Residential aged care funding arrangements

Regulatory Impact Statement

Contents

1. Introduction

This Regulatory Impact Statement (RIS) has been prepared by the Department of Health (the Department) to inform Australian Government decision-making on residential aged care funding reform. This RIS builds on the draft RIS 'subject to Early Assessment by the Office of Best Practice Regulation (OBPR)' prepared early in 2020. This draft RIS informed the decision to invest in preparatory funding for the Australian National Aged Care Classification (AN-ACC), including the development of a new residential aged care payment system.

The Australian Government is the major funder of residential aged care services in Australia, contributing approximately $13.4 billion in 2019-20 to cover the basic subsidy and supplements. The majority of this funding is allocated based on the classification of residents from the Aged Care Funding Instrument (ACFI).

Under the current residential aged care funding arrangements, funding is not aligned to the care needs of residents, is not contemporary and leads to funding volatility for the sector and the Australian Government. In addition, the incentives in the funding model can lead to perverse or negative quality outcomes, and inequality in funding between regions.

The causes of these issues relate to the design of the current ACFI and indexation not aligning to changes in residential aged care costs. In addition, funding for respite care in residential aged care settings no longer aligns with permanent residential care funding, creating distortions that favour use of beds for permanent care and limiting access to respite care.

Extensive work has been undertaken since 2016 to investigate and develop robust alternatives to the current funding arrangements. This RIS explores three potential options:

1. keep the existing ACFI model
2. adopt the AN-ACC model with independent assessors, and
3. amend the ACFI to make it better align with contemporary care practices

Option 2, the AN-ACC model, aligns care needs and cost drivers in residential aged care to ensure funds are directed where they are needed. The introduction of this model would address the issues with the ACFI, support delivery of better quality care for older Australians and improve funding certainty for the Australian Government, providers and investors. This approach is estimated to reduce the regulatory burden by approximately $225 million each year.

2. Background

Residential aged care in Australia

Residential care provides support and accommodation for people who have been assessed as needing higher levels of care, and choose or need to be cared for in an aged care facility. Residential care is provided on either a permanent or a temporary (respite) basis and is governed by the *Aged Care Act 1997* (the Act) and subsidised by the Australian Government.

In 2019-20, 244,363 people received permanent residential aged care at some point during the year and 66,873 people received residential respite care. At 30 June 2020, there were 183,989 care recipients in permanent residential care (81 per cent of operational capacity). As at 30 June 2020, there were 845 residential aged care providers (providers) operating in

Australia with 2,722 residential care services, 2,605 of which also provided residential respite services.

These providers are a mix of for-profit and not-for-profit and state and local government organisations.

Current residential aged care funding arrangements

Funding overview

The Australian Government contributes to care funding on behalf of eligible Australians to providers. Funding is used by providers to deliver care in accordance with the Act. The Australian Government determines its contributions for care funding on behalf of permanent residents in residential care by setting:

- The basic care subsidy; a payment to support the costs of providing personal and nursing services for permanent residents. It is calculated based on the assessed needs of residents as determined by the provider applying the ACFI.
- The rates of supplements paid to support various aspects of residential aged care. These are paid in addition to the basic subsidy and are either primary supplements that provide additional funds to meet specific care needs or other supplements that assist providers with the operation of the facility.

In 2020 the Australian Government contributed around $13.4 billion to residential care to cover the basic subsidy and supplements, an increase of 6.6 per cent over the previous year. This amounts to approximately $69,055 per resident in care per annum. The vast majority of the Australian Government funding is paid through the basic subsidy ($11.9 billion in 2018-19). A breakdown of subsidy and supplements payments is at Table 1.

Table 1: Summary of Australian Government payments by subsidies and supplements for residential aged care

Type of Payment		**2015–16 $M**	**2016–17 $M**	**2017-18 $M**	**2018–19 $M**	**2019-20 $M**
Basic Subsidy	Permanent	10,507.7	11,024.2	11,163.5	11,947.4	12,012.7
	Respite	264.4	280.6	312.3	348.8	371.3
Primary Care Supplements	Oxygen	16.5	17.5	18.3	18.3	16.8
	Enteral Feeding	6.3	5.9	5.9	5.2	5.0
	Respite Incentive	29.0	30.1	34.6	40.6	46.8
Other Supplements	Viability	35.6	43.2	55.8	62.0	82.3
	Veterans'	1.8	1.1	1.6	1.7	1.5
	Homeless	7.6	8.3	8.6	9.8	13.3
Hardship	Hardship	5.2	4.9	4.0	3.9	6.5
	Hardship Accommodation	3.6	2.9	2.6	2.5	1.9
Accommodation Supplements	Accommodation Supplement	845.7	907.5	1,029.6	1,134.2	1225.1
Supplements related to Grandparenting	Concessional	64.0	64.0	55.6	51.3	40.2
	Transitional	6.0	4.8	3.8	3.2	2.6

Type of Payment		2015–16 $M	2016–17 $M	2017-18 $M	2018–19 $M	2019-20 $M
	Accommodation Charge Top-up	2.1	1.4	1.0	0.7	0.4
	Charge Exempt	3.8	2.0	1.8	1.7	1.4
	Pension	36.3	27.2	20.7	16.3	12.8
	Basic Daily Fee	0.6	0.4	0.3	0.2	0.1
	Transitional Accommodation Supplement	22.3	15.5	10.7	7.6	5.4
Reductions	Means Testing Reduction*	-455.7	-560.8	-564.0	-627.2	-648.2
	Other	-31.5	31.5	42.0	-9.1	231.7
Total ($million)		**11,371.4**	**11,903.8**	**12,204.2**	**13,014.5**	**13,429.7**

* New means testing arrangements (combined income and asset assessments) were introduced on 1 July 2014. Prior to these arrangements residents were subject to income testing only.

The Aged Care Funding Instrument (ACFI)

The basic subsidy is currently determined by the ACFI. On entry to a residential aged care facility, the ACFI is completed by facility staff and this initial assessment results in the resident being classified on each ACFI domain to one of four levels of need – *nil, low, medium* or *high* need. The ACFI domains are:

- *Activities of Daily Living (ADL)* – covering nutrition, personal hygiene, mobility, toileting and continence
- *Behavioural Domain (BEH)* – covering cognitive skills, cognition, wandering, verbal and physical behaviour and depression, and
- *Complex Health Care (CHC)* – covering medications and complex health care needs.

The daily ACFI subsidy rates from 1 July 2020 to 30 June 2021 are:

Level	Activities of daily living	Behaviour	Complex Health Care
Nil	$0.00	$0.00	$0.00
Low	$38.28	$8.75	$16.98
Medium	$83.36	$18.14	$48.37
High	$115.49	$37.81	$69.84

Aged care residents are appraised by their provider using the ACFI tool once the resident has been in the facility for a minimum of seven days. Appraisers are typically registered or enrolled nurses or external consultants with equivalent clinical qualifications. All new entrants to a facility are appraised using ACFI and it is the industry norm to reappraise all residents regularly throughout the year as well as when the resident's circumstances change in ways that may affect their care needs.

Most providers have responded to the ACFI by employing dedicated staff that manage ACFI records. Most providers use specialised software to assist them in performing the ACFI appraisals and record-keeping.

Under the Act, ACFI appraisals must be retained by providers for two years. The Department can request access to client information within those appraisals at any time during this period.

Data collected from 80 providers by aged care accountancy firm StewartBrown shows that in 2018-19 providers spent an average of $842 per bed on staff working in specialist ACFI roles and on external ACFI consultants. When extrapolated this would equate to approximately $200 million per year across all providers which represents approximately 1.4 per cent of the ACFI subsidy.

The Department runs an ACFI Review Program to ensure the validity of ACFI claims. Approximately 50 staff are employed in the Health Grants and Network Division to deliver ACFI review and reconsideration processes. ACFI Review Officers are responsible for conducting reviews of resident classification under the ACFI. They respond to incorrect claiming through the ACFI and manage any merits review (reconsideration) requests and appeals that may arise from these reviews.

Table 2 shows the number of ACFI reviews conducted in the third quarter of 2018-19, the number of ACFI appraisals that were re-classified (downgraded or upgraded) and those that were unchanged. This data illustrates that over 42 per cent of ACFI appraisals reviewed were found to have over-stated the care needs of the resident and consequently, over-claimed subsidy. The downgrading of those appraisals represented $75 million in subsidy adjustments in 2018-19.

Table 2: ACFI Review statistics for 2018-19, by state/territory (Source: ACFI Quarterly Reports)

ACFI Review statistics for 1 April 2019 to 30 June 2019, by state/territory								
State	**Downgraded**		**Unchanged**		**Upgraded**		**Total**	**No. of Services**
	Reviews	**%**	**Reviews**	**%**	**Reviews**	**%**		
NSW/ACT	387	51.3	366	48.5	1	0.1	754	72
VIC	110	33.4	216	65.7	3	0.9	329	52
QLD	108	29.1	261	70.4	2	0.5	371	49
SA/NT	40	38.8	62	60.2	1	1.0	103	12
WA	50	24.0	158	76.0	0	0.0	208	31
TAS	13	30.2	30	69.8	0	0.0	43	5
Total	**708**	**39.2**	**1,093**	**60.5**	**7**	**0.4**	**1,808**	**221**

Overall the ACFI can be characterised as highly prescriptive, and as placing a high regulatory burden, both through the appraisal process and complying with rules around retention of records and review processes.

Respite funding

Respite care is defined in the Act as 'residential care or flexible care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or care recipient a short-term break from their usual care arrangement'.

