

DEPARTMENT OF HEALTH

PROPOSAL FOR A NEW RESIDENTIAL AGED CARE FUNDING MODEL: CONSULTATION PAPER

Submission

7 June 2019



ABOUT ACSA

Aged & Community Services Australia (ACSA) is the leading aged care peak body supporting church, charitable and community-based, not-for-profit organisations. Not-for-profit organisations provide care and accommodation services to about one million older Australians.¹

ACSA represents, leads and supports its members to achieve excellence in providing quality affordable housing and community and residential care services for older Australians.

Aged care providers make a significant \$17.6 billion economic contribution to Australia, representing 1.1% of GDP by producing outputs, employing people and through buying goods and services. The direct economic component is akin to the contribution made by the residential building construction and sheep, grains, beef and dairy cattle industries.²

ACSA members are important to the community and the people they serve, and are passionate about the quality and value of the services they provide, irrespective of their size, service mix or location.

ACSA CONTACT

Darren Mathewson

Executive Director, Strategy and Policy
TAS/VIC/NSW/ACT
Aged & Community Services Australia
19 Brisbane Street
Hobart TAS 7000
0447 376 519
Darren.Mathewson@acsa.asn.au

Derek Dittrich

State Manager SA&NT
Policy and Member Advice Manager
Aged & Community Services Australia
Building 3, Level 1
32-56 Sir Donald Bradman Drive
Mile End SA 5031
0417 812 620
Derek.Dittrich@acsa.asn.au

www.acsa.asn.au

¹ Australian Government, Department of Health, Review of National Aged Care Quality Regulatory Processes, Carnell & Paterson, October 2017.

² Australian Government, Department of Health, Aged Care Roadmap, D Tune Chair, Aged Care Sector Committee, March 2016.

PROPOSAL FOR A NEW RESIDENTIAL AGED CARE FUNDING MODEL: CONSULTATION PAPER

INTRODUCTION

In 2017 Government commissioned the University of Wollongong to develop a new funding approach for the residential aged care sector.

Early in 2019, Professor Kathy Eager of the Australian Health Services Research Institute, University of Wollongong tabled the findings of their study (the Study) to Government and the Department of Health. Her findings are contained within 7 Reports³ (the Reports) covering:

1. The Australian National Aged Care Classification (AN-ACC)
2. The AN-ACC assessment model
3. Structural and individual costs of residential aged care services in Australia
4. Modelling the impact of the AN-ACC in Australia
5. AN-ACC: A funding model for the residential aged care sector
6. AN-ACC: A national classification and funding model for residential aged care
7. AN-ACC: Technical appendices

The Reports, including findings and recommendations were made available to the sector and the public in March 2019, as was a consultation paper⁴.

In February of this year, as part of a \$662 million aged care package, \$4.6 million was allocated to conduct a trial of an alternate funding tool (the Trial), specifically to trial the AN-ACC funding model for residential aged care. This measure was reaffirmed in the 2019-20 Budget measures.

This submission is responding to the consultation paper described above.

³ <https://agedcare.health.gov.au/reform/resource-utilisation-and-classification-study>

⁴ Proposal for a new residential aged care funding model, Consultation Paper March 2019, Australian Government, Department of Health

COMMENTARY

ACSA supports a review of funding models where there is commitment to adequately fund providers to deliver quality, innovative services to older Australians.

Any new funding model developed must take into consideration the requirements contained within the Aged Care Quality Standards and support the attainment of these Standards.

Wellness and reablement must also be designed into any new funding model, services must be funded to maximise independence and function, not to do so, is to do a disservice to older Australians.

The aim of any funding tool is to ensure that older people are able to access quality and affordable services and support when and where they need them. The current funding does not support this outcome and the sector is showing the financial strains of trying to ensure quality with inadequate funding.

We discuss this in detail in our submission to the Royal Commission into Aged Care Quality and Safety, [see here](#).

The sector is experiencing the effect of inadequate base level funding compounded by inadequate indexation⁵. Put simply annual growth in expenses is outstripping the indexation factor applied and therefore each year the sector is falling further behind⁶.

The Australian National Aged Care Classification (AN-ACC) model is a cost allocation instrument. In Report 1⁷, the author describes the 'primary aim' as being the development of a casemix classification approach for residential aged care.

ACSA understands that the riding instructions on this work were that the model is to work within the existing funding envelope. This stands to render the new funding model and process ineffective in enabling quality service delivery.

Whilst the AN-ACC funding model addresses the allocation of funding across thirteen different categories of resident, it DOES NOT address pricing, it is government that will determine price i.e. the value of the National Weighted Activity Unit (NWAU) of 1.0. No funding system will be effective if there is not enough funding in the system.

