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Extension of the AN-ACC funding model to include community aged care

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Contents

1 Introduction and background

The purpose of this document is to outline how the principles that underpin the new Australian National Aged Care Classification (AN-ACC) apply equally to community aged care and to propose that the community aged care sector work together to design a branch of the AN-ACC classification and funding model that works for community aged care.

The AN-ACC funding model was designed for residential care to address a number of weaknesses in the current residential care (ACFI) funding model. The AN-ACC system provides funding transparency by focusing on what actually drives the need for care and best predicts resource use. This results in more funding equity and improved operational efficiency. In addition, the AN-ACC system enables greater consumer choice by not being prescriptive in the specific care activities that are funded and enables the outcomes of care to be assessed in meaningful ways. These are all major deficits in the current ACFI system.

They are also major deficits in the developmental work that the Department of Health is attempting to progress in the design of a new funding model to underpin its new "Support At Home" (SAH) Program.

Further, the extension of the one funding model across both residential and community care allows for costs and outcomes to be tracked across settings and over time. This is consistent with the goal of improving integration of aged care across care settings.

2 Audience and scope

Funding system design is necessarily a technical activity. The implication is that this document necessarily contains technical concepts. This document is written for those with a basic understanding of funding and costing. It is not written for a lay audience.

3 Glossary of Terms

Activity costs	The costs of providing care and support (***activity***) to meet the assessed needs of individuals. In the AN-ACC funding model, these costs are funded based on the AN-ACC casemix class of the resident.
Australian National Aged Care Classification (AN-ACC) system	Consists of the AN-ACC assessment, AN-ACC casemix classification and AN-ACC funding model. AN-ACC Version 1 was designed solely for residential care. This proposal is for the AN-ACC to be expanded so that AN-ACC Version 2 has a separate branch for community and home support.
Base Care Tariff (BCT)	The BCT is a payment designed to cover the core costs of a community aged care service so that it has the ***capacity*** to provide aged care services to individuals. These are costs that are not driven by the care needs of individual care recipients but are costs consumed equally by all care recipients plus overhead agency costs. These include management and office costs, care coordination, quality assurance, reporting and education. In the AN-ACC funding model, an approved provider

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	would receive an annual BCT payment at the beginning of each year to fund their capacity to deliver an agreed range of community and home aged care services.
Casemix	A system that allocates service recipients into classes. Care recipients within a class will have similar needs for care and their care will involve similar levels of resource consumption.
Individual care	Care and support that is tailored to the needs of an individual care recipients. Differences in individual care needs are associated with differences in assessed function, cognition, behaviour and health status plus external factors such as location. Individual care and support is funded through an AN-ACC ***activity*** component that covers the costs of delivering services to individuals once all the capacity costs are dealt with through a BCT. Different consumers need different amounts and types of services and so the AN-ACC classification is used to classify a consumer based on the mix of services they need. These are aggregated to form an ***annual price and volume contract*** each year. The AN-ACC funding model for community and home support is a price and volume contract, not an individual fee for service model.
National Weighted Activity Unit (NWAU)	A measure of relative **price across the whole of aged care.** An NWAU of 1.2 means that the price of the activity is 20% above the national average. An NWAU of 0.5 means that the price is 50% below national average. The 'national average' is the average of all aged care in Australia, both residential and community. The NWAU is a common currency for funding aged care across the care continuum. The Independent Hospital and Aged Care Authority will recommend the price of an NWAU of 1.00 from 2022/23. All other prices for aged care are determined relative to the price of 1.00 NWAU.
Relative Value Unit (RVU)	A measure of relative **cost specific to each service type**. So there are one set of RVUs for residential care, another for community transport, another for delivered meals etc. An RVU of 1.00 is given to the overall mean resource utilisation for all recipients of each type of aged care service. An RVU of 2 indicates that the people in the class need twice as much service compared to the overall mean for that service type and a class with an RVU of 0.5 indicates that the people in the class need half as much service as the average.

4 Overview of the residential care AN-ACC funding model

The AN-ACC funding model is similar to the activity based funding (ABF) system that is in place across the health system nationally. This approach is best known in its application in the acute hospital sector. However, it is an eminently flexible approach that has been successfully applied in subacute and non-acute care as well as non-admitted and community based care systems nationally and internationally. It has also been successfully implemented in the disability and education sectors.

The key characteristics of activity based funding systems are:

- A classification system with classes that describe the characteristics of those receiving care rather than describing what they receive. In health jargon, it is a 'casemix' classification, not a 'service mix' classification.

