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Let's talk ACFI and funding volatility

Readers will no doubt have picked up on aged care sector concerns about the changes to the Aged Care Funding Instrument (ACFI) announced in the 2015 MYEFO and the 2016-17 Budget. Modifications to these changes were announced by the Government on 6 December 2016 following consultations with the sector. But the modified ACFI changes are intended to achieve the same reduction in expenditure growth on personal and nursing care for residents of aged care homes which was otherwise projected to grow at a faster rate than budget.

The Australian Government contributes 96 per cent of the cost of personal and nursing care in aged care homes, estimated at around $10.5 billion in 2016-17.

The changes are estimated to reduce ACFI expenditure over the next four years by $2 billion. ACFI expenditure over this period is still projected by the Government to grow by $1.8 billion, including growth due to an increase in resident numbers, compared with $3.8 billion if no action was taken. The statistic that matters is changes in the level of funding per resident per day because this amount largely determines, on average, the standard of personal and nursing care that can be delivered.

Some of the changes have applied since 1 July 2016, but those with the biggest impact will apply progressively after 1 January 2017.

What is the ACFI?

The ACFI is primarily a tool for distributing funds budgeted annually by the Commonwealth for the personal and nursing care of aged care residents based on the relative needs of each resident, ie. a resource allocation tool for distributing a budgeted amount of money as fairly as possible.

Accommodation costs and daily living expenses are funded separately.

ACFI distributes funds by scoring each resident across 64 payment points based on answers to twelve questions designed to assess each resident's nursing and health care needs, level of assistance required with activities of daily living (eg. showering and toileting) and the level of care needed to manage any behavioural issues. These care needs are thought to be the primary drivers of care costs.

The Commonwealth's annual Budget allocation for distribution through ACFI is not based on cost of care studies. Instead the calculation of each year's Budget allocation has been based on:

- the amount of funding per resident per day provided in the previous year, indexed for minimum wage increases determined by Fair Work Australia and increases in CPI for non-wage costs;
- a margin on top which reflects the historical trend towards increased care needs on average of residents as their level of acuity has been increasing – about a 3% increase per resident per day; and
- an estimate of the number of residents.

When determining annual budgets for personal and nursing care, the Commonwealth does not take into account in any meaningful way the implications for the quality of care services, for the practical reason that care quality and personal wellness are not easy to measure and monitor across the sector on a systematic basis. Instead, the Government relies on its safety and quality regulatory regimes, including accreditation, compliance reporting and monitoring, the national complaints scheme and sanctions, to support the quality and safety of services.

However, Commonwealth budgeting under ACFI does have regard to financial and investment indicators of sector viability such as the level of applications for new places under the ACAR, the level of investment in new services and refurbishments, and the financial results achieved by the better performing providers (with allowances for providers that operate high cost services, such as those in rural and remote locations). The Aged Care Financing Authority has documented a gradual improvement, albeit from a low base, in these financial and investment indicators since 2014-15 when most of the financial changes under the *Living Longer Living Better* package took effect.

An important feature of the ACFI is that it is administered by providers or professional ACFI assessors on behalf of providers. To guard against inappropriate claiming by providers, the Commonwealth validates a proportion of ACFI assessments and can apply various sanctions in the event of persistent inaccurate or false claiming.

What are the changes?

As well as a number of new regulatory measures designed to identify and discourage inaccurate ACFI assessments, the original MYEFO and Budget changes targeted the complex health care domain of the ACFI in order to make it harder to score the higher points which would be needed to attract a higher amount of funding.

The most potent changes to the complex health care domain involve:

- reducing the points scored for complex pain management and physiotherapy,
- making the points scored for administering medications the same irrespective of the number of medications administered or complexity of administration, and
- reducing the points scored for management of arthritic joints and arthritic oedema involving the application of tubular elasticized support bandages.

The complex health care domain was targeted because, based on actual expenditure in 2014-15, per resident per day expenditure in this domain was projected to increase by 9.7% in 2015-16 and beyond (on top of indexation). Growth in relation to activities of daily living and behaviour management were each projected to grow by a more modest 3.9% (on top of indexation).