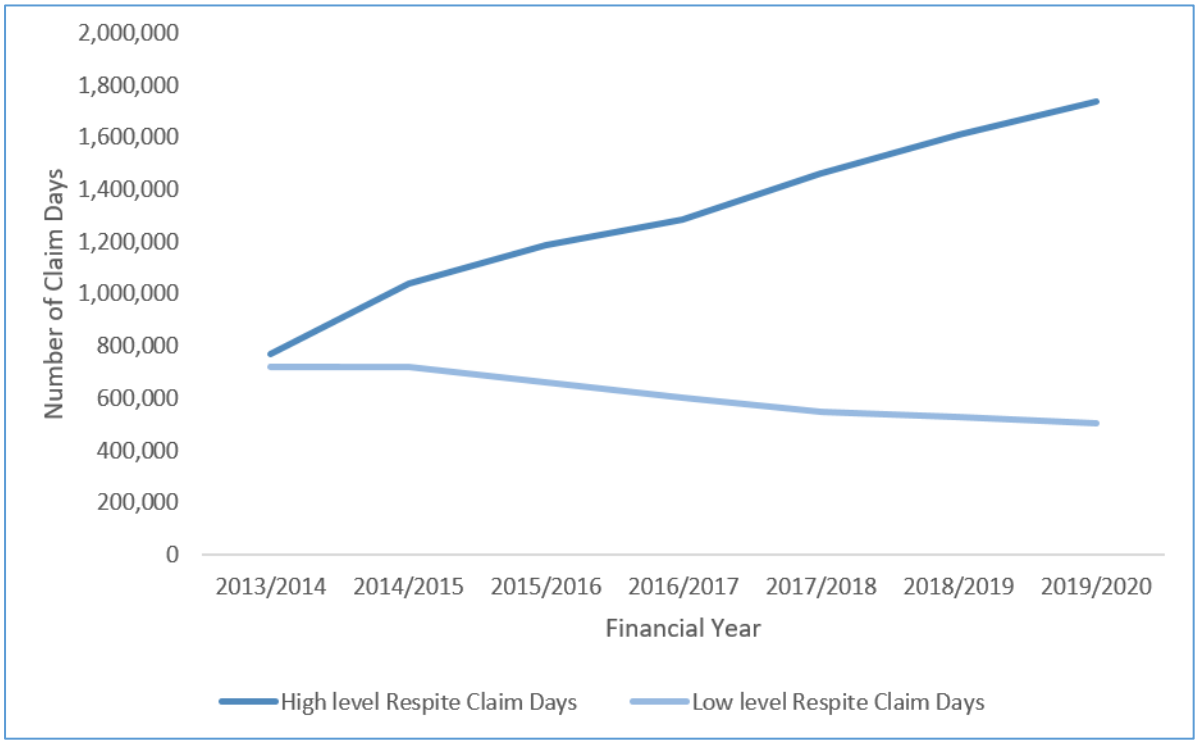
A person is eligible to use residential respite services following a face-to-face assessment by an Aged Care Assessment Team (ACAT) assessor. Respite users are entitled to 63 days of

subsidised respite care in a financial year. This approval can be extended by an ACAT assessor for up to 21 days at a time.

Residential respite approvals are issued at a *high* or a *low* level. As at July 2020, the total daily funding received by a provider for a resident classed as *high* is either $230.09 or $190.89 (depending on whether a provider uses more than 70 per cent of their respite allocation over a 12 month period, and excluding the temporary additional daily subsidy provided to August 2020 to assist with additional costs during the COVID-19 pandemic), whereas the total daily funding for resident classed as *low* is $88.02.

Over recent years there has been a significant increase in *high* level respite claim days, while the number of *low* level respite claim days has decreased (see Chart 1).

Chart 1: Provision of respite care days by high and low levels



Funding reform policy development to date

In 2016-17, the Government announced it would look into strengthening residential aged care funding, including possibly replacing the existing funding assessment tool, the ACFI and considering options for external assessment. This was in response to an unexpected increase of $3.8 billion over five years in the forward estimates for residential care expenditure.

As a first step in this reform process, the Australian Government commissioned two reports on residential aged care funding reform:

- Review of the ACFI by Applied Aged Care Solutions (AACS), and
- Alternative Aged Care Assessment, Classification System and Funding Models by the Australian Health Services Research Institute (AHSRI), University of Wollongong.

Review of the ACFI

Undertaken by AACS, this review of ACFI[1] made recommendations to align it with contemporary best practice as well as make it potentially suitable for external assessment. It proposed a revised ACFI (R-ACFI) and made a number of key recommendations including removing redundant items, attaching new weightings to items and mandating sign-offs on ACFI appraisals.

The review made clear that there was no quick fix for ACFI and highlighted the difficulty of making meaningful reforms without disrupting the whole funding model. The report was released in October 2017 and was not well received by the residential aged care sector, who were not convinced that the recommendations would address the issues in ACFI.

Alternative Aged Care Assessment, Classification System and Funding Models

AHSRI at the University of Wollongong was commissioned to undertake a study to develop options for future funding models that might be adopted for the residential aged care sector[2].

The study examined international evidence focusing on the assessment tools, classification systems and models for the allocation of funding for the provision of care and services in residential aged care.

The study explored five funding options:

- **Option one** – refinement of the current ACFI model
- **Option two** – a simplified model with four funding levels
- **Option three** – a simplified model with four funding levels, plus supplements and subject to external assessment
- **Option four** – a case-mix funding model with a branching classification
- **Option five** – a blended payment model with a variable (individualised) component based on residents care costs determined using a branching casemix classification, and a fixed (shared) component to account for care shared across all residents.

AHSRI's final report recommended that option five, the blended payment model, be adopted, and that a resource utilisation and classification study be undertaken to inform the development of the branching classification, and the proportion of fixed and variable costs.

Following the release of AHSRI's report, the Department consulted with the sector and the Australian public through a series of public events across ACT, NSW, VIC, SA, TAS, WA and QLD. Public feedback indicated an enthusiasm for funding reform, and further development of the proposed funding option.

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[1] The Applied Aged Care Solution Review of the ACFI is available here: https://www.health.gov.au/resources/publications/review-of-the-aged-care-funding-instrument-acfi

[2] Alternative Aged Care Assessment, Classification System and Funding Models Final Reports are available here: https://www.health.gov.au/resources/publications/alternative-aged-care-assessment-classification-system-and-funding-models-report

The Resource Utilisation and Classification Study

In August 2017 AHSRI, following a competitive procurement process, was commissioned to undertake the 'Resource Utilisation and Classification Study' (RUCS) of residential aged care.

The RUCS was a landmark study to provide an evidence base and inform the development of future funding models for residential aged care in Australia. The aims of the RUCS were to:

- identify the clinical and need characteristics of aged care residents that influence the cost of care (cost drivers)
- identify the proportion of care costs that, on average, are shared across residents (shared costs) relative to those costs related to individual needs (individual costs)
- develop a casemix classification based on identified cost drivers that can underpin a funding model that recognises both shared and individual costs, and
- test the feasibility of implementing the recommended classification and funding model across the Australian residential aged care sector.

The RUCS was composed of four separate but closely related sub-studies and included more than 80 facilities and over 3,000 residents. The final RUCS reports were received in January 2019 and published on the Department's website in March 2019. There were 30 recommendations in the reports to reform residential aged care funding including the implementation of a new blended funding model (based on the recommended option five, from AHSRI's original report), the AN-ACC funding model. This model is described in detail in Section 5.

Consultation on the RUCS reports was held from March to May 2019. The Department received 91 submissions which highlighted strong enthusiasm for ongoing conversations on funding reform and that the residential aged care sector is keen to be involved in the reform journey, while also noting concerns regarding the overall level of funding for the sector.

The Royal Commission into Aged Care Quality and Safety

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) was established on 8 October 2018 to look at the quality of aged care services and whether those services are meeting the needs of the Australian community. Further to this, the Royal Commission was tasked to examine the care provided in cities, as well as in regional and remote areas, and determine how aged care services could be improved.

The Royal Commission's final report was handed to the Governor-General on 26 February 2021 and included a number of findings relevant to residential aged care funding:

- Australian Government funding to approved providers should be done through a casemix-adjusted activity based model (**Recommendation 120: Casemix-adjusted activity based funding in residential aged care**). The Royal Commission recommended this model because it takes "into account the 'activity' of the approved provider at a given point in time (that is, how many residents it is caring for) and the 'casemix' of that activity (that is, the variation in needs of the

residents)."[3] This funding model, the Royal Commission explained, "…is to be based on assessment of needs and classification of individuals to one of a number of funding categories, each of which reflects the costs of caring for a person classified to that level of need."[4]

- **Recommendation 121: Incentives for an enablement approach to residential care** states that providers should get back paid to the date of request of reassessment where a reassessment determines a resident should attract a higher level of funding, and also that a resident should not be required to be reassessed for funding eligibility if their condition improves under the care of a provider.[5]
- There are two Royal Commission recommendations concerned with overall funding levels for residential aged care. **Recommendation 112: Immediate changes to the Basic Daily Fee**[6] proposed a $10 per resident per day increase to the sector, and **Recommendation 113: Amendments to the viability supplement**[7] proposed the continuation of the current temporary increases of the viability and homeless supplements until a new funding model is introduced.
- The Royal Commission also recommended a range of other reforms to improve the quality of care in residential aged care, most notably **Recommendation 86: Minimum staff time standard for residential care**, which proposed mandating minimum average care time per resident. The minimum staff time standard proposed by the Royal Commission is predicated on the operation of the casemix-adjusted activity based funding model for residential aged care (which allows the required staff time to then be adjusted to reflect the care needs of each resident class).[8]

The AN-ACC Trial

On 10 February 2019, the Prime Minister announced a $4.6 million trial of the AN-ACC assessment model. The purpose of the AN-ACC trial was two-fold:

1. Collect data to validate the expected distribution of care recipient classification under the AN-ACC model, as compared to the findings of the RUCS.
2. Field test the performance of:
    a. the AN-ACC assessment tool, which when administered produces residential aged care recipient functional status data required to calculate AN-ACC classification levels for individuals

[3] The Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3B*, Chapter 17, p.671

[4] The Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3B*, Chapter 17, p.671

[5] The Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3B*, Chapter 17, p.676

[6] The Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3B*, Chapter 17, p.645

[7] The Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3B*, Chapter 17, p.648

[8] The Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A*, Chapter 12, p.419

b. an independent assessment workforce trained to administer the AN-ACC assessment tool, and

c. the training, clinical and IT supports developed to equip assessors undertake assessments.

The impact of the COVID-19 pandemic, which included restricting non-essential access to aged care homes, led to the early conclusion of the AN-ACC trial and fewer assessments completed of residents than the original target of up to 12,000 residents of voluntarily participating RACFs across Australia. In the final analysis, 7387 AN-ACC assessments were completed (7276 permanent residents, 111 respite residents), across 122 homes.

The trial of the AN-ACC assessment model concluded that it is fit for purpose, can be expanded to a national scale, and AN-ACC assessments can be efficiently completed by an external assessment workforce.

The AN-ACC Shadow Assessment

A key preparatory step in the implementation of the AN-ACC, is the undertaking of independent care assessments for all new and existing permanent residential aged care recipients using the AN-ACC assessment tool. As such, the Australian Government is funding a year of 'shadow assessment', which began in April 2021.