This quantum of funds and setting of price are the most crucial unknown at this point, as these will determine the adequacy (or not) of funding.

Inadequate indexation (including periodic indexation pauses) is a chronic and serious problem for the sector⁸. The AN-ACC model proposes a mechanism for regular review of costs, in theory

⁵ Commonwealth subsidies and supplements are generally indexed either biannually (accommodation related) or annually (care related). Explanation of how indexation is determined can be found at: Sixth Report on the Funding and Financing of the Aged Care Sector, Aged Care Financing Authority, Australian Government, July 2018

⁶ Aged Care Financial Performance Survey, Sector Report (Six months ended December 2018), StewartBrown, 2019, p17

⁷ The Australian National Aged Care Classification (AN-ACC), University of Wollongong, 2019, p1

⁸ Submission to the Royal Commission into Aged Care Quality and Safety, Aged & Community Services Australia, May 2019

allowing for subsequent adjustment to the value of the NWAU price. This is said to mirror the approach taken in acute health.

Any 'price' set must reflect real costs and growth in costs across all care and service components.

We believe the introduction of a casemix funding model provides government with the opportunity to introduce a budget approach where price setting matches actual (rising) costs.

Transparency of process, methodologies, findings and recommendations of the Trial will be paramount. These should be shared with the sector, including any interim findings, in a timely manner to allow analysis and discussion. There should be an ongoing discussion with the sector during the trial and ACSA recommends establishing an advisory reference group to support this.

Any new funding model will need to fund all services appropriately rather than artificially moving funds from one service type to another. Vital services, including dementia care, palliative care, services for homelessness, ATSI and other special needs groups must do well under any new funding approach.

Whilst ACSA supports in principle positive elements of the AN-ACC funding model we are unable to provide any definitive comment until:

- Quantum and pricing questions are addressed;
- Rigorous testing occurs; and
- The findings of the Trial are released to the sector for analysis and consideration.

POTENTIAL POSITIVES OF THE AN-ACC FUNDING MODEL

- **Decoupling assessment for care from assessment for funding** – we support the decoupling of assessments for funding (notwithstanding our comments regarding the development of an external assessment workforce - see *External assessments and the assessment workforce* section below) away from assessments for care. The ability of providers to concentrate their assessment processes on determining the care and supports that an individual resident requires free of any consideration of funding will, we believe, be well received. In effect this will free up senior clinicians from having to produce extensive 'supporting documentation' (of ACFI claims) to being able to apply their clinical training to the identification, planning and provision of quality clinical care.

Recommendation 9 of the Study proposes 'that a best practice needs identification and care planning assessment tool be developed for use by residential aged care facilities'⁹. The development of a care-assessment package, co-designed with the sector, that could be made available to providers may add value. However, many providers will have in place their own care assessment process and for this reason adoption of such a package should NOT be mandated.

ACSA Recommends:

A clinical assessment package be co-designed with the sector, and that the adoption of such a package be voluntary.

Dismantling the validation system – as a consequence of any move to an external assessment process, including for reassessments, the ceasing of 'validations' would naturally occur. We believe this will be a positive for the sector.

ACSA Recommends:

The dismantling of the current validation system accompanies introduction of an external assessment for funding process. Commonwealth monies saved from the dismantling of the validation system should be reinvested back into the sector funding additional service provision.

- **Funding retained when function is improved** – If an outcome of a move to AN-ACC is that funding is retained when function is improved then this is a positive outcome, which would be broadly supported. We note that this is not wholly different to ACFI in its original design. This changed through implementation and validation process and this needs to be guarded against in any design and monitoring of the new system. Both in developing the ACFI and the AN-ACC the importance of maintaining funding when function improves has been highlighted. It is now time for this to be accepted as a fundamental funding design principle and enacted as such.

ACSA Recommends:

Funding is retained when resident function is improved as this allows the service to continue providing the needed supports to ensure it is maintained and does not slip back.

⁹ AN-ACC A national classification and funding model for residential aged care: synthesis and consolidated recommendations, Report 6, University of Wollongong, 2019, p11

- **Leveling of playing field for RRR providers** – The AN-ACC appears to address one of the fundamental flaws of ACFI disadvantaging providers in rural, regional and remote (RRR) areas. For these providers in that it removes the dependence on allied health practitioners for higher level funding claims.

Additionally, the per diem component (the base care tariff) looks to compensate providers for the additional cost burden of providing services in rural and remote locations (not withstanding our comments in the section *Funding and geographical location* below).

Separately, we also support the proposition in Recommendation 13 of the Study¹⁰ that for providers in remote locations their base tariff payment is based on approved bed numbers and not occupancy, noting the Study found that occupancy is a significant challenge for remote providers. This view about remoteness would appear consistent with the views of the Aged Care Financing Authority which links location to occupancy, their comment being ‘the greatest variation in occupancy continues to be by remoteness location. A clear trend is that more populous areas generally have higher occupancy rates than less populous areas¹¹’.