The amendments to the MYEFO and Budget measures announced on 6 December largely remove those that targeted pain management and physiotherapy. These would have contributed a large proportion of the $2 billion reduction in expenditure. Instead, the difference will be made up by an across-the-board indexation pause from 1 July 2017 and a 50% indexation of the complex health care domain from 1 July 2018. An across-the-board indexation pause spreads

the impact across all services (except rural and remote services who will be compensated) and lessens the impact on services who have been claiming additional revenue for pain management and physiotherapy.

The Government has also commenced a review of ACFI, including consideration of the option of introducing independent external assessment of each resident's care subsidy (rather than assessment by providers currently).

Some history

The recent decision to pull back growth in per resident per day expenditure under ACFI is not the first time a government has taken action in response to growth in excess of Budget estimates.

In 2012-13, growth in expenditure per resident per day was reduced by withholding indexation and making changes to some of the scoring under the ACFI. These changes resulted in average real growth in payments per resident per day being pulled back in 2012-13 and 2013-14 to 3.7% and 3.4% respectively, roughly in line with trend growth and a budgeted average growth of 3.5% and 3.2% respectively.

The pull-back in growth, however, was short lived.

Real per capita growth in 2014-15 and 2015-16 resumed, averaging 5.0% and 5.1% respectively, prompting the current Government response.

A distinctive feature of the current response is that the intended pull-back in growth is much greater than in 2012-13. That is, the original MYEFO and Budget changes were estimated to reduce average annual real growth per resident per day to 1.2% (or 1.6% in 2016-17, falling to 0.6% by 2019-20). This lower average growth rate, which is unlikely to have been materially affected by the recent changes, is intended to recover some of the 'excessive' growth that occurred between 2014 and 2016. One could also speculate that the size of the pull-back may be insurance against a resumption of higher growth, noting that it will take some time to implement any changes that might stem from the current ACFI review.

As it turns out, early data for 2016-17 (ie. since the 1 July changes to ACFI were introduced), suggest that the budgeted pull-back in growth may not be sustained and that provider claiming may have adjusted to the changes. While the elements targeted by the 1 July changes have experienced a decline, other elements in the complex health domain have increased.

Where does this leave providers and the Government?

The key point is that there is a history of provider claiming under ACFI exceeding budget allocations, and there is every reason to expect that this will continue to be a feature of the current ACFI model.

The fact is that many areas of the ACFI lend themselves to interpretation by assessors, including as care practices and technology change over time. This is evidenced by the fact that there has not been a material change in the rate of downgrades under the validation processes undertaken by the Department of Health despite the growth in funding claimed.

Given the subjectivity inherent in making ACFI assessments, careful attention to and investment in ACFI claiming is also a rational response by providers. Claiming under ACFI for personal and nursing care is effectively the only recurrent revenue item that providers can influence, noting that the prices for personal and nursing care are otherwise set by the Government and are constrained by indexation based on minimum wage adjustments.

It is therefore not surprising that the 2015 report of the Aged Care Financing Authority into factors influencing the financial performance of residential aged care providers found that better

performing providers had, inter alia, higher levels of ACFI revenue across all resident care profiles.

Many providers argue that the growth in per capita funding for personal and nursing care is simply the ACFI doing its job, ie. responding to the increasing number of residents with chronic and complex conditions. These providers argue that the additional funding has been used to improve care services and the wellbeing of residents, including greater use of physiotherapists for pain management and avoiding stressful (for residents) and costly transfers to hospitals.

The Government seems to have heeded this point by all but removing the Budget changes that would have affected claiming for pain management and physiotherapy.

Nevertheless, as providers will emphasize, average annual real growth in funding per resident per day is still projected to be very marginal compared with the past. Taken together with indexation based on minimum wage adjustments and the public sector being the pace setters in health wages, this level of growth if realized will make market competitive wages difficult to achieve even in a low wage growth environment, and would leave limited scope to cover future increases in acuity of residents. This outcome is contrary to expectations of rising resident acuity as the residential care provision ratio is reduced and the ratio for home care packages is considerably increased. Further attention to claiming under the complex health domain may be a result.

Governments on the other hand do not respond well when they lose control of key expenditure line items, especially when reducing the size of forecast budget deficits is a national priority for both the major political parties. We can be sure that the claiming behaviour experienced since the 1 July changes referred to earlier is sounding alarm bells amongst those in Canberra responsible for the Budget. As also noted earlier, those advising on the setting of budgets do not have explicit regard to quality of care benchmarks or targets. Their approach is primarily driven by the Budget bottom line and in the context of competing priorities.