- Classes that are both meaningful and resource homogeneous. This allows them to be used for funding purposes as well as providing a base for measuring the outcomes of care.
- A payment model in which there is an explicit relationship between cost and price informed by regular costing studies.
- National weighted activity units (NWAU) for all classes based on cost relativities between classes and a single price across all care activities regardless of care setting.

5 Key elements of the AN-ACC funding model

The AN-ACC funding model has three key design elements:

1. A base care tariff (for the service capacity component)
2. An activity payment (to meet individual care as determined by the person's AN-ACC class)
3. A one off adjustment payment for residents when a resident enters residential aged care. It is not proposed to apply an adjustment payment to community and home support. This element applies to residential aged care only.

The AN-ACC model is a streamlined model that does away with many of the separate adjustments and supplements used in the past. It is administratively simple yet it represents a more sophisticated approach to funding that is based on evidence of cost and cost drivers.

5.1 The Base Care Tariff (capacity component)

5.1.1 The base care tariff in residential care

The base care tariff is included in the funding model for two key reasons. The first is to recognise the fact that a large proportion (approximately 50%) of care costs within a facility are driven not by the individual care needs of the residents but by care delivered equally to all residents. The second is to provide stability in the funding model, where 50% of the facility funding is fixed regardless of changes in the individual resident care needs profile and, for some facilities, regardless of changes in occupancy.

The base care tariff covers capacity costs. These include activities such as clinical supervision and training, facility clinical management and shared care activities such as night supervision and resident observation during social activities and meal times. These costs do not change significantly with changes in individual resident care need or with small changes in occupancy. For example, the costs of a night supervisor are determined by the overall number of residents rather than the needs of a specific resident. Capacity care costs were found in the RUCS to be determined by structural characteristics of the facility including size, geographic location and service specialisation.

The structural factors that are associated with significant increases in capacity costs per day are remote and very remote facilities that provide indigenous care services, non-indigenous remote services that have less than 30 beds and specialised services to homeless people. Remoteness has been defined using the Modified Monash Model (MMM) a standardised measure of geographic isolation on a scale of 1 to 7. The MMM value of 1 represents the most urbanised parts of the country and, at the other end of the scale, the facilities with an MMM value of 7 are the most remote.

Each of the base care tariffs and their associated NWAUs are included in Table 1.

Table 1 Base care tariffs and NWAUs

Base Care Tariff	Facility description	RVU	NWAU
1	Indigenous, MMM=7	463%	$390.24
2	Indigenous, MMM=6	162%	$169.10
3	Non-indigenous, MMM=6-7, < 30 beds *	187%	$147.42
4	Non-indigenous, MMM=6-7, 30+ beds *	106%	$112.74
	MMM = 5	TBC	
5	Specialised homeless	179%	$199.46
6	All other RACFs	95%	$106.23
All		100%	$108.40

5.1.2 The base care tariff in community aged care

The two reasons that the base care tariff is included in the residential funding model apply equally to community aged care.

Capacity or structural costs

A large proportion of community aged care costs are driven not by the care needs of individual care recipients. Rather, they are the structural costs required to deliver the service to all care recipients. Examples include the cost of renting office accommodation, the cost of the organisation's management team and the embedded cost of core activities such as staff supervision, quality assurance and activity reporting. There are also structural costs that vary by service type. For example, the cost of purchasing and maintaining a bus in a Community Transport Organisation is independent of the needs of the people who ride on the bus.

Stability

The second issue is to need for stability in the funding model. Like residential care, community aged care services have a range of capacity or structural costs. Every organisation needs a cash flow to cover their capacity costs. These costs do not fluctuate in response to the needs of individual care recipients.

In designing the AN-ACC for residential aged care, we recommended that, in homes in remote areas, the base tariff be based on approved beds (capacity) with all other base tariffs being based on occupancy.

The same approach is recommended for community aged care. There should be an annual base care tariff paid in advance to each community aged care provider based on their location, size and service type. Like the residential model, these should be translated into a schedule of base care tariffs.

An illustration of the idea is shown in the following table.

