Service Provided (Start time and End time)
2.4	❑	Type and Level of Service
2.5	❑	Staff to Participant Ratio
2.6	❑	Name and Signature of Direct Support Worker
2.7	❑	Name and Signature of Service Supervisor

Step 2: Audit

Audit

- Fiscal audits will be done annually. Additional audits may be performed during the year if needed.
- The Participant list will be provided to the Provider's contact person on the morning of the audit date.
- Fiscal audit period will cover three (3) consecutive months, starting six (6) months prior to the month the audit is conducted. For example, see table:

Audit Date	Fiscal Audit Period
8/1/2022	2/1/2022 – 4/30/2022
1/15/2023	7/1/2022 – 9/30/2022

Audit (continued)

The Provider will have until 3:00 P.M. on the audit date to produce copies of the required documents listed in 3.7-A.

All documents submitted after 3:00 P.M. on the audit date is considered late and will not be considered towards the initial audit.

Documents submitted by mail for desk audit must be postmarked no later than the audit date. Auditor will contact to confirm the number of pages submitted for fax and email submissions.

Please do not send your original documents.

Service Documentation Requirements

Providers must have a system in place to ensure all service documentation meets the service documentation requirements, and substantiate that the authorized service are delivered, coded, and paid for in accordance with the reimbursement methodology specified in the approved Waiver.

The Provider will submit 2 sets of documents for each participant on the participant list:

1. Individualized Service Plan (ISP)
   - ✓ Approved ISP must cover the entire fiscal audit period. Multiple ISPs may be needed to cover the entire fiscal audit period.
2. Participant Attendance Log
   - ✓ Service documentation must contain seven (7) data elements to verify that authorized services were delivered, coded, and paid for in accordance with the reimbursement methodology specified in the approved Waiver.
   - ✓ Hard copy or electronic document submitted must contain the following seven (7) data elements:
     1) Participant name
     2) Date(s) of service provided
     3) Time of service provided (Start time and End time)
     4) Type and level of service (ex: ADH Tier 1)
     5) Staff to participant ratio
     6) Name and signature of direct support worker delivering the service
     7) Name and signature of service supervisor verifying the service and information above

Note: A participant attendance log outside the audit period may be necessary to complete the audit. If you file claims weekly for example from April 25 to May 1, Auditor may request the claims submitted for May 1.

Step 3: Audit Results

Audit Results

- The Audit Rating letter will indicate the Provider's compliance score and rating based on their audit results.
- The table shows the 3 possible rating outcomes:

Score	Rating
100%	Fully Compliant
86% to less than 100%	Substantially Compliant
Below 86%	Not Compliant

Step 4: Post Audit Actions

Post-Audit Actions

- The audit report and letter will be sent indicating the Provider's rating within thirty (30) calendar days of the audit date. If funds are to be recouped, a recoupment letter will be sent as well.
- The table shows the provider's action requirements, if any, based on the rating the provider receives after the audit.

Rating	Type of Report/Letter	Provider Action Requirements
Fully Compliant (100%)	• Audit Report • Fully Compliant Letter	• None
Substantially Compliant (86% to less than 100%)	• Audit Report • Substantially Compliant Letter • Recoupment Letter	• Appeal request options available to submit additional support documents.
Not Compliant (Below 86%)	• Audit Report • Not-compliant Letter • Recoupment Letter	• Review Waiver Provider Fiscal Accountability Training video posted on the DOH/DDD website and submit Corrective Action Plan (CAP). • Appeal request options available to submit additional support documents.

Step 5: Informal Appeal Request

Informal Appeal Request

- A Provider with an audit result below 100% will have an option to submit an applicable ISP(s) or participant attendance log(s) that was not provided on the audit date by requesting an informal appeal.
- The request for an informal appeal must be submitted in writing with supporting documents within fourteen (14) calendar days from the date indicated on the initial audit report by following the instructions indicated on the initial audit report.
- An informal appeal request received after fourteen (14) calendar days from the date on the initial audit report will not be accepted.

Informal Appeal Request (continued)

- If a written informal appeal request along with support documents is not submitted within fourteen (14) calendar days from the date indicated on the initial audit report, a recoupment letter will be initiated.
- If the support documents are determined by the Auditor to meet the requirements, the Provider will receive a written response to the informal appeal request, an adjusted audit report, and an adjusted recoupment letter.
    - ✓ Note: Initial compliance rating and audit score will remain unchanged.
- If the supporting documents are determined by the Auditor as not meeting the requirements, the Provider will receive a written review of informal appeal letter and a recoupment letter.

➢ Remember, it is important to ensure all records are readily available, current, legible, and organized.

Step 6: Formal Appeal Request

Formal Appeal Request

- Formal appeals are conducted by the Department of Human Services (DHS).
- The Provider will submit a request in writing within thirty (30) calendar days from the date of the latest Recoupment Letter audit report to:

  Administrative Appeals Office

  Department of Human Services

  P.O. Box 339

  Honolulu, HI 96809
- The Provider must follow the formal appeal request instructions provided by DHS.
- Based on the formal appeal decision, the Provider may receive a final determination letter from DHS.

Step 7: DDD Training for Providers

DDD Training for Providers

Providers with a Not Compliant rating (below 86%) must review this training video prior to creating a CAP.

Training video is available to all Providers on our website.

Step 8: Provider Corrective Actions

Provider Corrective Actions

To assist the Provider to meet necessary document requirements indicated in 3.7-A of the Waiver Standards Manual.

- Providers with a Not Compliant audit rating (below 86%) must submit a Corrective Action Plan (CAP) within fourteen (14) calendar days from the date indicated on the latest recoupment letter.
- Providers that do not submit a Corrective Action Plan (CAP) within fourteen (14) calendar days from the date indicated on the recoupment letter may be subject to additional actions.

Step 9: Follow-up Audit

Follow-up Audit

- Conducted for all Providers with a Not Compliant rating (below 86%) to ensure CAP is implemented, and issues identified in the CAP are corrected.
- Conducted at least six (6) months after the initial audit date
- The same pre-audit and audit procedures apply; however, the follow-up audit period will cover one (1) month, starting four (4) months prior to the month the audit is conducted. See table for an example.
- If a Provider receives a Not Compliant result for 2 consecutive years, the Provider will be issued a letter of termination from DHS-MQD.

FOLLOW-UP AUDIT DATE	FISCAL AUDIT PERIOD
8/1/2022	4/1/2022 - 4/30/2022
1/15/2023	9/1/2022 - 9/30/2022

Training Wrap Up

- Ensure that services are delivered, coded and paid for in accordance with the reimbursement methodology.
- Required documentation include ISP(s) and participant attendance log(s).
- Participant attendance log must contain the seven (7) data elements.
- All records must be readily available, current, legible, and organized.
- Please do not send your original documents.
- Documents submitted after 3:00 p.m. will not be considered towards the fiscal audit.
- Adjusting claims to match our audit findings is not allowed.

For Further Information or Questions

Please email: DOH.DDDFiscalAudit@doh.Hawaii.gov

Thank you