The shadow assessment work is designed to lay the foundations necessary for a smooth and clean transition to the operation of the AN-ACC. The legislation to enable shadow assessment, the *Aged Care Amendment (Aged Care Recipient Classification) Act 2020*, was passed in December 2020.

During the shadow assessment phase, the ACFI continues to operate and be the mechanism through which funding assessments are made. The AN-ACC shadow assessments, in which all residents are assessed by an independent assessor using the AN-ACC assessment tool occur in parallel to ACFI assessments. That is, there are no changes to ACFI processes. The AN-ACC shadow assessment process does not affect the funding received by providers in relation to care recipients.

3. What is the problem you are trying to solve?

The current residential aged care funding model is no longer fit for purpose.

The model has contributed to a culture in the sector that focusses on funding ahead of care delivery. Funding levels determined by the ACFI are not aligned to the care needs of residents. The model has resulted in funding volatility for the sector and the Australian Government, has delivered unequal funding between regions and the incentives it creates can lead to perverse or negative quality outcomes. The Aged Care Financing Authority (ACFA) observed in their 2018 annual report that:

> *'[T]he current ACFI tool may suffer from no longer being contemporary (such as incentivising certain, sometimes outdated, types and modes of care delivery), it could encourage inefficiencies (through providers focusing limited resources on ACFI claiming) and appears to lack stability (with a history of cycles of high growth followed by low or no growth as higher than expected provider claiming leads to Government taking measures to reduce funding growth rates back to estimated levels)'.*

Moreover, funding for respite clients in residential aged care facilities no longer aligns with funding for permanent residential aged care, which creates distortions that favour use of beds for permanent care and limits access to respite services.

It is clear from the Royal Commission's final report that there are problems in residential aged care that extend beyond the funding arrangements, and that reforms to these arrangements will need to be part of a suite of reforms to the sector to ensure the system is fit for purpose going forward. As the scope of this RIS only extends to residential aged care funding arrangements, this section only provides analysis on problems that relate to such arrangements.

The remainder of this section provides a detailed description of the different elements of the problem with the current funding model.

Problem Element One – The ACFI incentivises poor and outdated modes of care

The ACFI directly links funding to the delivery of certain care activities. This has resulted in perverse incentives to deliver these care activities irrespective to whether they are necessary or appropriate to the resident. For example, four sets of twenty-minute pain management physiotherapy sessions are routinely provided to large numbers of residents due to the high level of ACFI funding they attract. However, this may not be in the residents' best interests as many residents have skin conditions such as paper thin skin which means such treatment can be detrimental and inflammatory to their condition. Alternative treatments such as light exercise may be better but are not offered to residents because they are not linked to specific additional funding under the ACFI.

ACFI can also incentivise dependence – for example, there is a perverse incentive to encourage dependency, such as immobility, in the resident as it may score higher in the ACFI, notwithstanding that the resident may benefit from greater reablement therapy to help them be more mobile.

Problem Element Two – Funding assessments detract from care planning and care provision

Providers currently use the ACFI tool to assess their own residents and so self-determine the funding they receive. The ACFI tool is heavily reliant on several detailed clinical assessments which require observational, multi-day measurements. Appraisers are typically registered or enrolled nurses or external consultants with equivalent clinical qualifications. Undertaking ACFI assessments and the completion of related paperwork consumes a substantial proportion of facilities' clinical resources, which would be better directed to providing quality care.

Data collected from 80 providers by aged care accountancy firm StewartBrown shows that in 2018-19 providers spent an average of $842 per bed on staff working in specialist ACFI roles and external ACFI consultants. When extrapolated this would equate to around $200 million per year across all providers which represents approximately 1.4 per cent of the ACFI subsidy.

Service providers indicated that the current ACFI processes takes the focus of care staff away from what they do best, delivering care, and requires them to undertake funding related 'paperwork'. Some providers even use external 'ACFI Consulting' services to perform the ACFI assessment. These businesses are increasingly operating under a 'no win no fee'

business model. In addition, the Australian Government runs a costly and time consuming validation processes, the ACFI Review Program, which has been one of the main sources of tension between providers and the Department.

Estimates from section 6 of this RIS suggest that the regulatory burden on providers of undertaking and submitting ACFI assessments, reassessments and meeting ACFI record keeping requirements is over $200 million per year. While any funding model providing care funding based on resident need will require resident assessments and reassessments, which under any model will place some regulatory burden on providers, the current model places a particularly excessive burden.

Problem Element Three – Inequity of funding to rural and remote

The distribution of funding across the sector is not equitable across geographic regions (see Chart 2). Daily average ACFI subsidies in 2018-19 were $179.20 in metropolitan areas and between $152.28 and $163.53 in the outer regional to very remote areas of Australia. This represents a significant difference in funding per resident between metropolitan and rural and remote providers.

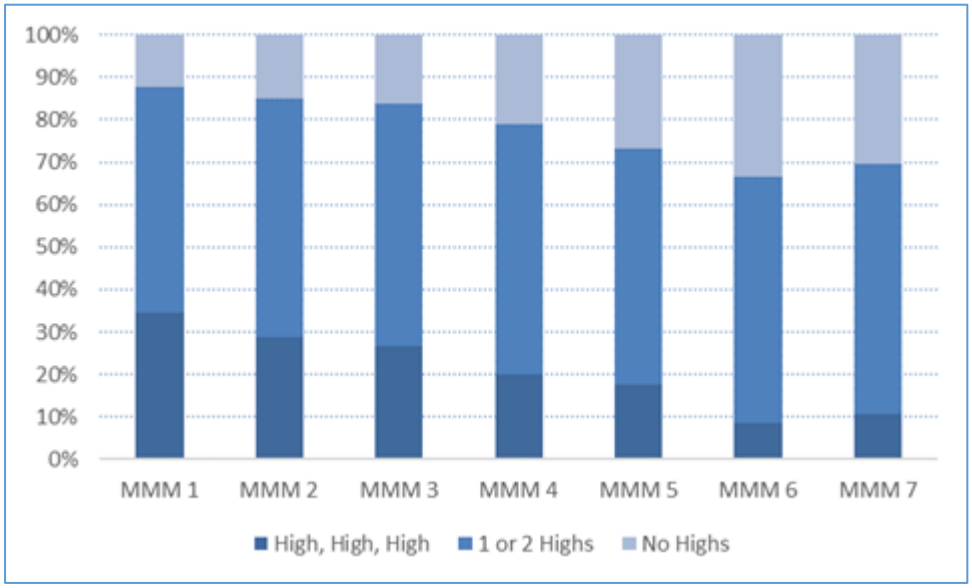
While it is possible that some of this difference in funding between regions can be attributed to genuine differences in resident characteristics, differences in ACFI claiming behaviour and less access to allied health professionals also contributes to lower subsidy rates in regional and remote areas.

Facilities (and providers) operating in outer regional, remote and very remote areas are often small in size and lack the economies of scale and scope which are found in more urban areas. Metropolitan providers can utilise these economies of scale to develop sophisticated approaches to maximising ACFI, including hiring specific staff to manage residents' ACFI scores across facilities to maximise funding.

In addition, in order to access the maximum funding under the ACFI, residents need to receive specific treatments from allied health professionals. Part of the reason for the lower ACFI scores in rural and remote areas relates to limited access to allied health professionals, to deliver these specific types of care.

Overall around 39 per cent of providers operate in only regional areas, and a further 10 per cent of providers operate in metropolitan and regional areas.

Chart 2: Proportion of ACFI classification mixes in claims from providers, by Modified Monash Model[9] remoteness classification 2019-20 (Source: ACFI data)



Problem Element Four – ACFI can no longer distinguish care needs of residents

The two reviews of the ACFI in 2017 (ACFI Review 2017; AHSRI 2017a) and ACFA's analysis of residential aged care funding indicate that the ACFI's ability to reliably guide funding calculations for residential aged care subsidy has degraded. In particular:

- ACFI cannot properly distinguish the care needs of residents and consequent funding support required, and
- ACFI has not been re-calibrated to reflect contemporary residential aged care service offerings or delivery.

The ACFI does not satisfactorily discriminate between residents based on their care needs. AHSRI found that ACFI explained only 20 per cent of the variation in costs of providing care to residents, creating strong incentives for facilities to cherry-pick residents based on their ability to attract a high ACFI revenue stream relative to their actual care costs. This creates potential access issues for high cost residents, while also creating financial risk for providers who care for residents with high costs relative to the subsidy they attract.

Problem Element Five – ACFI design leads to funding volatility

In 2015 and 2016, the Government increased the forward estimates for residential aged care funding by a total of $3.8 billion over five years to 2019-20. This followed a similar, unexpected blow out in funding in 2012-13. As a result, the Australian Government announced in the 2016-17 Budget that it would examine longer-term reform options as a way to ensure residential aged care spending does not fluctuate as it had previously.

[9] Remoteness here is defined using the Modified Monash Model (MMM), with MMM 6-7 defined as remote and very remote.

The Australian Government has responded to these unexpected funding increases by making changes to indexation arrangements or the ACFI tool itself in order to ensure the sustainability of spending on aged care. This pattern has resulted in Budget uncertainty for the Government and funding uncertainty for aged care providers.

Analysis completed by the Department, and also supported by the Applied Aged Care Solutions Review of ACFI[10], suggest that the increase in ACFI expenditure that led to the 2015-16 forward estimates adjustment did not appear to correlate with a commensurate overall increase in resident frailty.

The expense growth patterns are neither linear, nor consistent across all three domains of the ACFI, falling predominantly within the Chronic Health Care domain. These claiming patterns are not present across all parts of the sector. Applied Aged Care Solutions noted that the increase in claims coincided with benchmarking services becoming widely available, and specialist ACFI co-ordinator roles being established in most organisations.