Table 2 An example of possible Base Care Tariffs for community organisations

Base care tariff	Description
1	Community transport organisation in major metropolitan or regional area providing a large service (more than 1,000 care recipients per year)
2	Community transport organisation in major metropolitan or regional area providing a medium service (500-999 care recipients per year)
3	Community transport organisation in major metropolitan or regional area providing a small service (less than 500 care recipients per year)
4	Community transport organisation in outer regional or remote area providing a large service (more than 1,000 care recipients per year)
5	Community transport organisation in outer regional or remote area providing a medium service (500-999 care recipients per year)
6	Community transport organisation in outer regional or remote area providing a small service (less than 500 care recipients per year)
7	Meals on Wheels service in major metropolitan or regional area providing meals only in a large service (more than 500 care recipients per year)
8	Meals on Wheels service in major metropolitan or regional area providing meals, social support and health and wellbeing monitoring in a large service (more than 500 care recipients per year)
9	Meals on Wheels service in major metropolitan or regional area providing meals only in a small or medium service (less than 500 care recipients per year)
10	Meals on Wheels service in major metropolitan or regional area providing meals, social support and health and wellbeing monitoring in a small or medium service (less than 500 care recipients per year)

This table is just for illustrative purposes and it raises two key points. Each base care tariff has to be defined based on clearly identifiable capacity costs. Costs that relate to the needs of individual care recipients are addressed in the activity (casemix) component. Also, there has to be limited number of base care tariffs. Too many tariffs make the model unwieldy.

5.2 The activity (AN-ACC) component

The individualised care or activity payment is additional to the base care tariff and relates to the tailored care received by individual care recipients. The activity payment is based on the AN-ACC class assigned for each individual care recipient (see Figure 1).

Figure 1 show the classification tree for Version 1.0 of the AN-ACC. Expansion of the AN-ACC to include community aged care would require the development of a different branch of the classification tree for community aged care recipients.