We do believe though, that remoteness and bed occupancy also need to be further analysed for providers in the Modified Monash Model (MMM) MMM3,4or5 regions as anecdotally these providers express experiencing similar occupancy pressures to those in MMM6 or MMM7.

ACSA Recommends:

The upcoming Trial analyse the occupancy challenges for providers in MMM3, 4 and 5 regions to determine whether they experience the same occupancy challenges as those providers in MMM6 & 7 regions.

- **Potential to never have to review a resident under AN-ACC** – we support the proposal ‘there be no requirement for reassessment in the AN-ACC funding model¹²’, unless a change in care needs indicates reassessment is required.

ACSA Recommends:

The adoption of Recommendation 8. Specifically, ‘there be no requirement for reassessment in the AN-ACC funding model¹³’.

- **Services positively served under AN-ACC model** – AN-ACC is touted as providing positive outcomes for (but not limited to):
 - Homeless services;
 - ATSI services;
 - Remote; and
 - Small services.

¹⁰ Ibid, p13

¹¹ Sixth report on the Funding and Financing of the Aged Care Sector (short form report), Australian Government Aged Care Financing Authority, July 2018, p 17

¹² AN-ACC A national classification and funding model for residential aged care: synthesis and consolidated recommendations, Report 6, University of Wollongong, 2019, p10

¹³ Ibid p10

This is a good and important outcome given the additional challenges and cost pressures these services face in delivering quality care and the role they play within the community.

ACSA Recommends:

That analysis of specialist service providers is undertaken in the upcoming Trial and the findings are made available to the sector for consideration. Specialist services must be treated positively under the AN-ACC funding model.

- **One-off adjustment payment** - A one-off adjustment payment is proposed in the AN-ACC model for all new residents. ACSA supports this recognition of the additional time and support provided to new residents as they settle into their new home. We understand the suggested weighting is to the equivalent of approximately 5.3 'care days' funding¹⁴ (i.e. 5.3 NWAUs).

The study prescribes this as a 'one-off' payment for any individual when they first enter residential aged care. Residents may choose to move from one facility to another and when this occurs they need support to settle in. Limiting this one-off payment to first entry may negatively impact on a resident's ability to choose to move.

Additionally, Recommendation 19 of the Study¹⁵ prescribes a range of conditions related to the adjustment payment, including that payments are to 'be used for the intended purpose, not added to the bottom line and not contracted to third party providers¹⁶'.

ACSA Recommends:

1/ Providers always receive the adjustment payment when they accept a new resident, regardless of whether the resident has been in another aged care facility; and

2/ Adjustment payments are 'untied' payments to providers.

¹⁴ AN-ACC A national classification and funding model for residential aged care: synthesis and consolidated recommendations, Report 6, University of Wollongong, 2019, p15

¹⁵ Ibid, p15

¹⁶ Ibid, p15

GENERAL COMMENTARY

Funding to Innovate

A perceived risk with AN-ACC is that it was developed by analysing current activity patterns of direct care staff and is therefore at risk of funding to conventional service delivery approaches.

Many providers are innovating in service delivery, including approaches that focus on wellness, reablement, functional independence, innovative dementia programs and dementia specific built forms, non-nurse centric, house-models etcetera.

The Aged Care Quality Standards are founded in principles of continuous improvement and service innovation.

In our recent submission to the Royal Commission into Aged Care Quality and Safety we describe a range of innovative approaches to dementia care, [see here](#).

Separately we also described innovative models in aged care in our Witness Statement to the original hearings of the Royal Commission into Aged Care Quality and Safety, [see here](#).

Innovative models of service delivery need to be well supported by whatever new funding model is adopted.

ACSA Recommends:

That the upcoming Trial include providers who have innovative models of service delivery in situ, to determine the impact that a transition from ACFI to AN-ACC would have on their funding.

Announced Trial of AN-ACC by government

In February of this year, as part of a \$662 million aged care package, \$4.6 million was allocated to conduct a trial of an alternate funding tool (the Trial), specifically to trial the AN-ACC funding model for residential aged care. This measure was reaffirmed in the 2019-20 Budget measures.

ACSA will look to work closely with members who participate in:

- The RUCS Trial; and
- The Regional Structural Costs Micro-study (MMM3,4,5)

to better understand the impact of AN-ACC on providers.

Development of the 13 AN-ACC Classes

ACSA is confident significant work has been attended within the Study to develop the 13 classes.

The upcoming trial will be important to independently test the rigor of the 13 classes and whether they contain appropriate groupings of 'like for like' residents.