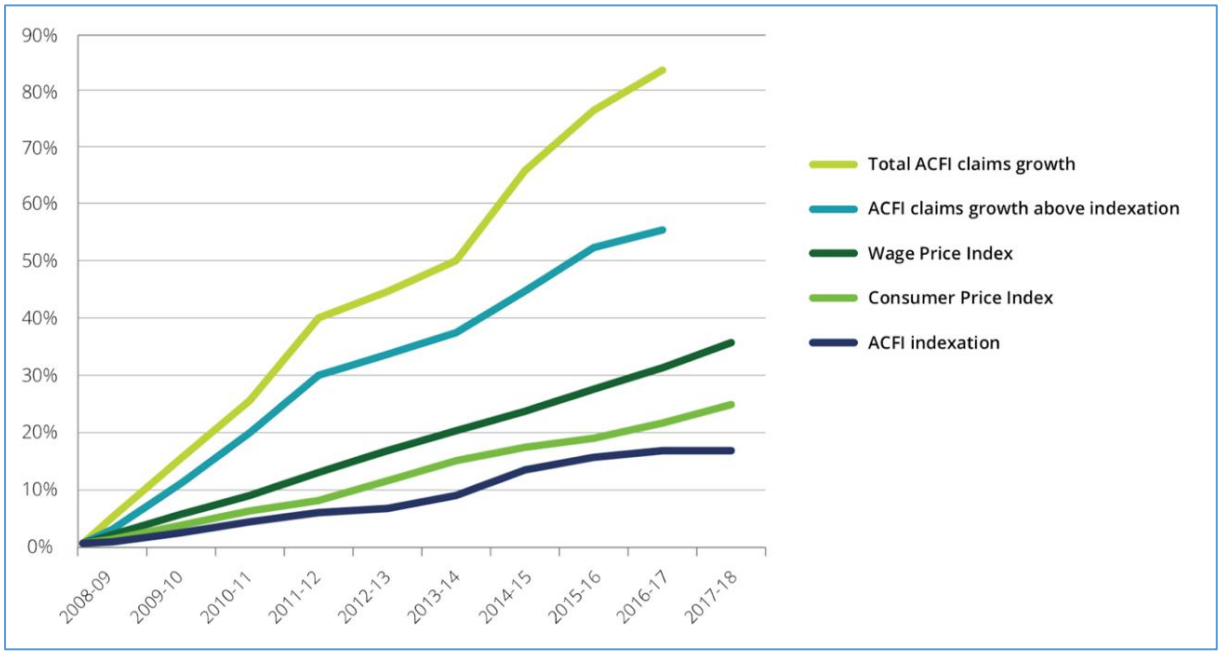
Together, this suggests that the ACFI is open to 'gaming' by providers seeking to maximise resident subsidies. This is further supported by the fact that 42 per cent of ACFI reviews in 2018-19 were found to have over-stated the care needs of the resident and consequently over-claimed subsidy.

Problem Element Six – Indexation does not align with changes in cost in residential aged care

The ACFA undertook a historical analysis of growth in ACFI subsidies and compared this to changes in cost indices. A key finding of their analysis was that the indexation applied to ACFI has been noticeably lower than the growth in a range of cost indices. Wages (which account for nearly 70 per cent of total costs) have grown approximately twice as fast as ACFI indexation. Noting that, overall, the actual average amount of ACFI subsidy paid to providers per resident per day has grown at nearly three times as much as wage and price indices. This growth reflects claiming behaviour under ACFI by providers.

[10] See page 36 of https://www.health.gov.au/sites/default/files/documents/2019/11/review-of-the-aged-care-funding-instrument-acfi-review-of-the-aged-care-funding-instrument-acfi-part-2-main-report_0.pdf

Chart 3: Cumulative change in aged care subsidies and costs, 2008–09 to 2016–17



The current ACFI arrangements cannot satisfactorily resolve the extent to which resident's care needs have been increasing over time compared with the extent to which providers have maximised the potential to use the ACFI tool to increase revenue growth (including as a response to low indexation).

Over time it is likely that the ability of the sector to gain revenue growth through ACFI claiming behaviours will diminish. This will put further pressure on the need for indexation arrangements to adequately reflect the growth in costs.

Policy Problem Seven – Respite funding does not align with permanent residential aged care funding

Respite provided in residential aged care currently operates on its own funding model without any relationship to the funding of permanent residential aged care. As providers have a set number of beds allocated by the Government, which they are able to choose to offer to permanent residents or residential respite residents, this has led to issues around resident access to respite as providers favour more profitable permanent residential care beds.

Stakeholder consultation by ACFA on respite in residential aged care noted concerns around the funding of respite, that it does not meet the costs of care and accommodation, has proportionally high administration costs compared to permanent residents and exposes providers to more financial risk compared to permanent residents.

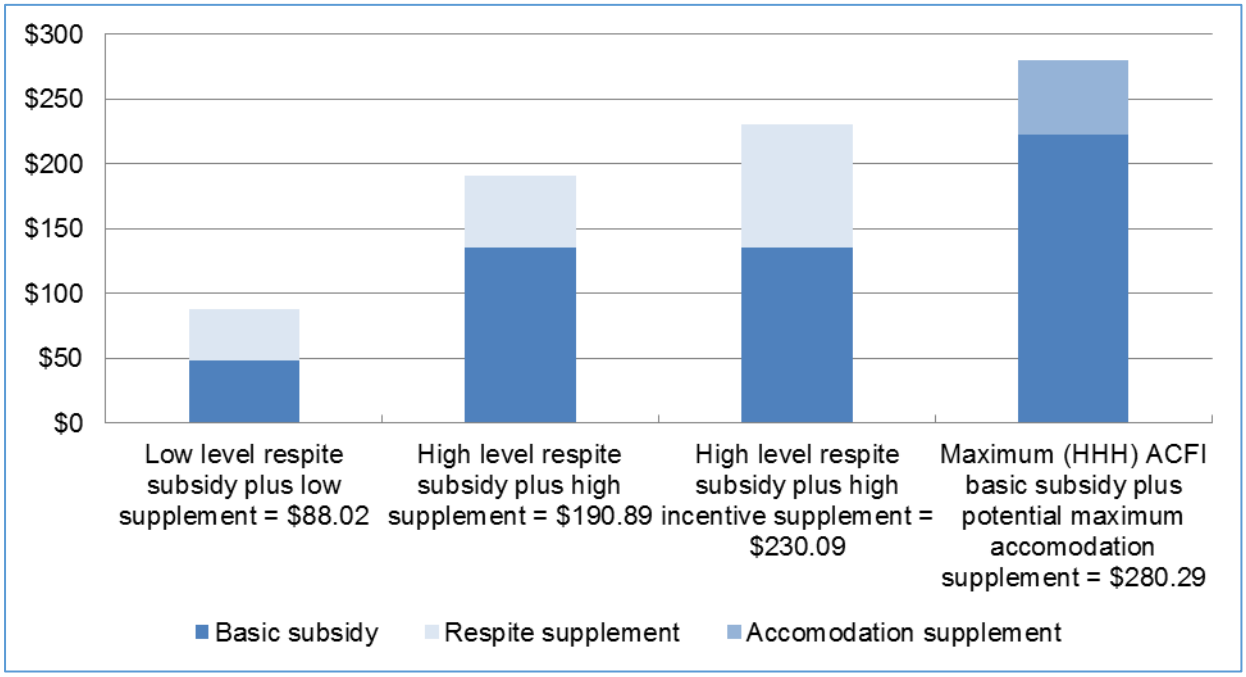
The highest ACFI rate plus the accommodation supplement for permanent residential care residents is notably higher than the funding for respite including with the care supplement and the 70 per cent occupancy incentive (see Chart 4).

The ACFA consultations also found a significant decrease in the provision of *low* level respite days over the last few years (see Chart 1).

As a result of this consultation, ACFA recommended that funding arrangements should be neutral between respite residents and permanent residents and not act as a disincentive to

provide respite care. ACFA also recommended looking at how the outcomes of the RUCS could be used to align respite and permanent residential aged care.

Chart 4: Amount of respite care basic subsidy plus respite care supplement compared to the maximum permanent care ACFI basic subsidy and potential accommodation supplement at 1 July 2020



4. Why is government action needed?

The Australian Government has policy responsibility for funding and regulating residential aged care in Australia. The Australian Government's funding of residential aged care is vital to ensuring residential aged care is affordable and available to all Australians who need it. Around three quarters of funding to providers comes from the Australian Government, with the remainder coming from resident contributions (noting that these resident contributions are currently regulated and set by the Australian Government not aged care providers).

Without Australian Government action to reform the current residential aged care funding arrangements, the sector will continue to focus on funding before care. Funding arrangements need to:

- Be more contemporary, efficient and effective, allowing provider assessment resources to be devoted to assessment for care planning purposes and supporting delivery of the right types of care, and
- be stable, providing greater certainty of funding levels for government, providers and investors, encouraging investment in the sector to meet future demographic challenges as demand for aged care grows.

In addition, having a robust and equitable residential aged care funding model would allow any future funding increases to the sector, for example to support improved sector viability and the delivery of higher quality care, to be delivered with confidence that it is being distributed appropriately. This will be particularly important as the Australian Government considers the appropriate funding level for the sector including to support the introduction

of minimum staff time standards and other potential changes in response to the Royal Commission's recommendations.

5. What policy options are you considering?

The Australian Government commenced investigating options to reform residential aged care funding arrangements in 2016. Since this time a number of options have been developed, considered, and based on earlier analysis are deemed to not be viable options for further detailed consideration.

The table below outlines these options:

Option	Assessment of option
Simplified model with four funding levels (see option two in AHSRI 2017 for further information)	Four funding levels means residents within each class are diverse in terms of their care needs and costs. This presents a financial risk to both providers and the Australian Government. This model also provides incentives for providers to select residents with low care costs relative to their funding class, creating access issues, especially for those with the highest care needs.
Simplified model with four funding levels, plus supplements and subject to external assessment (see option three in AHSRI 2017 for further information)	This model overcomes the issue of having residents with diverse care needs in the same payment bands by adding in a range of supplements. However, it was determined to be quite complicated and a significant policy change to implement, without all the benefits provided by a casemix funding model.
A casemix funding model with a branching classification (see option four in AHSRI 2017 for further information)	This model is very similar to the preferred option two in this RIS, but does not have the fixed /shared funding component. Given the RUCS showed that around 50 per cent of funding is shared between all residents, this option has been ruled out on the basis that a model which recognises this is fixed component is preferable.
R-ACFI with independent assessment upon entry to residential aged care and provider reassessment (see option one in AACS 2017)	It was determined that even with amendments to some items, the ACFI is not suited to independent assessment because it is too comprehensive to be undertaken effectively in a short period of time. In addition, the changes to the ACFI to get the R-ACFI were considered very significant without a sufficient benefit.
R-ACFI with independent assessment upon entry to residential aged care and a minimum of 25 per cent of reassessments (see option two in AACS 2017)	It was determined that even with amendments to some items, the ACFI is not suited to independent assessment because it is too comprehensive to be undertaken effectively in a short period of time. In addition, the changes to the ACFI to get the R-ACFI were considered very significant without a sufficient benefit.