Figure 1 The Australian National Aged Care Classification (AN-ACC) Version 1.0

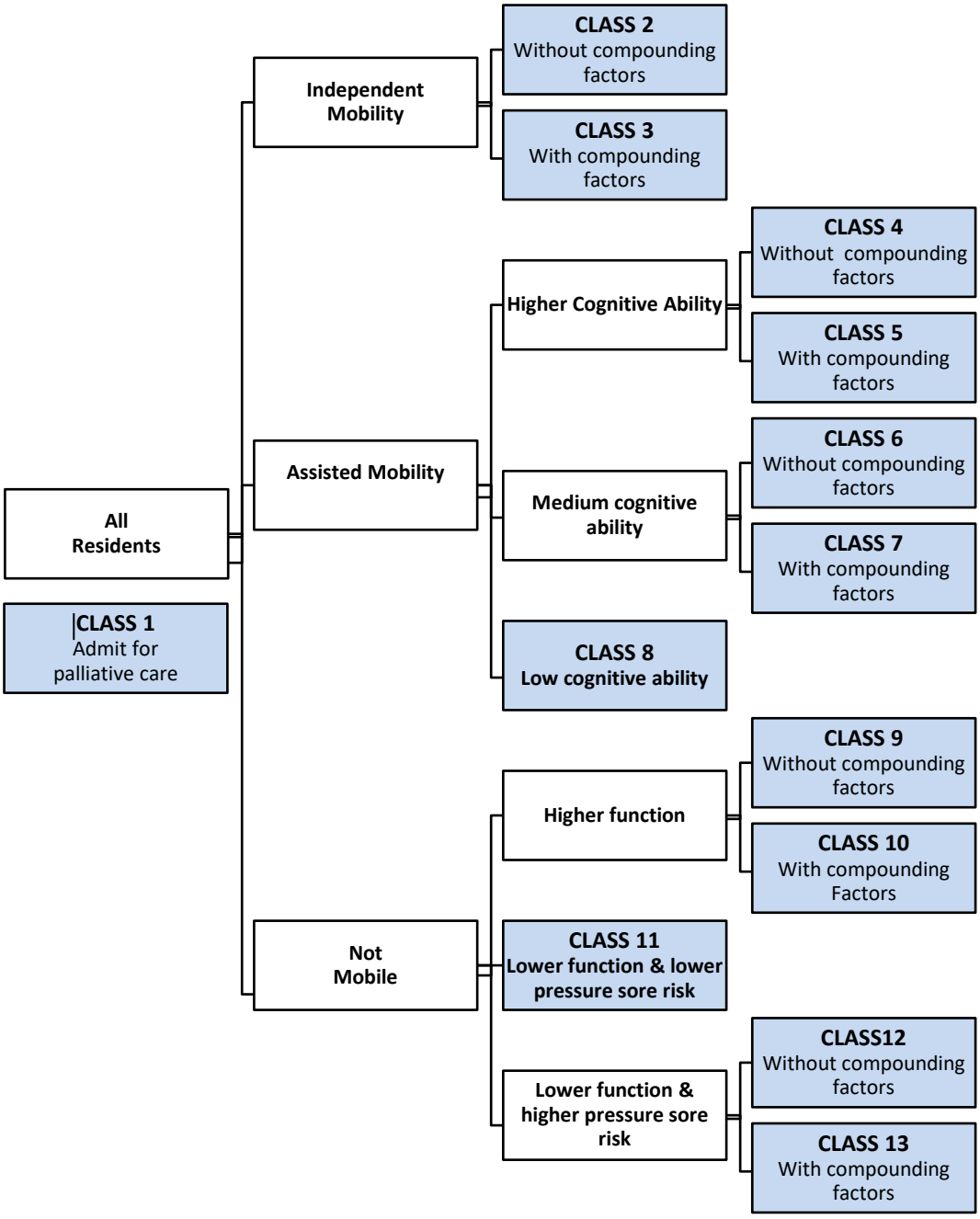
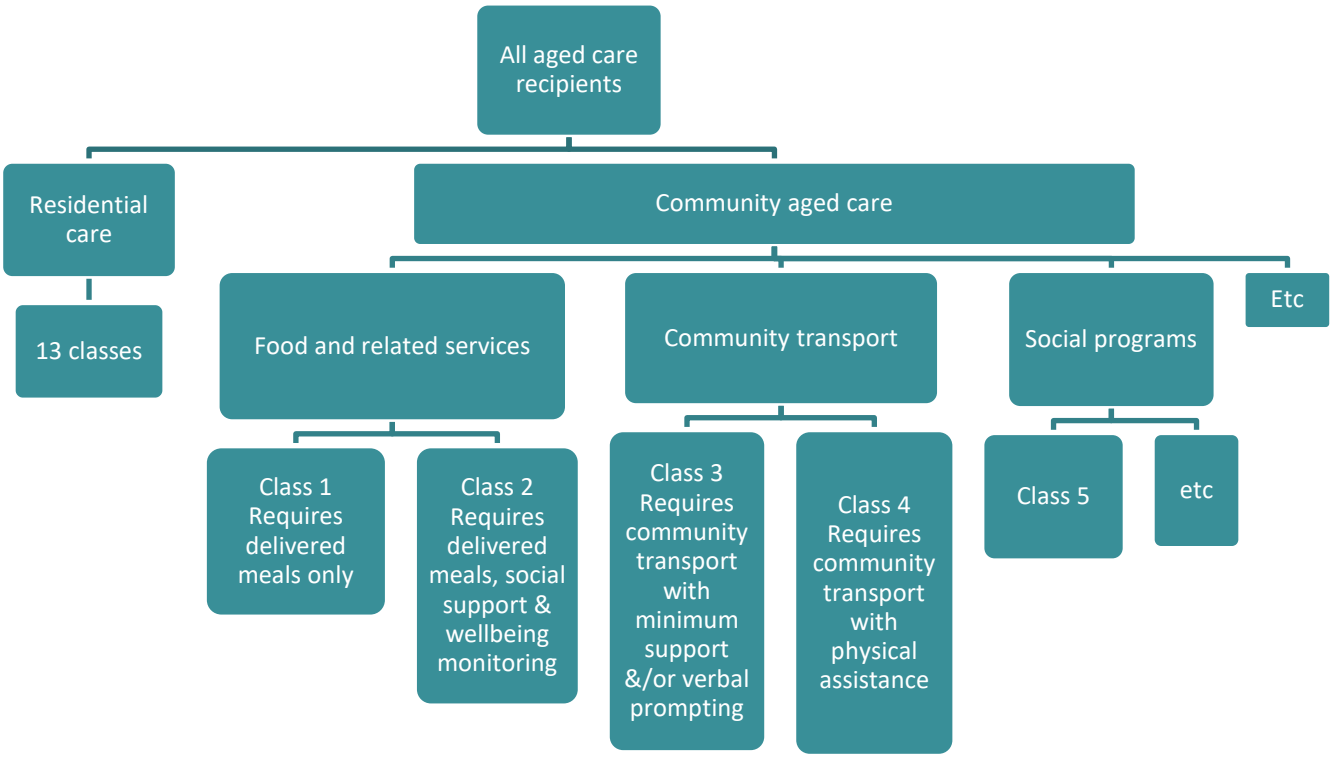


Figure 2 shows how the AN-ACC might be developed in future to incorporate community aged care. A care recipient might only be in one class or might be receiving multiple services, with the care recipient classified according to each service they need.