Additionally, the upcoming Trial should look to identify if there are other characteristics of care inputs that have not been captured to date that should be considered for inclusion in the 13 branch classes, this includes how well the funding tool captures care requirements of people with dementia and who are also mobile.

ACSA Recommends:

The upcoming Trial analyse the appropriateness of the stated characteristics of the 13 classes, including determining if there are additional defining characteristics that should be incorporated within particular classes.

Limitations of RUCS

The provision of respite services was not addressed in the study, nor was the application of a range of supplements, for example oxygen supplement, enteral feeding supplement and veteran's supplement. These services will need to continue to be provided and must be supported in any new funding model.

ACSA recommends this is addressed as part of the upcoming Trial so that the ongoing provision (or not) of these supplements can be properly understood and considered by the sector prior to any change in their arrangements.

ACSA Recommends:

The upcoming Trial analyse additional components of funding that have been acknowledged as not having been addressed in the RUCS study, i.e. residential respite and a range of supplements to ensure these services continue to be supported in a new funding model

Homeless Supplement

The Study proposes that the Homeless supplement be 'discontinued' under the AN-ACC model.

ACSA Recommends:

The upcoming Trial actively analyse Recommendation 20 which proposes to remove the homeless supplement. The supplement should not be removed until it is demonstrated that these services are 'better off' under the AN-ACC model than they are currently.

Default Payment Level

The proposed assessment process for AN-ACC provides an ability for assessments for funding to occur pre or post admission. For those residents who are not assessed for a funding class pre-admission, it is proposed there be a 4-week window within which to assess them post admission. The Study proposes (Recommendation 17¹⁷) that for these residents they be funded at Class 2 (the lowest NWAU weighted class) until the assessment for funding occurs. This proposed approach results in providers delivering a higher level of care than they are funded to deliver and in addition this creates a negative impact on cash flow.

Given the nature of residents now entering care the proposed level of funding is too low. ACSA is recommending that a higher level of funding, more aligned to the care needed and provided, is set.

¹⁷ AN-ACC A national classification and funding model for residential aged care: synthesis and consolidated recommendations, Report 6, University of Wollongong, 2019, p14

Our view is that only a low percentage of new residents will ultimately be in AN-ACC class 2, with the majority of residents ultimately being assigned a higher weighted funding class meaning providers need to be ‘back paid’.

ACSA Recommends:

That interim funding be set at a more realistic AN-ACC class, for example AN-ACC class 6 or 7.

Review of Price

We support the principle that a new funding model incorporate a regular process to review price.

Price must be reviewed in a manner that is open and transparent to the sector AND that incorporates consideration of ALL costs associated with care and service delivery.

Recommendation 24 proposes ‘that the Commonwealth undertake an annual residential aged care costing study and, informed by that, determine the dollar value of an NWAU each financial year¹⁸’.

ACSA Recommends:

1/ That government work with the sector to determine what criteria is to be considered in a regular and ongoing process to review price; and

2/ The upcoming Trial determines whether ALL relevant costs are captured by the proposed funding model and that the Trial’s findings in this area are made available to the sector for analysis and consideration.

Transitioning from ACFI to AN-ACC

Understanding, at an individual provider level the impact of transitioning from their current funding profile (under ACFI) to their potential funding profile (under AN-ACC) will be very important in the upcoming Trial.

Some early member modelling is indicating potentially significant losses under AN-ACC. Whilst there is a stop-loss policy recommended in the Study, this policy is for a time-limited period, effectively providing only a period of reprieve, with the full impact of the change to be felt after the transitioning period ceases. In a sector under significant financial pressure this is likely to result in service closure and reduced accessibility to residential care for the community.

Case Study: Early modelling by an ACSA member of the potential impact of transitioning from ACFI to AN-ACC

While the NWAU has not been set at this stage, the example of \$172 is used as the NWAU for our calculations. (this is based on the average National ACFI per resident per day (prpd)). All our homes are considered to be metropolitan and so come under Tariff six¹⁹. Calculations were made using current ACFI score for each resident – reviewing mobility,

¹⁸ AN-ACC A national classification and funding model for residential aged care: synthesis and consolidated recommendations, Report 6, University of Wollongong, 2019, p20

¹⁹ AN-ACC A funding model for the residential aged care sector, Report 5, University of Wollongong, 2019, p7

cognition and other health factors that would be considered Compounding Factors according to the AN-ACC.

250 ACFIs were reviewed - 17% of our cohort. These were chosen at random from 16 out of the 17 sites. One Memory Support Unit (MSU) was also used as an example and a total of 57 ACFIs for residents requiring memory support unit accommodation were included in the 250. Residents with dementia/cognition problems reside throughout our homes regardless of memory support units.