The remaining options to be explored in this RIS are:

Option one – Keep the existing ACFI model

Option two – Adopt the AN-ACC model with independent assessors

Option three – Amend the ACFI to make it better align with contemporary care practices

These options are outlined and assessed in detail below.

Option one – No policy change

If the Australian Government made no changes to residential aged care funding arrangements, the current model where providers use the ACFI to assess residents, and then lodge claims for the subsidy based on the current ACFI scores would continue (outlined in detail in Section 2). ACFI reviews would continue to be undertaken in this scenario.

Option two - The AN-ACC model with independent assessors (the preferred option)

The AN-ACC model, derived from the University of Wollongong's RUCS, is based on real evidence on what drives relative care costs, and has an evidence-based methodology for determining funding increases.

Under the AN-ACC, the subsidy paid to the provider would consist of three components, a fixed component to account for costs across all residents, a variable/individualised casemix component based on each residents care needs, and an adjustment payment, paid on a time-limited basis when a new resident enters the facility. The staff time data collected in the RUCS indicated that close to 50 per cent of staff time was spent delivering care tailored to the specific needs of the resident, while the remaining 50 per cent was spent delivering shared care across all residents. This supports a payment model that includes a fixed per diem price for the costs of shared care and a variable price per day for the costs of individual resident care.

Resident assessments under the AN-ACC

A core element of the AN-ACC model is that resident assessments would be completed by external AN-ACC assessors (working for Assessment Management Organisations procured by the Department), within 28 days of a resident entering residential aged care.

Reassessments would also be undertaken by this workforce. These will be able to be requested by the provider where: (1) the resident has had a significant hospitalisation (2) the resident has a significant change in mobility; or (3) a standard time period has passed since the residents previous assessment (twelve months for Classes 2 to 8 (those classes with lower mortality rate) and six months for Classes 9 to 12 (classes for people who are not mobile and are expected to deteriorate at a higher rate)). Providers and residents would be able to request a reclassification.

This assessor workforce would consist of qualified registered nurses, physiotherapists and occupational therapists with at least 5-years' experience in caring for older people, who have complete approved AN-ACC assessment training and comply with continuing professional development requirements. These are more stringent qualification requirements than are currently placed on those able to undertake ACFI assessments.

This is because undertaking AN-ACC assessments requires a high degree of professional judgement that takes into consideration variance in a person's abilities and behaviours over a 24 hour period, where assessors may have to 'piece together' sometimes conflicting information to make professional judgements in a relatively short amount of time regarding the person's capabilities. Having a workforce that is suitably experienced and qualified to

skilfully undertake AN-ACC assessments is important for ensuring the accuracy of assessments and therefore the distribution of funding under the AN-ACC model.

As the Australian Government would fund the AN-ACC assessor workforce, providers would be free from bearing the costs of undertaking funding assessments; this would allow provider resources and staff to focus on care. Assessments related to care planning would continue to be undertaken by the residential aged care facility based on resident care needs and underpinned by consumer directed care principles.

The fixed funding component under the AN-ACC model

The fixed component reflects the costs of shared care for residents and includes costs of care that all residents generally benefit from equally. The fixed cost is the same for all residents in a particular facility.

Examples of fixed care include general supervision in common areas and night supervision. These costs are considered 'fixed' as they are not affected significantly by changes in individual resident care need.

Under the AN-ACC aged care homes will receive a per diem base care tariff (for fixed care) for all resident care days within the funding period. This fixed care tariff will vary between certain classes of facilities. For example, it will be higher in very remote facilities and for services catering for the homeless in recognition of their higher fixed costs. The differences in fixed care tariffs between different types of facilities are determined based on cost data collected as part of the RUCS.

The variable funding component under the AN-ACC model

The variable component is the casemix classification portion of the subsidy. Each resident is allocated a class based on their characteristics. This component will be different for different residents in a facility. In addition, there will be no limits on the mix of cases an individual provider can provide. The classification system is a branching model which enables the factors that drive care cost to be addressed interactively rather than operate in isolation. For example, two residents have cognitive impairment but one is mobile and the other is not. In the current ACFI system, cognition and mobility are each considered separately. In the AN-ACC, they are considered in combination.

In order to determine the variable funding component, residents will be externally assessed using the new AN-ACC assessment tool and placed into one of thirteen AN-ACC classes (see RUCS report 2 for further information on the 13 classes).

The AN-ACC assessment tool has been designed to capture the core resident attributes that drive care costs in residential aged care. It is designed to be robust and concise and is able to be undertaken by an external expert clinician who is not familiar with the resident in around one hour. The assessment would be undertaken within 4 weeks of entry into care.

Under the AN-ACC model there would not be any limit on the number (or proportion) of residents a provider (or facility) can have from each of the 13 classes at any time.

The adjustment payment component under the AN-ACC model

This payment recognises the additional, but time-limited, resource requirements when someone initially enters care. The 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 assessment e.g. pain management, and
- developing an advanced care directive in partnership with the resident and their family.

Annual costing study to inform price

Under the AN-ACC funding model, an annual costing study would be undertaken, involving the collection of cost data from all providers. An independent authority would be tasked with undertaking these annual costing studies, and using this information to recommend annual price increases to Government. It is proposed that the Independent Hospital Pricing Authority (IHPA) perform this role given their expertise in this area for the hospital sector. The annual price recommendations from IHPA would be made public to ensure accountability and trust between the sector and Government.

Integration of residential respite and permanent residential aged care funding models

As outlined in section 3, respite provided in residential aged care currently operates on its own funding model without any relationship to the funding of permanent residential aged care, or the costs of caring for respite residents of different care needs. This has led to issues around resident access to respite as providers favour more profitable permanent residential care provision. The introduction of the AN-ACC model presents an opportunity to align these funding models.

The RUCS demonstrated that the De Morton Mobility Index (DEMMI) – modified assessment a component of the AN-ACC assessment tool, which determines the first branch in the AN-ACC casemix classification) explains much of the difference in individual costs of care. The DEMMI is also relatively quick and easy to complete.

To align respite funding with the AN-ACC model it is proposed that the existing two classes (*low, high*) of respite care subsidy be replaced with a subsidy that incorporates a fixed component for costs that are shared across residents (aligned with AN-ACC) and an individual component with three funding classes (*one, two, three*), determined by the outcomes of an assessment using the DEMMI by the aged care entry assessment workforce.

The existing respite supplement and respite incentive would be replaced with a new accommodation supplement for respite care, which would be aligned with the accommodation supplement rates payable for permanent residential care (without the reduction applied for not meeting the supported resident ratio).

This will effectively align respite with permanent residential aged care funding and ensure that both are indexed/priced using the same model, preventing the divergence in funding that is currently occurring.

Is it necessary to adopt all elements of the AN-ACC model?

While it would technically be possible to adopt some aspects of the AN-ACC model, and not others, this would significantly risk the success of the model, for example:

- if the AN-ACC classification and funding model was adopted without the introduction of an external assessment workforce (providers continued to undertake funding assessments) the model would likely be gamed by some providers, and so the issues with funding uncertainty with the current ACFI model would persist;
- if the AN-ACC model was adopted without the annual costing study and price determination process, then the current issues with subsidy increases not reflecting changes in the costs of providing care would remain; and
- if the AN-ACC model was adopted without integrating respite funding arrangements with permanent residential aged care funding arrangements, then the disparity in funding between the two systems would remain, and likely become exacerbated over time, leading to further issues for older Australians seeking respite care.

Appendix 1 provides further detail on the AN-ACC model.

Transition fund

Finally, a short-term transition fund is to be established to support providers that may face a funding reduction in the move to AN-ACC.

Option three – Amend the ACFI to make it better align with contemporary care practices

This option is being considered because it brings incremental improvements from the current model, without major change to the system.

Under this option the key features of the current ACFI are maintained, including provider assessment and the ACFI Review process, but adjustments would be made to rationalise ACFI items and remove items found to be redundant, and better align the ACFI with contemporary care practices.

Redundant items that could be considered for removal include grooming checklist items, and some of the conditions in the CHC domain found to only be relevant for a very small number of residents. Removal of these items would have the benefit of making the ACFI assessment pack slightly quicker to complete.

The restrictions on the therapies that can be carried out to claim the pain management items (ACFI 12.4.a. and b.), would be replaced with a more broad based therapy program as was recommended in the Applied Aged Care Solutions review of ACFI (see AACS 2017 for further details). This program would be available to all residents, and would encompass a broad range of physical therapy interventions to manage pain, maintain general wellness, and where relevant re-able residents.

Providers would need to keep records (which would be audited) to prove that they are providing evidence based therapies, and to ensure therapies are indeed being provided where they are claimed to be.

Respite arrangements would not be amended under this option, and respite funding levels would continue to be determined externally to providers by the aged care assessment workforce, rather than the refined ACFI assessment. This is because having providers undertake ACFI assessments on respite residents is considered too administratively burdensome to be worthwhile for the short-term nature of respite stays.

6. Impact analysis

Option One: No policy change

Under this option, no change to residential aged care funding arrangements would be made by Government, and the current funding model would continue.

The regulation imposed on providers would remain unchanged, and there would be no improvement in outcomes.

Option Two: The AN-ACC model

Assessment of the benefits

Option two aligns care needs and cost drivers in residential aged care to ensure funds are directed where they are needed. In addition, the introduction of independent assessment of residents for funding purposes will remove incentives for providers to focus on funding over care, and will assist in driving a culture of quality. Option two addresses **all seven problem elements** with the current residential aged care funding system outlined earlier in this RIS.

Option two, it must be noted, does not address all of the problems that exist in the residential aged care sector as a whole; it is just focused on the funding element of the equation. In order to respond to the additional problems, a broader package of measures is being implemented alongside the AN-ACC. These measures are the subject of a separate regulation impact process.

The benefits of the AN-ACC model for **older Australians** include:

- better quality care driven by the removal of incentives for providers to focus on funding claims over care delivery (see **Policy problem two**)
- outdated and ineffective care no longer being incentivised by the funding model, which would encourage delivery of better care (see **Policy problem one**)
- more equitable access to care, particularly for residents with very high care needs as providers will have much lesser incentives to 'cherry pick' residents with relatively low care costs compared to funding level (see **Policy problem four**)
- more access to respite care as the funding is better aligned with permanent residential care, and (see **Policy problem seven**)
- the casemix resident classification system in the AN-ACC, which comprises 13 classes, provides a better measurement of care outcomes, which would drive improvements in care (see **Policy problem one**).