Figure 2 How the AN-ACC might be developed to incorporate community aged care in Version 2.0



Each CHSP provider organisation would receive an annual Base Care Tariff to cover their capacity costs. They would also receive an annual activity payment based on the volume and mix of care recipients in each AN-ACC class.

Once classes are developed for each service type, the final stage is to create AN-ACC classes based on combinations of service needs. These would then be available to be used in various combinations to replace the current 4 level HCP funding model. The outcome would be a funding model in which a care recipient may be in one or multiple funding classes at different times.

5.3 The one-off adjustment payment

An important feature of the residential AN-ACC funding model is the inclusion of a one-off adjustment payment for each resident when they first enter residential aged care. This one-off adjustment payment recognises that there are additional, but time-limited, resource requirements when someone initially enters residential care.

These time-limited additional costs cover the following activities:

- time spent getting to know the resident and their family
- individualised care planning
- behaviour management
- health care assessments
- facilitating health care arising from assessments (including pain management, dental care, palliative care and other issues that need attention)
- developing an advanced care directive in partnership with the resident and their family.

In developing a suitable funding model for community aged care, stakeholders will need to consider whether an adjustment payment can be justified in community aged care and, if so, how it might work. At this stage there are no apparent reasons why an adjustment payment would be required in community and home support.

6 Price and volume contracts

While CHSP funding would continue initially to be funded via block grants, the goal would be to progressively introduce price and volume contracting with each provider organisation.

The volume would be specified in total units of care counted and funded as 'National Weighted Activity Units' (NWAU) separated into the two components in the AN-ACC funding model. The term NWAU is used because the cost and price of units of care are harmonised so that the same unit of activity (one NWAU) is used across all aged care streams and across all service types.[1]

The price would be the National Efficient Price (NEP) for one NWAU and would be the same across Australia. It is the NWAU (not the price) that is adjusted to take account of regional differences.[2]

A risk sharing mechanism would be built into each price and volume contract. For example, a home support service might have a price and volume contract for 1,000 NWAU of home support services plus or minus 10%. If the total volume of care provided is within the 1,000

[1] A National Weighted Activity Unit (NWAU) is a unit of care expressed as a measure of relative price. It is sometimes termed a Relative Value Unit. The term NWAU is used deliberately in this paper to align the aged care funding model with the health system funding model as specified by the Independent Hospital Pricing Authority. An NWAU of 1.2 means that the price of the unit of care or activity is 20% above the average of all aged care activities. An NWAU of 0.5 means that the price is 50% below national average. A unit of care may be anything from a restorative care program over many months to a day of care or a week of delivered meals. The cost of each of these activities is calibrated against each other and the NWAU becomes the common unit of both activity and price.

[2] This approach is well established in the health system. For example, the national public hospital funding model includes a series of NWAU adjustments including an Indigenous adjustment and a patient residential remoteness adjustment.

± 10% band, there is no adjustment in the total annual price of the contract. The funding for activity variations outside this band is adjusted at a marginal rate. The purpose of this risk sharing mechanism is both to share financial risk and to simplify contract management.[3]

7 Conclusion

The AN-ACC funding model represents a significant change for the residential aged care sector and the same would be the case if it was extended to cover community aged care. Initially, this model may be perceived as complex by the sector with a new language and concepts. These concepts are sophisticated. However, they are at the same time sensible and easily explained.

However conceptually sophisticated, these ABF type models are administratively simple, straightforward and do not require complex information systems. In contrast, the current ACFI and the proposed 'Support at Home' funding models are conceptually straightforward (because they fund outputs not linked to outcomes), time—consuming and expensive to administer.

Planning for the technical implementation of the model needs to be accompanied by an investment in change management. The government will need to enter into a partnership with the sector to implement the new model, recognising that this is in the interests of care recipients, providers and government.

At the same time, there will inevitably be the need to fine-tune the model as implementation progresses. The Department will need systems in place for sector engagement and consultation as implementation progresses, as well as ongoing access to technical expertise.

As the system becomes embedded the government should both access external, and begin to develop internal, expertise in using the data to better measure the needs of care recipients and changing needs over time. The data should also be used in future planning to predict ongoing demand for both community and residential aged care.