Results: Overall, 83% of ACFI funding would decrease and 17% would see an increase.

Increases: For the increases, the largest occurred where residents were non-weight bearing- these varied from \$23 per day to \$76 per day. As we have a restorative approach the organisation only has approximately 15 % of residents who are non-weight bearing (NWB), whereas the RUCS study showed that 30% of their cohort were NWB.

Of the 250 residents in our calculations, only 4 % were considered immobile. Increases varied but were as small as \$1per day. The highest was \$76 per day, which was a resident ACFI of MLH (\$158) to Class 10 (\$234). 37 % of the increases not including the NWB residents were \$10 per day or less.

Losses: Due to the ACFI system having 64 possible scores/dollar combinations, 83% of ACFI scores that would see a loss on income, were quite diverse.

- 19 % were HHH ACFI reduced to Class 8 with a loss of \$40.77 per day
- 12% were HHH ACFI reduced to Class 7 with a loss of \$48.77 per day
- 1.6 % were HHH reduced to Class 6 with a loss of \$72.77
- 4.5 % were HHH ACFI reduced to Class 5 with a loss of \$69.77 per day

Further calculations of losses excluding the HHH above are:

- Class 4 decreases: 7 % and loss ranging from \$2 to \$96.77
- Class 5 decreases: 8.5 % and loss ranging from \$10 to \$50
- Class 6 decreases: 9 % and loss ranging from \$1 to \$57
- Class 7 decreases: 7 % and loss ranging from \$4 to \$48
- Class 8 decreases: 9 % and loss ranging from \$9 to \$22

The Memory Support Unit was included in the above figures, calculations were also made looking at those 57 residents in MSU in isolation.

Results were as follows:

When reviewed:

- 60 % of the residents in the MSU were reclassified as Class 8 at \$177 per day
- 11% of these had increased funding and 89% lost funding.
- 37 % of the residents in the MSU were reclassified as Class 7 at \$169 per day
- The remaining 3 % were reclassified in Class 5 at \$148
- 65 % of residents were classified as HHH in ACFI funding - \$217.77

Class 7 –assisted mobility, medium cognition with CF- so some behaviours will be considered and be included in funding however this rating will not cover the behaviour strategies and management that needs to occur for these residents who are able to walk with assistance and still require full assistance due to moderate cognition.

Class 8 –assisted mobility, low cognition – regardless of any CF- this class does not cover the cost of assisting these residents to walk, stay mobile and manage behaviours and /or health issues.

See footnote 22 below²⁰

The upcoming Trial must be utilised to identify the funding impacts on those residents classified as having high needs and the financial impact on that care and provider viability as a result. In addition, the model seems to work against models which have had a focus on reablement and independence which is counter intuitive to the results we are trying to seek.

Report 4²¹ of the study tells us that:

- Services that specialise in homeless people or indigenous people do better under AN-ACC;
- Residents in care the longest are more likely to fall into the more complex and costlier AN-ACC classes;
- Residents who are Aboriginal and/or Torres Strait Islander attract an average payment under AN-ACC that is 20 per cent higher than the sample average (as compared with 8 per cent lower than the sample average they attract under ACFI);
- Clinical complexity is measured differently under AN-ACC with a lower proportion under AN-ACC being in the highest weighted AN-ACC classes;
- In remote regions funding under AN-ACC is showing as 0.8 per cent of the total budget verses 0.5 per cent currently; and

²⁰ While every effort has been made to align the ACFI scores with the proposed Class system in the AN-ACC, the overall rating with the AN-ACC will be decided by an external auditor spending one hour with the resident. Our figures have considered 'Standby assist' with mobility currently being scored in ACFI as 'assisted mobility'. If the auditors assess this 'standby assist' as being 'independent', our figures and calculations will be much worse as these residents would then attract a much lower rate of funding.

²¹ Modelling the impact of AN-ACC in Australia, Report 4, University of Wollongong, 2019, p1

- That population projections show that small and medium facilities gain slightly at the expense of large facilities under the AN-ACC model.

We note the following comment from Report 4 that indicates ‘Payments under AN-ACC are highest for the youngest aged group (age 65 years or less), which is the reverse of funding under ACFI²²’. This finding needs to be further explored and analysed as part of the upcoming Trial to ensure there is no adverse impact on the care of these residents or the services who care for them.

The AN-ACC funding model has been developed under instruction that it is within the existing funding envelope. The challenge is that with the changed nature of residents the funding no longer enables providers to meet their needs. Productivity Commission data highlights increased high need across all ACFI domains, particularly in the percentage of people in residential aged care funded at the highest level for Complex Health Care, this group having grown from 12.7% in 2008-09 to 53% in 2017-18²³, (see Table One).