The benefits of the AN-ACC model for **residential aged care providers** include:

- The time consuming task of conducting and maintaining funding assessments would no longer need to be completed by providers, allowing more time for staff to focus on quality care provision (see **Policy problem two**)
- The variable/individual funding component for each resident is based on known cost drivers (based on evidence from the RUCS), so the subsidy each resident attracts aligns with care costs. This alignment of care costs with subsidy received leads to a reduction in financial risk and greater equity for providers (see **Policy problem five**)

- A shift to an annual costing process would also ensure that the subsidy is more aligned with changes in care costs overtime compared to the current indexation model, ensuring financial sustainability for providers (see **Policy problem six**).

The AN-ACC funding model provides fairer funding arrangements for rural and remote providers (see **Policy problem three**), because:

- Facilities operating in MMM 6-7 regions would receive a greater amount of fixed funding per resident to account for the extra costs they face in providing care in these regions
- Rural and remote providers would not receive less funding because of reduced access to allied health professionals (under the AN-ACC, certain funding levels require specific treatments from allied health professionals, whereas the variable/individual funding component is solely determined by resident's characteristics)
- Smaller providers (often in rural and remote areas) who are less able to dedicate resources towards maximising their funding claims would not be disadvantaged under the AN-ACC because of the independent assessment process.

Allied health professionals working in residential aged care would also benefit from the AN-ACC model, as they will have a greater ability to provide care that is aligned with clinical best practice and residents' aspirations. However, there is a risk that providers reduce allied care services within residential aged care when the requirement to provide certain treatments to access additional funding is removed. This risk will be addressed through a broader package of measures that is being implemented in response to the Royal Commission.

The only group that would be affected negatively in a substantive way by the introduction of the AN-ACC model are companies that work on assisting aged care facilities with maximising their ACFI claims. Data collected from 80 providers by aged care accountancy firm StewartBrown show that around $200 per operational place is spent on specialist ACFI consultants per year. If this level of spending exists more broadly across the sector then this equates to around $42 million spent on ACFI consultants per year.

Given ACFI consultants are generally qualified health professionals such as registered nurses, or physiotherapists, it is likely that this workforce would not have great difficulty gaining alternative employment. Indeed, some of these consultants may be employed in the aged care system as care givers (as providers spend some of the funding on care that they currently spend on ACFI assessments and record keeping), or become part of the AN-ACC funding assessment workforce.

Risks

The key risks with the AN-ACC model relate to implementation. The model represents a significant shift from the current model, and requires significant changes to legislation. Some of the implementation risks, however, have already been mitigated with the passage of legislation in December 2020 (the Aged Care Amendment (Aged Care Recipient Classification) Bill 2020) that has enabled the operation of the AN-ACC shadow assessment phase, which began in April 2021. To undertake the shadow assessment phase, the Department has procured the services of six independent Assessment Management

Organisations, and a Registered Training Organisation to conduct training. In addition work is well underway at Services Australia to develop the IT system to support the implementation of the AN-ACC model.

The completion of the AN-ACC shadow assessment phase will require careful management of the risk posed by COVID-19 transmission, particularly in residential aged care facilities. To manage and mitigate this risk, all assessors will be required to have been vaccinated against COVID -19 as soon as it available to them, and follow the advice of the relevant state and territory health authorities.

The risks of providers being able to 'game' the AN-ACC model to maximise funding above what is equitable is considered low because of the external assessment process. While AN-ACC assessors do take into consideration clinical notes, and discussions with care and clinical staff in undertaking their assessments, they are trained to ensure any incongruence between what they are observing and the information they are being provided from those working in providers is fully explored. Furthermore, the annual costing process also limits the financial impact of any unjustified up-coding of residents.

The introduction of AN-ACC would bring about a redistribution of residential aged care funding between different providers. In general, the AN-ACC model will move some funding away from providers in major cities towards regional and remote areas. This is tied to expected changes in funding by resident classification (based on each individual resident's characteristics) and the introduction of the fixed funding component (which will cover the costs of care that are shared equally by all residents). This redistribution of funding is considered an acceptable outcome on the basis that it is correcting inequalities in the current funding model, and supports those providers currently facing the greatest threats to their viability. The short-term transition fund will provide transitional grant funding to providers that may face a funding reduction in the move to AN-ACC that they are unable to otherwise manage effectively.

Assessment of regulatory burden

The regulatory savings and costs of this model are outlined in Table 3 below. The AN-ACC model would provide around $225 million of regulatory savings, with $127 million of this to not-for-profit providers and $98 million to for-profit providers.

Table 3: Regulatory costs and savings of AN-ACC model[11]

Activity	Regulatory impact
Providers no longer need to undertake and submit ACFI assessments, reassessments and meet ACFI record keeping requirements	**$235.59 million save for providers per annum** • $132.83 million to community organisations (not-for-profit providers) • $102.75 million to business (for-profit providers) Estimate is based on survey data from StewartBrown showing the average amount providers spend on specialist ACFI staff and consultants per bed per annum.
Providers need to provide financial data to the Department at the facility level to enable the annual costing studies	**$1.36 million cost to providers per annum on average** • $0.78 million to community organisations • $0.58 million to business Estimate is based on the assumption that it will take providers approximately 5 hours of an accountant's time per facility per year.
Having external assessors come to do AN-ACC assessments and reassessments	**$9.26 million cost to providers per annum on average** • $5.30 million to community organisations • $3.95 million to business Estimate is based on the assumption that it will take approximately 20 minutes of a nurse's time per resident per year.
Participation in periodic studies to update the classification tool (every three years)	**$0.14 million cost to providers per annum on average** • $0.08 million to community organisations • $0.06 million to business Estimate is based on the assumption that these studies will occur every three years, involving 30 facilities, and take approximately 150 hours of nurse time per facility.
Administration work for new entrants categorised as Class 1 (Palliative)	**$0.05 million cost to providers per annum** • $0.028 million to community organisations (not-for-profit providers) • $0.021 million to business (for-profit providers) Estimate is based on the assumption that it will take providers approximately 10 minutes of managerial/administration time per new entrant categorised as Class 1 (Palliative care) in a residential aged care facility.
AN-ACC Temporary Transition Program	**$0.0054 million cost to providers per annum** (only in 2022-23 and 2023-24) • $0.0032 million to community organisations (not-for-profit providers) • $0.0021 million to business (for-profit providers) Estimate is based on the assumption that it will take approximately 4 hours of managerial/administration time to apply for and manage access to the grant per year (for two years only).
Total regulatory burden	**$224.77 million save** • $126.64 million to community organisations (not-for-profits) • $98.13 million to business (for-profit providers)

[11] The regulatory costs included in this RIS include the costs to community organisations (i.e. not-for-profit providers, and to business (i.e. for-profit providers). The regulatory costs to state government residential aged care providers are excluded to ensure consistency with the Regulatory Burden Measurement Framework.

Net impact of option two

Overall, this option provides a substantial reduction in regulatory burden while also addressing the seven problems with the current model, and providing substantial benefits to residents and providers. For this reason it is the recommended option.

Option Three: Amend the ACFI to make it better align with contemporary care practice

This option provides modest benefits to providers, residents and allied health professionals.

Residents would benefit from receiving allied health care that is more clinically appropriate and in line with their preferences and aspirations.

Providers would benefit from greater freedom to provide clinically appropriate allied health care, and also by no longer having to spend time completing redundant ACFI items in ACFI appraisals and reappraisals.

Providers would, however, also face costs in maintaining records of allied health treatments for each resident, and ensuring these treatments meet the criteria to be funded.

Allied health professionals working in aged care would benefit from having greater ability to provide care that is aligned with clinical best practices.

While this option addresses problem element one, by reducing incentives for poor and outdated care, it does not address the other six problems with the current ACFI model.

Risks

This model remains open to significant gaming as it is a provider assessment model. This model would be inconsistent with the recommendations of the Royal Commission given its support for a casemix model. Furthermore, if the Australian Government were inclined to provide a significant funding boost to the sector in response to the Royal Commission, it would be near impossible to do it in an equitable way under an ACFI model that is open to gaming, and does not distribute funding based on known care costs.

There is also a very high risk that this model could exacerbate the funding disparity between metropolitan and rural and remote providers, as there is a shortage of allied health professionals available in some rural and remote areas, and so providers in these areas would miss out on the additional funding to provide the therapy program included in this model.

Assessment of regulatory burden

The regulatory savings and costs of this model are outlined in Table 4 below. The amended ACFI model would provide around $13 million of regulatory saves, with $8 million of this to not-for-profit providers and $6 million to for-profit providers.

Table 4: Regulatory costs and savings of the amended ACFI model

Activity	Regulatory impact
Providers to provide evidence that the allied health therapies provided to residents are evidence based, relevant to each residents needs and actually provided.	**$5.66 million cost for providers per annum** • $3.24 million to community organisations • $2.42 million to business Estimate is based on the assumption that it will take approximately 15 minutes of a nurse's time per resident per year.
Providers no longer need to have to verify that they are providing one of the approved allied health treatments to claim 12.4 a or b in the CHC domain	**$20.13 million save for providers per annum** • $11.53 million to community organisations • $8.60 million to business Estimate is based on the assumption that it takes approximately one hour of a nurse's time per resident per year.
Providers no longer need to fill out a number of redundant ACFI items	**$1.08 million save for providers per annum** • $0.62 million to community organisations • $0.46 million to business Estimate is based on the assumption that it takes approximately 5 minutes of a nurse's time per resident per year.
Net regulatory burden	**$13.40 million save for providers per annum** • $7.68 million to community organisations • $5.72 million to business

Net impact of option three

Overall, this option provides a reduction in regulatory burden to providers of $13.40 million as well as some modest benefits to residents, providers and allied health professionals. However it does not address the majority of the problems with the current model outlined in Section 3.

Comparison of the regulatory impacts of the three options

Average Annual Regulatory Costs (from business as usual)				
Change in Costs ($m)	**Business**	**Community Organisations**	**Individuals**	**Total change in cost**
Option one	0	0	NA	0
Option two	98.13	126.64	NA	224.77
Option three	5.72	7.68	NA	13.40

7. Consultation

Upon the announcement in 2016-17 that the Australian Government would investigate options to strengthen residential aged care funding, the Department commenced consultation with a broad range of internal and external stakeholders to gauge appetite for residential aged care funding reform.