Funding reform is not an end in itself. As well as being a more efficient and equitable funding model, this funding reform (if done well) provides an important opportunity to drive fundamental improvements in care recipient experiences and outcomes. It also provides the evidence base necessary to evaluate the value for money that the sector delivers.

[3] A further reason is that this provides a mechanism to allow agencies to better predict and manage income and expenditure. This in turn will assist agencies to recruit and maintain a stable workforce. There is considerable evidence that staff continuity is a critically important factor in driving quality and safety.

Attachment 1 An example: community transport

This is a worked example of how the AN-ACC funding model would be implemented in aged care community and home support. This example is for a community transport service called the Anytown Community Transport Service. However, the overall approach applies equally to other types of community and home support services.

7.1 Steps in extending the AN-ACC to include community and home support

The first step in extending the AN-ACC to cover community and home supports is to develop a set of Base Care Tariffs for each community and home support service type. This example is for community transport organisations and their Base Care Tariffs are illustrated in Table 3. The Anytown Community Transport Service meets the definition of a Base Care Tariff 2 organisation. At the beginning of the financial year it will receive a Base Care Tariff grant of $300,000 to cover its capacity costs. Note that the RVUs and the prices in this table are for illustrative purposes only. A costing study would be required to determine actual RVUs and costs. But the first step could be a set of weights based on expert opinion of community transport providers derived from a review of their current expenditure.

Table 3 Base Care Tariffs for community transport

Base care tariff (BCT)	Description	RVU for BCT	National RVU price	Base care tariff
1	Community transport organisation in major metropolitan or regional area providing a large service (more than 500 care recipients per year)	3000	$200	$600,000
2	Community transport organisation in major metropolitan or regional area providing a medium service (500-999 care recipients per year)	1500	$200	$300,000
3	Community transport organisation in major metropolitan or regional area providing a small service (less than 500 care recipients per year)	1000	$200	$200,000
4	Community transport organisation in outer regional or remote area providing a large service (more than 1,000 care recipients per year)	3500	$200	$700,000
5	Community transport organisation in outer regional or remote area providing a medium service (500-999 care recipients per year)	2000	$200	$400,000
6	Community transport organisation in outer regional or remote area providing a small service (less than 500 care recipients per year)	1250	$200	$250,000

The second step is to develop a classification of community transport activities. Some of the work being undertaken to develop the proposed Support at Home program may help to inform this. In the interim, assume that there are only 5 classes as shown in Table 4 (in practice there would likely be more than 5 classes). Each activity has an associated Relative Value Unit (RVU), which is an index of relative costliness. RVUs would be based on a costing study of the relative cost of providing different types of activities. But the first step could be a set of weights based on the expert opinion of community transport providers.

Table 4 Community transport activity classification

Activity	RVU	$ per RVU	Total
Short return trip to local appointment	0.125	$200	$25
3 hour round trip to city appointment from rural town	3.000	$200	$600
Half day group outing per person	0.200	$200	$40
Full day group outing per person	0.375	$200	$75
2 hour escorted shopping one on one	0.300	$200	$60

Each year the Independent Hospital and Aged Care Pricing Authority will recommend the national price of one NWAU for aged care overall, from which the dollar value of an RVU will be derived. In this example, the national price for one RVU of community transport is set at $200. The RVU for each activity is multiplied by the national price to determine the price for each activity on this list. These activities and prices are standard across all community transport organisations regardless of location or size although not all organisations would provide every activity.

The Anytown Community Transport Service has three consumers. Their transport needs are summarised in the following 3 tables. The notional service plan for Mary Jones (Table 5) assesses her as needing 28.35 RVUs of service over a year. She is classified as having medium community transport needs.

Table 5 Mary Jones: medium community transport needs

Notional service plan for 2023/24	RVU	Activity units	Total RVU per annum	$ per RVU	Total
Short return trip to local appointment	0.125	10	1.25	$200	$250
3 hour round trip to city appointment from rural town	3.000	1	3	$200	$600
Half day group outing per person	0.200	26	5.2	$200	$1,040
Full day group outing per person	0.375	12	4.5	$200	$900
2 hour escorted shopping one on one	0.300	48	14.4	$200	$2,880
Total		**97**	**28.35**		**$5,670**

The notional service plan for Harry Smith assesses him as needing 63.35 RVUs of service over a year. He is classified as having high community transport needs.