This challenge in meeting increased care needs is compounded by inadequate indexation. Put simply annual growth in expenses is outstripping the indexation factor and as a consequence each year the sector is falling further behind²⁴. The indexation factor used by government needs to consider the major cost drivers for the sector and ensure the indexation figure applied keeps pace with real cost growth.

As Professor Kathy Eagar notes in her presentation to the Department of Health’s Stakeholder Forum in November 2018²⁵, there are three components to the work her Study attended; cost, funding model and price (her Study attended the first two of these components – but not the last) and for this to be a ‘sustainable system going forward the funding has to be right’. She further noted that the Study won’t determine price but that they will make ‘explicit the relationship between price and cost’.

Table One: Proportion of residents funded as High ACFI need level

| Year | Activities of Daily Living | Behaviours | Complex Health Care |
|---------|----------------------------|------------|---------------------|
| 2008-09 | 34% | 37.1% | 12.7% |
| 2017-18 | 58.9% | 64.1% | 53% |

ACSA members, representing a wide and diverse mix of:

- Service size (small to large);
- Service type (stand alone, multi service, generalist, specialist services); and

²² Modelling the impact of the AN-ACC in Australia, Report 4, University of Wollongong, 2019, p1

²³ Report on Government Services 2019, Chapter 14 Aged Care Services, Table 14A 12, Productivity Commission

²⁴ Aged Care Financial Performance Survey, Sector report (Six months ended December 2018), StewartBrown, 2019, p17

²⁵ Professor Kathy Eagar, Australian Health Services Research Institute at the University of Wollongong, presenting on the Resource Utilisation and Classification Study and the Australian National Aged Care Classification at the Department of Health’s Stakeholder Forum on 19 November 2018

- Geographical location (metropolitan, regional, rural and remote);

are facing increasing financial sustainability and viability challenges as their focus is on providing quality care. Many are losing money on a daily basis with their daily expenses exceeding their daily care income. Many are choosing to carry these losses by cross subsidising from other parts of their business. Many are running deficit budgets year on year or are on the brink of running deficit budgets.

In the end the funding model is only effective if there are enough funds to support resident needs.

ACSA Recommends:

The upcoming Trial include a range of providers who have different service models (wellness, reablement and other service models), resident profiles, geographic location, facility size etcetera to gain an accurate 'across-the-board' picture of the impact of AN-ACC across a range of provider types and service models.

Stop-Loss Policy

It is good that a transition approach has been identified as part of the move to a new funding model.

The upcoming Trial will need to identify a profile of providers who would likely trigger the 5 per cent stop-loss threshold.

Additionally, the Trial should test the criteria listed as needing to be in place, before the stop-loss policy is triggered²⁶.

With approximately 42 per cent of providers currently losing money on a daily basis, rising to 61 per cent for rural, regional and remote providers²⁷ it is unlikely that these services, plus those that are now on the cusp of losing money on a daily basis, will remain viable should they experience a further 5 per cent loss in income, given the stop-loss policy is only provided for a 2 year transition period²⁸.

ACSA Recommends:

1/ The upcoming Trial is used to develop multiple 'transition options' for the sector to consider, including an option to 'grandfather' current residents to the ACFI model (as was done for residents funded under the Resident Classification Scale (RCS) when ACFI was introduced). Options developed to be shared with the sector for consideration and discussion;

²⁶ AN-ACC: A funding model for the residential aged care sector, Report 5, University of Wollongong, 2019, p20

²⁷ Aged Care Financial Performance Survey Sector Report (six months ended Dec 2018), StewartBrown, February 2019

²⁸ Recommendations 21 and 22 of the Study address 'transitioning' issues²⁸ (from ACFI to AN-ACC). The Study refers to a two-year transitioning period, which includes moving current residents over to the AN-ACC model (within six months following the completion of the two-year transition period).

2/ Transition options developed should include an option to not transition to the new AN-ACC funding model if it will worsen rather than enhance financial viability and therefore the ability to deliver quality care; and

2/ The upcoming Trial model a range of stop-loss thresholds from 1-2% and up; and the modelling shared with the sector for analysis and consideration.

External Assessments and the assessment workforce.

The model is built upon the availability of an external workforce (replacing the ACAS/RAS) that has *capacity* (assessor numbers appropriate to the task at hand) and *capability* (the requisite skillset to attend the assessments) noting that the Study recommends that assessors are either Registered Nurses, Physiotherapists or Occupational Therapists.

There is sector concern regarding the ability to build a requisite external assessment workforce of enough capacity (size) and with the appropriate skillset in a timely manner.

Assessors will need to be well trained and resourced, with ongoing development opportunities provided, to ensure they are appropriately skilled and trained.