Funding volatility

The juxtaposition of a funding model which is open to subjective interpretation and governments concerned to have control over expenditure items leaves funding for personal and nursing care exposed to periodic changes to the ACFI, and consequent unpredictability and volatility in funding.

Unpredictability and volatility in ACFI funding is not welcomed by either Government or providers. Governments have to deal with the political sensitivities involved in taking action to control expenditure, while volatility is antithetical to efficient and effective budgeting and service delivery by providers and for confidence to expand services. It also amplifies sovereign risk concerns which in turn negatively impact on the willingness of investors and financers to provide the capital necessary to fund the expansion of services that will be required.

The prospect of recurring pull-backs in growth also raises concerns about how best to achieve the reduction in funding growth. The options include across-the-board reductions in prices by withholding indexation or by targeting those who have maximized claims by targeting specific elements of the ACFI where claiming has been the greatest. The former penalizes all services irrespective of their resident profile and claiming history, while the latter penalizes those residents who would stand to benefit from the additional care activity that could be funded.

Where to from here?

The options are to persevere with the ACFI and ‘wear’ the potential for continuing volatility in funding for personal and nursing care; or use the opportunity presented by the current review of ACFI to develop a new funding model.

Under either option, there are two threshold issues that will need to be addressed:

a. whether assessments of residents for the level of care subsidy should continue to be administered by providers or by an independent external body, as currently applies for home care packages; and
b. whether the funding model is essentially a resource allocation tool, as at present, or somehow it is designed to be responsive to changes in care costs.

Independent external assessment funded by the Government has the advantage of providing greater certainty and equity in funding; frees up resources that many providers currently deploy to maximize ACFI funding; saves the cost of the current validation processes; and reduces the Government's fiscal risk as the sector moves towards the Roadmap's destination of uncapped supply. Independent external assessment could also be integrated with the 'front door' role of MyAgedCare, which will experience further development and refinement under the Roadmap destinations now that the ACAT function has become a Commonwealth responsibility.

Matters to be considered in assessing the merits of independent external assessment include the timeliness of assessments and re-assessments, their consistency and accuracy across the country, the extent of administrative savings by providers, and the extent to which it delivers greater certainty in funding.

Of course, the simplicity of the funding model itself will have a significant bearing on the above considerations, noting that a simple funding model with fewer payment tiers is more compatible with external assessment and less compatible with provider assessment because of claiming behaviours it is likely to encourage.

Whether a new funding model takes on the attributes of a resource allocation tool or is more attuned to responding to changes in resident care needs and actual care costs raises difficult issues.

Experience suggests that governments will favour a resource allocation tool in order to manage financial risks. If this is the case, it would mean that a new funding model would be designed to result in expenditure that is within the current Budget forward estimates (which already factor in changes in resident numbers under the provision ratio).

The Government currently has two principal options for managing their residential aged care budget – controlling expenditure per resident per day or controlling the number of residents. The former effectively puts a cap on the standard of care that can be provided while, with regard to the latter, the Roadmap envisages the uncapping of supply (the affordability of which is one of the matters to be considered by the 2017 legislated review).

Moving to a system which is responsive to actual care costs raises the practical issue of agreeing a universal standard of care and wellness outcome that should be funded and provided - assuming that such a standard can be defined and measured. Achieving this is problematic, not the least because of variations in provider efficiency and effectiveness, variations in the cost of inputs, different mission/business objectives of providers, and different consumer expectations and preferences.

A more pragmatic response would be to fund reasonable outcomes for consumers for whom the Government funds the full cost of their personal and nursing care needs, and allow flexibility for consumers who can or wish to, to purchase additional services in accordance with their preferences, and rely on a competitive market in an uncapped supply environment to lift standards that are underwritten by a quality regulatory framework. This would be more in line with the Roadmap's destinations.

Conclusion

From whichever perspective funding for personal and nursing care is viewed, it is clear that the status quo is not fit for purpose. The challenge for the government, as the major funder and regulator, and the sector is to devise a new funding system that is compatible with the market-based approach envisaged under the Roadmap, while ensuring that those with fewer means or who live in communities with thin markets receive quality services.

Disclosure statement: The author of this Update, Nick Mersiades, is a member of the Aged Care Financing Authority. The opinions in this Update should not be read as being an expression of the views of the Aged Care Financing Authority.

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