Table 6 Harry Smith: high community transport needs

Notional service plan for 2023/24	RVU	Activity units	Total RVU per annum	$ per RVU	Total
Short return trip to local appointment	0.125	26	3.25	$200	$650
3 hour round trip to city appointment from rural town	3.000	12	36	$200	$7,200
Half day group outing per person	0.200	26	5.2	$200	$1,040
Full day group outing per person	0.375	12	4.5	$200	$900
2 hour escorted shopping one on one	0.300	48	14.4	$200	$2,880
Total		**124**	**63.35**		**$12,670**

The notional service plan for Nell Graham assesses her as needing 7.8 RVUs of service over a year. She is classified as having low community transport needs.

Table 7 Nell Graham: low community transport needs

Notional service plan for 2023/24	RVU	Activity units	Total RVU per annum	$ per RVU	Total
Short return trip to local appointment	0.125	0	0	$200	$0
3 hour round trip to city appointment from rural town	3.000	0	0	$200	$0
Half day group outing per person	0.200	0	0	$200	$0
Full day group outing per person	0.375	0	0	$200	$0
2 hour escorted shopping one on one	0.300	26	7.8	$200	$1,560
Total		**26**	**7.8**		**$1,560**

Table 8 summarises the funding agreement for Anytown Community Transport Service. As a level 2 Base Care Tariff organisation, it receives $300,000 as its Base Care Tariff. It also receives $19,900 as an AN-ACC activity payment. This is funding for 99.50 RVUs of activities (28.35 RVU for Mary, 63.35 for Harry and 7.80 for Nell) plus or minus 10%. If its final activity for the year is in the range 89.55 to 109.45 RVU, Anytown Community Transport Service has met its activity goal.

Table 8 Funding agreement for Anytown Community Transport Service

Funding agreement	Total RVU to be delivered per annum	Minimum activity	Maximum activity	$ per RVU	Total
Base Care Tariff 2				$200	$300,000
RVUs (+/- 10%) for Mary, Harry and Nell	99.50	89.55	109.45	$200	$19,900
Total					**$319,900**

While the budget has been built up based on meeting the assessed needs of Mary, Harry and Nell, the funding agreement is a lump sum price and volume contract based on total activity (99.50 RVU). Anytown Community Transport Service can cross-subsidise between Mary, Harry and Nell and can substitute one transport activity with another. It can vary the mix of activities it delivers in response to the changing needs of Mary, Harry and Nell and can be innovative in delivering different types of transport activity over the course of the year.

The service has two requirements:

1. It needs to meet the transport needs of Mary, Harry and Nell. If Mary, Harry or Nell are unhappy about the services they receive from the Anytown Community Transport Service, they can transfer to another community transport provider and take their notional RVU allocation with them.
2. It needs to meet the total quantum of activity, in this case 99.50 RVU plus or minus 10%. If activity falls below 89.55 RVU, the Commonwealth may require that the unspent activity funding be returned. If activity is more than 109.45 RVU, Anytown Community Transport Service has a good case for increased activity funding in the next year. These RVUs are adjusted to account for any consumer who joins or leaves the service during the course of the year. The goal is that services compete on quality and consumer experience rather than compete on price.

In this example there are only three consumers - Mary, Harry and Nell – and each one forms their own RVU class. In practice, there would be many more community transport users and treating each individual consumer as their own class is both impractical and unnecessary.

Instead of treating each person as their own RVU class, each person requiring community transport would be assessed and allocated to one of four community transport AN-ACC classes as shown in Table 9.

Table 9 AN-ACC classes for community transport

AN-ACC classes for Community Transport	Definition	RVU for the purposes of a price and volume contract
Class 1. High community transport needs	Person needs >50 RVU per annum	60 RVU
Class 2. Medium community transport needs	Person needs 20-49 RVU per annum	30 RVU
Class 3. Low community transport needs	Person needs 5-19 RVUs per annum	10 RVU
Class 4. Casual community transport needs	Person needs <5 RVU per annum	5 RVU

Table 10 summarises the funding agreement for Anytown Community Transport Service once AN-ACC is introduced. As a level 2 Base Care Tariff organisation, it receives $300,000 as its Base Care Tariff. It also receives $20,000 as an AN-ACC activity payment. This is funding for 100.00 RVU of activities plus or minus 10%. If its final activity for the year is in the range 90.00 to 110.00, Anytown Community Transport Service has met its activity goal.