A series of 10 roadshows and a webinar (held from May to July 2017), emphasised stakeholder's openness to reform. The internally prepared evaluation report on these

events recorded strong support for a new approach to care classification and funding, and demonstrated a groundswell of disenchantment with ACFI. Through these events, stakeholders were first introduced to the concept of a fixed/variable funding model based on the findings from the University of Wollongong's Alternative Aged Care Assessment, Classification System and Funding Models. The Department also flagged with stakeholders that a resource utilisation classification study would be commissioned to inform the adoption of a fixed/variable model.

Upon commissioning the University of Wollongong to undertake the RUCS, the Department appointed a Resource Utilisation Classification Study Sector Reference Group (RUCS SRG) in 2017-2019 to provide a sounding board on the aged care sector's impressions of the RUCS early findings, and to discuss the practicalities of implementing a fixed/variable funding model via external assessment. Members were appointed based on their technical expertise and experience – and included a mix of aged care managers, clinicians, finance officers and other administrators.

In tandem, several stakeholder forums were held with a broader audience to communicate the RUCS findings, with all material published online for transparency.

RUCS SRG members were optimistic that the AN-ACC proposals would transform and improve the payment of residential care subsidy (permanent and respite), with many members volunteering to act as change champions should the Australian Government agree to the reform. This engagement signalled to the Department that the sector was ready to transition away from ACFI, and that the AN-ACC, recommended through RUCS, held broader appeal.

The Department also released a Consultation Paper in March 2019 (closing in May 2019) to explain the AN-ACC model in plain language, and seek sector feedback. 91 submissions were received. The majority of these submissions indicated general enthusiasm for the AN-ACC model and re-emphasised the sector's disenchantment with ACFI.

The idea of external assessment was also generally supported, although some submissions raised concerns over whether workforce could be found to efficiently undertake assessments in rural and remote areas. Other submissions questioned whether the external assessment process will significantly reduce the administrative burden on providers, given the external assessment process still involves some level of interaction and assistance from staff within a facility.

Most submissions also emphasised the need for the total level of funding to the sector to also be considered.

Later in 2019, the RUCS SRG was superseded by a broader based committee in recognition that the RUCS research was now finalised, and a greater number of stakeholders needed to be engaged. The majority of members transitioned onto the new Residential and Aged Care Funding Reform Working Group. This group was inaugurated in November 2019 to advise the Department on residential aged care funding reform activities, including how to prepare the reform readiness of the residential aged care sector.

The Residential and Aged Care Funding Reform Working Group is made up of around 25 members, and includes former RUCS SRG members, and also includes peak bodies, consumer representatives, academics and rural and remote representatives. This group is integral to helping the Department finesse its approach to change and transition over time.

The Department is also planning to undertake further consultation with the sector through the release of the changes to Principles as exposure drafts for consultation immediately subsequent to the passage of the primary legislative changes. This will allow for refinement of the finer details of the model in early 2022, prior to final implementation of the model.

There would be additional opportunities for regular consultation with stakeholders on the operation of the AN-ACC model through the evaluation strategy the Department would roll out. After two years of full operation in 2024, the Department would commission a broader review of the AN-ACC model.

8. What is the best option from those you have considered?

As has been outlined in Section 3 and Section 4, the case for government intervention and significant reform to the current residential aged care funding arrangements is strong and compelling.

Option 2 (the AN-ACC model with independent assessors) is the best option of those considered in this RIS by a significant margin. This model clearly addresses all seven policy problems outlined in Section 3, and in doing so provides clear benefits to permanent and respite residents, providers and the Australian Government.

This model also provides the largest regulatory savings of all options $225 million per annum).

9. How will you implement and evaluate your chosen option?

The aim of the preferred option is the staged introduction of the AN-ACC residential aged care funding system as an approach to funding providers that, in comparison to current arrangements based around use of the ACFI, is:

- more contemporary, efficient and effective, allowing provider assessment resources to be devoted to assessment for care planning purposes and supporting delivery of the right types of care, and
- more stable, providing greater certainty of funding levels for the Australian government, providers and investors, encouraging investment in the sector to meet future demographic challenges as demand for aged care grows.

Stages in implementation

There are two stages in implementation of the new residential aged care funding model.

The first stage of implementation, announced in 2020, involved the commencement of work on a new residential aged care payment system, and changes to the Department's IT systems to support the potential implementation of the AN-ACC, as well as undertaking a year of what is known as 'shadow assessment', which commenced in April 2021. During the shadow assessment period, all existing and new care recipients will be assessed using the AN-ACC assessment tool to allow a clean transition to the new funding model without complicated grand-parenting arrangements.

The legislation to enable shadow assessment was passed in December 2020, now referred to as the *Aged Care Amendment (Aged Care Recipient Classification) Act 2020*. During the shadow assessment period, current procedures for care recipient appraisal and classification

and for determining rates of subsidy for provision of residential aged care (that is, ACFI arrangements) continue as normal.

The second stage of implementation, agreed by the Australian Government in the 2021-22 Budget, and subject to passage of legislation, would see funding commence under the AN-ACC model from 1 October 2022.

Legislation will be introduced in the Spring 2021 session to enable the commencement of the AN-ACC funding model.

Implementation governance

For both tranches, the responsible Minister is responsible for introducing and ensuring passage of enabling primary legislation changes.

For both tranches, the Minister with responsibility for Aged Care will be responsible for signing associated legislative instruments to establish detailed procedures for the new arrangements allowed by primary legislation.

For the first tranche, the Secretary of the Department, and other officers of the Department as delegated, are responsible for operationalising the detailed assessment and classification procedures created by legislative instruments. This includes:

- procuring an assessment workforce to operate under formal delegation of the Secretary
- procuring an assessment workforce training content and delivery provider
- ensuring the quality and consistency of workforce and workforce training operations, and
- creating and maintaining departmental (predominantly My Aged Care-hosted) IT tools and systems to enable assessment activity and the processing of resulting data to determine care recipient AN-ACC classifications.

For the second tranche, the Secretary of the Department, and other officers of the Department as delegated, are responsible for operationalising the detailed subsidy determination procedures created by legislative instruments. This includes:

- ceasing all ACFI-related activities, allowing for a transitional period to complete audits of ACFI claims made by providers close to the cut-over date; and
- ensuring care recipient classification and other data required to calculate payments to providers is provided to Services Australia.

For the second tranche, the Secretary of the Department of Human Services (through the CEO, Services Australia), is responsible for delivering, maintaining and operating subsidy payment capability.

For the second tranche, providers and care recipients of residential aged care are responsible (under legislated terms) for providing AN-ACC assessors with reasonable assistance to complete their assigned assessment tasks.

The Minister responsible for aged care will be responsible for setting the AN-ACC starting price. From July 2023 the price will be set by the Minister based on advice provided by the independent aged care pricing authority (proposed to be the expanded existing

Independent Hospital Pricing Authority). The advice provided by the pricing authority will be made public to ensure transparency.

A formal governance structure has been established between the Department and Services Australia to manage the Residential Aged Care Funding Reform (RACFR) Programme. The Governance arrangements described here reflect the joint delivery, recognising that both the Department and Services Australia have existing internal governance requirements and arrangements, as well as the collective RACFR Programme governance described below.

The primary point of Governance intersection is the **AN-ACC IT Delivery Board**. The AN-ACC IT Delivery Board is the governance forum that provides oversight and executive support for the joint delivery of Funding Reform, including the IT build of the new payment system for residential aged care and associated changes to Aged Care IT systems. The Board will provide policy, business and technical direction, and make decisions affecting the joint delivery, and is responsible for overseeing implementation, and ensuring there is appropriate coordination across Services Australia and the Department.

Each of the groups referenced below contribute to the overall governance and delivery of the RACFR Programme.

The Residential Aged Care Design Authority **(RDA)** - a subset of the AN-ACC IT Delivery Board, which it supports by providing design direction, assurance, and recommendations. This role includes considering both business design and technology implementation, guiding design development and application, and ensuring alignment with strategic programme intent.

Programme Delivery Working Group - a forum to discuss integrated planning and delivery activities across both Agencies to support the delivery of the reform. Meetings will include an update from all key work streams including Policy, Procurement, User Experience & Transition and ICT Delivery with the recording of key actions, decisions and Programme risks and issues.

Architecture and ICT Working Group - Responsible for progressing the joint technology integration to deliver the new end to end system functionality across the Department of Health and Services Australia's required for residential aged care funding reform.

Policy Working Group - responsible for identifying the policy questions that are required to drive the development of the enabling systems for residential aged care funding reform.

User Experience and Transition Working Group - responsible for the identification and integration of stakeholder engagement and communication activities, particularly where they impact on shared stakeholders.

Risks, Assumptions and Dependencies

A major risk outside the Department's control to the implementation of the AN-ACC is the timing of the passage primary legislative changes to support the move to the AN-ACC model. This risk is accepted and monitored closely for impact on the implementation timeframe.

The Department is confident that services required to implement the AN-ACC assessment function is readily available. This is based on the findings of the AN-ACC trial, and recent experience in procuring a workforce for shadow assessment.

Further, development of the AN-ACC assessor training program and materials has already been completed. AHSRI at the University of Wollongong developed the initial material and program for the RUCS, and then the AN-ACC trial. This has now been refined by Latrobe University (procured to deliver the shadow assessment training) and is currently being rolled out to AN-ACC assessors for shadow assessment. Data sharing arrangements and an assessment quality framework require further development before national rollout, but are included in forward planning.

The changes to the Department's IT systems to enable the commencement of the AN-ACC are resourced, and significant work is already underway to ensure capability is in place prior to the October 2022 start date.

The major dependency for implementation of the reform as planned is Services Australia delivering the new payment system capability to handle AN-ACC payments by 1 October 2022. The department is already working closely with Services Australia on scope, design, build, test and delivery tasks, at both governance and operational levels.

Evaluation

The Department is planning a multi-level evaluation strategy, consistent with the systemic nature of the AN-ACC reform.

The contract with the ongoing workforce training provider would include a training evaluation and continuous improvement requirement, to be informed by quantitative and qualitative data sourced from assessor performance information and from assessor and provider experience interviews and surveys. The evaluation approach would be required to use both process and outcome measures.

