25 February 2015

Various matters in early 2015

This edition of Aged Care Update reports on the current status of a number of matters as we move into 2015.

The potential flight from Refundable Accommodation Deposits (RADs) to Daily Accommodation Payments (DAPs)

Readers may recall that when the new accommodation payment arrangements under the Living Longer Living Better (LLLB) package were announced in 2012, there were some in the sector who predicted the demise of services because a rapid flight from lump sum payments to daily payments would leave providers with liquidity pressures as they struggled to replace repaid lump sums.

Responding to those concerns, the former government sought the advice of the Aged Care Financing Authority (ACFA). A KPMG report commissioned by ACFA concluded that, in aggregate, lump sum deposits held by providers would increase by $3 billion in the first year of the new accommodation payment arrangements. The KPMG report also concluded that providers who were heavily leveraged on lump sums as a source of capital, including some extra service and low care providers, would experience some liquidity pressures. Such providers also had considerable time to adapt given that the new arrangements were not due to take effect until 1 July 2014.

Taking no risks, the former government (and the current government), asked the ACFA to monitor and report RAD payments on a monthly basis via a voluntary survey until the end of 2014, and quarterly in 2015.

The latest available report published by ACFA is based on survey data collected up to the end of October 2014.

In October 2014, lump sum payments (RADs and RACs) were the preferred mode of payment (44%), followed by daily payments (DAPs and DACs) at 32%. About 25% chose a combination of RAD and DAP payments. This distribution of payment preferences has remained relatively stable since the new payment arrangements were introduced, and RADs received have consistently offset the accommodation bonds paid out for departing residents in each month.

There are some noteworthy differences emerging depending on factors such as service ownership, location and care type.

- Compared with other areas, there tends to be a preference towards RADs in major cities and,

more recently, in inner regional areas.
- RADs are preferred in the for-profit sector, with over half choosing this method.
- In September and October, DAPs and combination payments took over from RADs as the preferred payment mode in low care, whereas RADs remained the preference in mixed and high care services. The low care result should be treated with caution as the sample size is very small.
- RADs were the preferred payment mode for all provider sizes, gaining a significant share among larger providers.
- As expected, extra service facilities are reporting a modest decline in the amount of lump sums held and receivable (-7% over the period June to October 2014). Low care services experienced a similar decline in lump sums held.

In aggregate, the data suggests that the feared rapid shift away from lump sums is not happening. This is not to say that some drift away from lump sums will not occur in the medium term, for example, should consumers become more familiar with the choices open to them through their financial advisors or if favourable equity release arrangements should emerge. Any drift, however, is likely to be gradual and give providers time to adjust their business financing models.

It is also arguable that the relatively low participation rate in the survey (just over a third of the sector) is indicative of the level of concern among providers with the new arrangements. Also, Catholic Health Australia understands that the Transition Business Advisory Service, which was funded to help providers transition to the new arrangements and which is due to wind up in June 2015, has not come across any services whose continuing viability is under threat as a result of the new payment arrangements.

The ACFA monthly reports **may be accessed here**.

Expenditure under the higher accommodation supplement

The LLLB package increased from 1 July 2014 the Accommodation Supplement paid to providers on behalf of supported and partially supported residents living in new and significantly refurbished aged care homes.

In announcing the termination of the Dementia and Severe Behaviours Supplement in June 2014 due to a ten-fold increase of expenditure over the Budget estimate, Minister Fifield set the cat amongst the pigeons when comments he made were interpreted as meaning that there may be a similar blow-out of expenditure under the higher Accommodation Supplement, ie. "we are seeking to avoid a repeat of this situation ... due in large part to inadequate preparation and modelling before its introduction by the previous government."

Catholic Health Australia followed up the Minister's comment by requesting that regular reports be provided to the Aged Care Sector Committee on how expenditure under the higher Accommodation Supplement was trending against the Budget estimate. While it is still relatively early days, Catholic Health Australia understands that expenditure is trending fairly comfortably under the Budget estimate. This suggests that the Department of Social Service’s modelling is holding up, which is not too surprising because there is much less discretion under the higher Accommodation Supplement eligibility guidelines, compared with the Dementia and Severe Behaviours Supplement, for providers to interpret eligibility for the higher payment.