Table 10 AN-ACC funding agreement for Anytown Community Transport Service

Funding agreement	Total RVU to be delivered per annum	Minimum activity	Maximum activity	$ per RVU	Total
Base Care Tariff	0			$200	$300,000
RVU (+/- 10%) for Class 1, 2 and 3	100	90	110	$200	$20,000
Total					**$320,000**

This example only covers community transport. Many care recipients need multiple services, each with their own AN-ACC class. The last stage in the development of AN-ACC is to create classes that are combinations of different types of service needs. For example, there would be an AN-ACC class for people with high needs for case management, community transport, delivered meals, personal care and house cleaning.

These classes would be progressively developed and added to the AN-ACC classification, starting with classes to cover the combination of services currently being provided to the Home Care Package (HCP) recipients. But the first step is to develop service specific AN-ACC classes before moving progressively to bundled classes as a future step.

7.2 Implementation

While the AN-ACC model is more conceptually sophisticated than the Support at Home model, it is actually simpler (and ultimately cheaper) from an administrative perspective for both the Commonwealth and providers. However, these are new concepts in the community and home support sector and it would take some time before the system could be completely bedded down. For this reason, the AN-ACC should be progressively developed and implemented in stages over two to three years.

Attachment 2 Differences between the AN-ACC funding model and the proposed Support at Home funding model

There are three critical differences between this model and the fee for service model being proposed for the new Support at Home program.

1 Base Care Tariff

The proposed Support at Home Program does not include a Base Care Tariff (Table 1).

There are two reasons why the AN-ACC funding model includes a base care tariff:

Capacity or structural costs

A large proportion of community aged care costs are driven not by the care needs of individual care recipients. Rather, they are the structural costs required to deliver the service to all care recipients. Examples include the cost of renting office accommodation, the cost of the organisation's management team and the embedded cost of core activities such as staff supervision, quality assurance and activity reporting. There are also structural costs that vary by service type.

For example, the cost of purchasing and maintaining a bus in a Community Transport Organisation is independent of the needs of the people who ride on the bus. This is no different to the costs of running a car. There are fixed costs with running a car whether it sits in the driveway unused or whether it is used each day.

Stability

The second issue is to need for stability in the funding model. Like residential care, community aged care services have a range of capacity or structural costs. Every organisation needs a cash flow to cover these costs. These costs do not fluctuate in response to the needs of individual care recipients.

In designing the AN-ACC for residential aged care, we recommended that, in homes in remote areas, the base tariff be based on approved beds (capacity) with all other base tariffs being based on occupancy. The same approach is recommended for community aged care. There should be an annual base care tariff paid in advance to each community aged care provider based on their location, size and service type. Like the residential model, these should be translated into a schedule of base care tariffs.

2 The units of activity being purchased/funded

Both the AN-ACC and the proposed Support at Home model include an activity schedule similar to Table 4. However, the activity schedule has different roles in each model.

In the AN-ACC model, the activity schedule is an intermediate product. It is used for care planning and for counting and reporting activity. But the activity schedule is not used as the purchasing currency. Total RVU per annum is the unit of activity being funded in the AN-ACC model.

This is quite different to the proposed Support at Home program. In the Support at Home program, the activity schedule is the purchasing currency. A price is set for each activity and the provider is paid in arrears for delivering each specific activity. Mary, Harry and Nell are each approved for a maximum number of activity units and providers are paid in arrears for delivering these. Funding for any approved services that are not used is retained by the Commonwealth. Providers are not funded for any services that are not pre-approved.

3 Program flexibility in response to changing needs

The most important critical difference between the AN-ACC and the Support at Home funding models relates to flexibility and the ability to cross subsidise.

In the proposed Support at Home program, activities are approved and capped for each consumer. The Anytown Community Transport Service providers cannot cross-subsidise between Mary, Harry and Nell. It cannot substitute one transport activity with another or vary the mix of activities it delivers in response to the changing needs of Mary, Harry and Nell. It cannot innovate in delivering different types of transport activity over the course of the year. Instead, if Mary, Harry or Nell have changing needs, they must apply for re-assessment and be approved for a new set of specified services.

In the AN-ACC model, the funding agreement is a lump sum price and volume contract based on total activity expressed as total RVU. A tolerance band of plus or minus 10% is built into the model to help manage financial risk for both parties. The Anytown Community Transport Service can cross-subsidise between Mary, Harry and Nell and can vary the mix of activities it delivers in response to the changing needs of Mary, Harry and Nell. Most importantly, it can be innovative in delivering different types of transport activity over the course of the year.