An external assessment workforce will also need to be resourced to service the regional, rural and remote providers in a timely and equitable manner. This may be more readily achieved by licensing individual practitioners to undertake the assessment where there has been training.

Good practice would indicate that a comprehensive assessment of a resident occurs or unfolds over time, with some care needs becoming apparent only after ongoing interactions with the resident, a commonly cited example would be incontinence. The Study indicates that AN-ACC assessments can be conducted in approximately one hour. Our concern relates to a risk of under-assessment occurring with the concomitant risk of incorrect funding to the provider, ultimately requiring an application for re-assessment.

Recommendation 7 of the Study proposes ‘that the Commonwealth consider the introduction of reassessment charges for any home that routinely triggers unnecessary reassessments²⁹. This recommendation should not be implemented during the trial or transition period as assessors and providers will be learning the new model, associated assessment processes and subsequent allocation of residents to funding classes.

This recommendation should be considered post transition and include the development of clear criteria and definitions be included to determine penalty criteria.

The upcoming Trial should also use the opportunity to test and refine the processes around assessments and reassessments, for example:

- How long pre-admission assessments under AN-ACC (remembering these will determine funding class) remain valid for, to ensure ‘currency’ of the information and class allocation;

²⁹ AN-ACC A national classification and funding model for residential aged care: synthesis and consolidated recommendations, Report 6, University of Wollongong, 2019, p10

- Test the reassessment criteria as currently defined in Recommendation 6³⁰ in the Study, and determine if there are additional reassessment triggers that should be incorporated; and
- Consider reassessment criteria for existing residents who transition into palliative care (as distinct from those who are admitted as Class One under AN-ACC).

and any learnings are taken up and adjustments made.

Where a provider applies for reassessment, the external assessment workforce will need to be adequately resourced to attend reassessments in a timely manner, and where this is not possible, then reassessments where approved are back paid to the date of application for reassessment.

Separately, consideration needs to be given to the possibility of older people being subjected to multiple assessment processes; for example, at the gateway point (triaging at the My Aged Care entry point), through to an 'assessment for funding' stage and then thirdly for 'assessments for care' at the provider level. Impacts of multiple assessments on individuals needs to be considered and addressed.

Recommendation 14 of the Study proposes that 'residential aged care facilities not be advised of the resident's exact AN-ACC class until after the person is in care'³¹. It is important, for a variety of reasons, that providers understand the care and support needs of people applying to enter their service. Providers must have access to the same level of preadmission information on prospective residents as they currently have.

ACSA Recommends that the upcoming Trial:

1/ Validates the accuracy of the external assessment process in allocating AN-ACC classes to potential residents;

2/ Tests for 'length of currency' of assessments attended pre-admission;

3/ Validates the reassessment criteria as proposed in Recommendation 6³²;

4/ Considers the possibility of licensing individual practitioners to undertake external assessments in rural, regional and remote locales to ensure equity of access for these older Australians, and

5/ Address the multiple proposed rounds of assessments that older people will be asked to sit through and consideration given to how this can be addressed.

Additionally, ACSA recommends:

- *That Recommendation 7, which relates to reassessment charges, is not implemented until any transition period to a new funding model is complete; and*
- *That providers still have access to a potential residents ACAT pre-admission assessments as they do now.*

³⁰ Ibid, p10

³¹ Ibid, p14

³² Ibid, p10

AN-ACC model as a ‘system’

The AN-ACC model (including its recommendations) is said to be designed as ‘a whole’. There are thirty recommendations³³ that accompany the model.

Before we can endorse or support the AN-ACC model we will need to understand whether government is going to adopt the Report’s 30 recommendations in toto, and if not, which recommendations are to be adopted/rejected?

AN-ACC and loneliness, social isolation, boredom and quality of life (QoL)

The AN-ACC tool assesses functional capacity; with the Study indicating AN-ACC is more ‘reliable’ in predicting cost inputs (care inputs) than the current funding instrument. However, it is unclear (or not addressed at all?) how loneliness, social isolation and boredom will be valued and funded in the new system. These are effectively Quality of Life (QoL) issues. The Resident Classification Scale (RCS), the precursor to ACFI, included domains for emotional dependence and social and human needs).

ACSA Recommends:

The upcoming Trial include analysis of how providers will be able to continue to support these incredibly important resident supports under the AN-ACC funding model.

Funding and the Aged Care Quality Standards

The ‘new’ Aged Care Quality Standards are to be introduced on the 1 July 2019. These Standards promote wellness, reablement, and a consumer centric approach including addressing dignity of risk.

A new funding model needs to align and support the attainment of these Aged Care Quality Standards. It should not be developed and implemented in isolation from the Standards.

ACSA Recommends:

That as part of the upcoming Trial, analysis is undertaken to determine whether the funding model actively supports providers attaining resident outcomes as prescribed in the Standards.