Assessor performance would be monitored and evaluated, including for lessons learned about the ongoing suitability of the assessment tool and enabling IT. Methods would include management audit, peer review, and a formal, department-led programme of inter-rater reliability testing of the comparative consistency of assessments across the assessor cohort.

The Department is exploring the feasibility of publishing the de-identified data resulting from assessments, to encourage independent academic research on factors correlating with better practice care provision by providers and improved care experience for recipients.

The Department will monitor financial impacts through payment system data produced by Services Australia. The annual independent pricing review function will additionally use costs data supplied by providers as a key input in forming its recommendations about the overall funding envelope and specific subsidy rates within it.

At the overall level, the department would report various financial and output metrics annually in the Portfolio Budget Statement, the Annual Report and in the Report on the Operation of the Act.

While ACFI and other legacy funding arrangements would cease in October 2022, ACFI influences on provider behaviour may take some time to wash out of the system. The Department proposes to undertake a review of the AN-ACC model as a whole after two years of full operation, once it becomes possible to assess accurately the extent to which it is achieving reform objectives.

10. Appendix 1: Detailed overview of the AN-ACC model

The new assessment and funding model developed as part of the Resource Utilisation and Classification System (RUCS) has been termed the Australian National Aged Care Classification (AN-ACC) system. The AN-ACC assessment and funding model is based on six key design elements:

1. Resident assessment for funding to be separate from resident assessment for care planning purposes
2. Assessment for funding purposes to be undertaken by external assessors capturing the information necessary to assign a resident to a payment class
3. Assessment related to care planning to be undertaken by the residential aged care facility based on resident needs and underpinned by consumer directed care principles
4. Provision of a one off adjustment payment for each new resident that recognises additional, but time-limited, resource requirements when someone initially enters residential care
5. A fixed price per day for the costs of care that are shared equally by all residents. This may vary by location and other factors
6. A variable price per day for the costs of individualised care for each resident based on their AN-ACC casemix class.

Under the AN-ACC, the subsidy paid to the provider would consist of a fixed component and a variable component for each resident. Providers would also be paid an adjustment payment on a time-limited basis when a new resident enters the facility.

The staff time data collected in the RUCS indicated that close to 50 per cent of staff time was spent delivering care tailored to the specific needs of the resident, while the remaining 50 per cent was spent delivering shared care across all residents. This supports a payment model that includes a fixed per diem price for the costs of shared care and a variable price per day for the costs of individual resident care.

The fixed funding component under the AN-ACC model

The fixed component reflects the costs of shared care for residents and includes costs of care that all residents generally benefit from equally. The fixed cost is the same for all residents in a particular facility.

Separating the funding in this way has two benefits:

- Fixed care recognises that a large proportion of care costs within a facility are driven not by the individual care needs of the residents but by the care delivered equally to all residents
- Fixed care provides stability to the funding model as a large portion of the facility's funding is fixed regardless of changes in individual resident care needs.

Examples of fixed care include general supervision in common areas and night supervision. These costs are considered 'fixed' as they are not affected significantly by changes in individual resident care need.

Aged care homes will receive a per diem base care tariff (for fixed care) for all resident care days within the funding period. This fixed care tariff will vary between certain classes of facilities. For example, it will be higher in very remote facilities and for services catering for the homeless in recognition of their higher fixed costs. Base care tariffs are mutually exclusive and each facility can only qualify for payment under a single tariff.

The factors that were found by the RUCS to be associated with an increase in fixed care costs per day were:

- remote and very remote facilities that provide Indigenous care services
- non-Indigenous remote services that have less than 30 beds
- non-Indigenous remote services that have less than 30 beds, and
- specialised services to homeless people.

Remoteness here is defined using the Modified Monash Model (MMM), with MMM 6-7 defined as remote and very remote.

The variable funding component under the AN-ACC model

The variable component is the casemix classification portion of the subsidy. Each resident is allocated a class based on their characteristics. This component will be different for different residents in a facility. The classification system is a branching model that enables the factors that drive care cost to be addressed interactively rather than operate in isolation. For example, two residents have cognitive impairment but one is mobile and the other is not. In the current ACFI system, cognition and mobility are each considered separately. In the AN-ACC, they are considered in combination.

The adjustment payment component under the AN-ACC model

This payment recognises the additional, but time-limited, resource requirements when someone initially enters care. The 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 assessment e.g. pain management, and
- developing an advanced care directive in partnership with the resident and their family.

This one-off payment relates only to an initial admission into residential aged care. The adjustment payment is not payable if a resident transfers between homes.

Resident classification for the variable payment

Under the AN-ACC model residents will be externally assessed using the new AN-ACC assessment tool, and placed into one of thirteen AN-ACC classes (see RUCS Report 2 for further information on the 13 classes).

The AN-ACC assessment tool has been designed to capture the core resident attributes that drive care costs in residential aged care. It is designed to be robust, concise and able to be undertaken by an external expert clinician who is not familiar with the resident.

The assessment would be undertaken within 4 weeks of entry into care. Given the high degree of professional judgement required to make clinical judgements in a relatively short period of time, assessors will need to have expert clinical skills in aged care assessment, sophisticated professional and organisational capabilities and be provided with comprehensive training and ongoing clinical and operational support to ensure consistency in assessment.

External assessors will need to be credentialed registered nurses, occupational therapists or physiotherapists who have experience in aged care and have completed approved assessment training.

The AN-ACC assessment tool is suitable for both the initial assessment and reassessment of a resident as needed.

Pricing and the National Weighted Activity Units

Under the AN-ACC, the total funding for each facility would be calculated based on the relative costs of providing care (both individual care and shared care) expressed in terms of the National Weighted Activity Unit or NWAU. The NWAU is the 'currency' used to express the price weights for each classification category (both fixed and variable). It represents cost relativities between classes and allows a single price to be set across all care activities.

For example if, for the individual resident flexible care payment, Class A has an NWAU of 0.25 and Class B an NWAU of 0.5, then Class B is twice as costly as A and will receive twice the funding.

Government will determine the price for an NWAU of 1. This price is expressed in terms of $ per resident per day. So, in the above example, if the Australian Government set the NWAU of 1 at a price of $1 per day then Class A would receive $0.25c per day and Class B $0.50c per day. If it set the NWAU of 1 at a price of $2 per day then Class A would receive $0.50c per day and Class B $1 per day.

The total weighted care day per resident comprises three components:

1. The total base care tariff (fixed component) NWAU: This is the standard daily bed day tariff determined for each different type of facility related to fixed (shared) care costs. This tariff is paid for every resident bed day in the funding period.
2. The total variable component NWAU: This is the variable component based on the AN-ACC class for each resident in care. This accounts for the variable care costs for residents with different individual care needs. An AN-ACC NWAU is assigned for each resident bed day based on the resident AN-ACC class. The total AN-ACC NWAU for the facility is the sum of NWAU across all residents for their total days of stay within the funding period.
3. The total entry adjustment period NWAU: This is an additional payment set at a standard rate per new resident admitted for the first time during the funding period.

11. Appendix 2: Calculating annual regulating costs and savings

- 41 per cent of residential aged care facilities are for-profit
- 55 per cent of residential aged care facilities are not-for-profit
- 4 per cent of residential aged care facilities are government owned
- Number of facilities: 2722
- Number of aged care residents to be assessed for the AN-ACC: 300,000
- Number of aged care residents (in 2019-2020): 244,363
- Number of operational places at 30 June 2020: 217,145
- Number of new entrants categorised as Class 1 (palliative care): 3,000
- One hour wages for an accountant/business manager = $103.95 per hour (includes loading)
- One hour wages for a nurse = $96.4 per hour (includes loading)

Option 2

Regulatory Savings

Data collected from 80 providers by aged care accountancy firm StewartBrown shows that in 2018-19 providers spent between $589 and $1209 per bed on staff working in specialist ACFI roles and external ACFI consultants (depending on the provide size). The average spend per bed was reported to be $842.

When extrapolated to account for the number of occupied beds per organisational type (charitable; community based; private incorporated body; publicly listed company; religious; and religious/charitable) and the provider size (single; 2 to 6; 7 to 19; and 20>) and indexed to account for wage increase since 2018-19, this would equate to approximately $230 million per year across all providers.

Regulatory Costs

Providers need to provide financial data to the Department at the facility level to enable the annual costing studies:

- Number of facilities x 5 hours of an accountant's time / 55 per cent not-for-profit
- Number of facilities x 5 hours of an accountant's time / 41 per cent for-profit

Having external assessors come to do AN-ACC assessments and reassessments:

- Number of residential aged care residents to be assessed for the AN-ACC x 20 minutes of a nurse's time / 55 per cent not-for-profit
- Number of residential aged care residents to be assessed for the AN-ACC x 20 minutes of a nurse's time / 41 per cent for-profit

Participation in periodic studies to update the classification tool (every three years):

- Number of facilities in study (30) x 150 hours of nurse time / 55 per cent not-for-profit
- Number of facilities in study (30) x 150 hours of nurse time / 41 per cent for-profit

Administration work for new entrants categorised as Class 1 (Palliative):

- Number of new entrants categorised as Class 1 x 10 minutes of accountant/business manager time / 55 per cent not-for-profit
- Number of new entrants categorised as Class 1 x 10 minutes of accountant/business manager time / 41 per cent for-profit

AN-ACC Temporary Transition Program:

- Number of affected providers x 4 hours of accountant/business manager time x 2 years (2022-23 and 2023-24) / 55 per cent not-for-profit
- Number of affected providers x 4 hours of accountant/business manager time x 2 years (2022-23 and 2023-24) / 41 per cent for-profit

Option 3

Regulatory Savings

Providers no longer need to have to verify that they are providing one of the approved allied health treatments to claim 12.4 a or b in the CHC domain

- Number of aged care residents x 1 hour of a nurse's time / 55 per cent not-for-profit
- Number of aged care residents x 1 hour of a nurse's time / 41 per cent for-profit

Providers no longer need to fill out a number of redundant ACFI items:

- Number of aged care residents x 5 minutes of a nurse's time / 55 per cent not-for-profit
- Number of aged care residents x 5 minutes of a nurse's time / 41 per cent for-profit

Regulatory Costs

Providers to provide evidence that the allied health therapies provided to residents are evidence based, relevant to each residents needs and actually provided:

- Number of aged care residents x 15 minutes of a nurse's time / 55 per cent not-for-profit
- Number of aged care residents x 15 minutes of a nurse's time / 41 per cent for-profit