Funding and geographical location

It is well recognised and understood that providers who operate outside of metropolitan environs experience higher cost imposts that directly relate to their location^{34,35}.

³³ Ibid

³⁴ Financial Issues Affecting Rural and Remote Aged Care Providers Part 1, Australian Government Aged Care Financing Authority, February 2016, Key Findings page v.

³⁵ Sixth report on the Funding and Financing of the Aged Care Sector, Australian Government, Aged Care Financing Authority, July 2018, Chapter 9. Residential aged care: operational performance, p28

We discuss the financial challenges faced by regional, rural and remote providers in our recent submission to the Royal Commission into Aged Care Quality³⁶.

In her presentation to the sector in March 2019³⁷ Professor Kathy Eagar indicated ‘very remote facilities’ (MMM³⁸ 7) incur significantly higher fixed care costs, and additionally that ‘remote small facilities’ (MMM 6 and <30 beds) also reported ‘high costs’.

What we are not able to currently understand is the cost burden on providers who are not metropolitan based AND who are also not MMM 6 or 7 category providers (i.e. those classified as MMM 3, 4 or 5). Anecdotally many providers report increased costs associated with delivering their services in rural and regional (including inner regional) areas some of whom also report not qualifying for viability supplements.

As part of the trial of AN-ACC we believe analysis should be undertaken to understand more fully the cost burden of providing services in the rural and regional areas that are classified as MMM 3, 4 or 5.

ACSA supports the Regional Structural Costs Micro-study (MMM3,4,5) which is to build on the work of the RUCS, with a view to determining accurate base tariff funding for these service types.

On a separate point, albeit still related to MMM classifications, Recommendation 13 of the Study³⁹ indicates that for providers in remote locations (MMM6 or MMM7) their base tariff payment is based on approved bed numbers and not occupancy. We are concerned that there may well be providers of services in areas classified as MMM 3, 4 or 5 that may have similar occupancy challenges as those providers in areas classed as MMM6 or MMM7. Certainly, anecdotally this is the feedback we receive.

ACSA Recommends that the upcoming Trial:

1/ Analyse the cost burden of providers classified as MMM3, 4 or 5 with a view to accurately determining their base tariff funding; and

2/ Analyse the occupancy challenges of providers classified as MMM3, 4 or 5 to determine if their funding should be based on occupancy or approved bed numbers.

Funding model options

Initially there were several funding options ‘on the table’, including a modified ACFI instrument developed by Richard Rosewarne⁴⁰ (referred to as Revised-ACFI, (R-ACFI)).

³⁶ Royal Commission into Aged Care Quality and Safety, Residential Care Submission, Aged & Community Services Australia, May 2019

³⁷ Australian National Aged Care Classification (AN-ACC) Version 1.0, Senior Professor Kathy Eagar, Director, AHSRI, March 2019, PowerPoint Slide ‘Major Findings – 1)

³⁸ Modified Monash Model (MMM); supplements are paid monthly to aged care providers in eligible areas, in order to cover the higher costs of delivering their services in these areas. MMM classifications between 3 and 7 can receive various payment amounts.

³⁹ Ibid, p13

⁴⁰ Review of the Aged Care Funding Instrument Report, Part 1 Summary Report, Applied Aged Care Solutions Pty Ltd, June 2017

The original study conducted by the University of Wollongong itself identified five funding model options⁴¹.

We now appear to have arrived at a point where there are no longer a range of funding model options to be considered and weighed up by government and the sector.

Several not-for-profit organisations (ACSA, Anglicare, Baptist Care Australia et al) have developed a document outlining key principles for funding⁴², including:

- Outcome focused;
- Equity;
- Consumer choice and control;
- Flexible and scalable;
- Efficient;
- Certainty and sustainability;
- Transparent;
- Integrated; and
- Value for money and affordability.

We believe any proposed funding model should be evaluated against these principles, [see here](#).

ACSA Recommends:

1/ That any proposed funding model should be evaluated against these funding principles; and

2/ that if the proposed model does not support these outcomes that alternate models be investigated.

Transition Plan

Further into the future, once government decides on a new funding model then it will be vital that they and the sector co-design a transition plan that addresses the major actions required to transition to a new funding model.

These could include (but would not be limited to):

- ICT related activities and development
- DHS payment systems preparation
- External assessment workforce preparation
- Development of sector guidelines, business rules etcetera
- Development of sector resource and training materials

Service continuity to residents, and reliable funding payments to providers must be able to occur.

⁴¹ Alternative Aged Care Assessment, Classification System and Funding Models, Final report, Volume One, University of Wollongong, February 2017

⁴² Principles for Aged Care Services Funding, ACSA, Anglicare et al