Nonetheless, expenditure under the higher Accommodation Supplement will continue to be monitored, including to see whether the perceived threat that the higher Supplement may be withdrawn or reduced may have deterred some providers from refurbishing their services.

Severe Behaviours Response Teams (SBRTs)

This brings us to the SBRTs which the government has announced will be established in each state and territory to replace the Dementia and Severe Behaviours Supplement in residential aged care.

One thing the government can be confident about is that, because the funding for the SBRTs is capped, there is no risk of a blow-out in expenditure.

But the question is left open as to whether SBRTs are the answer to caring for older people with very challenging behaviours. The same question can just as validly be posed in relation to the former Dementia and Severe Behaviours Supplement.

Catholic Health Australia commends the extent of consultation with providers, consumers and health professionals on support for people with severe behaviours and psychological symptoms of dementia, but considers that the opportunity was not taken to develop a more comprehensive response.

In its advice, Catholic Health Australia advocated for a more comprehensive strategy for responding to the needs of older people with very challenging behaviours, based on the following elements:

1) Consistent with the rationale for dementia being a national health priority, the Commonwealth and the states/territories jointly funding a phased expansion of a network of specialist high dependency units for the care of people with very severe behaviours.

2) Increasing the capacity of aged care providers to deliver best practice behaviour management services for people with severe behaviours and step-down care, where appropriate, for those with very severe behaviours.

3) An expansion of Dementia Behaviour Management Advisory Services (DBMAS) to provide ready access to dementia out-reach services, and a review of existing DBMAS arrangements to ensure a consistent and effective capability across states and territories.

4) Giving priority under the current review of workforce training and development programs to an assessment of the capacity of the current training arrangements to deliver the skilled workforce required for dementia care.

5) A review of existing dementia programs to identify gaps and overlaps and to assess their collective effectiveness, particularly with regard to workforce development and the dissemination of applied research into better practice.

A few points are worth making in relation to this strategy.

First, extending the network of specialist high dependency units for people with very severe behaviours can be achieved without additional Commonwealth Budget outlays beyond that which will occur under existing policy. Commonwealth recurrent funding (mainly ACFI) could flow from the allocation of places from within the target service provision ratio, and capital could be provided under the Rural, Regional and Other Special Needs Building Fund.

Negotiations would be required with state/territory governments to secure a contribution of mental health funding and expertise. A number of joint funded high dependency units already exist, which suggests that states and territories see the benefits in a collaborative response to the care of older people with very challenging behaviours.

To be fair, the government's SBRT announcement did acknowledge a role for specialised units, but for examination in the longer term in conjunction with state and territory responsibilities in relation to psychogeriatric care. The immediate needs of the community requires greater urgency than this response implies.

Second, a criticism of the former Supplement was that a large proportion of the funding was spread so thinly across a large number of providers that it would have limited benefit for the target group as it would be insufficient to fund a material improvement in staffing capacity and expertise.

However some providers did use the Supplement to employ skilled staff to support services specialising in the support of people with challenging and severe behaviours in purpose-designed accommodation. Such providers are now left contemplating other sources of funding for their services, when one option that was available was to target the former Supplement funding to such services according to eligibility criteria.

It may be that using the Supplement funding to create a new targeted program to support dedicated services posed administrative difficulties, but this case has not been made by the government.

Third, a criticism of the SBRTs is that they will be of limited value in increasing the ongoing in-house capacity of aged care services to care for people with severe behaviours. Catholic Health Australia did support an improvement in DBMAS, into which SBRTs are to be integrated, but we also advocated that there should be a review of the existing DBMAS arrangements to gauge their effectiveness. Many in the sector have commented that their effectiveness and mode of operation is inconsistent across services.

We now have a doubling in DBMAS funding without an assessment as to the effectiveness of the existing DBMAS arrangements, though a review of existing dementia programs, including DBMAS and Dementia Training Study Centres, has been promised for the first half of 2015.

Red Tape Reduction

A high profile election commitment by the Coalition was 'to work to streamline administrative processes and cut red tape so that dedicated staff can spend more time providing care rather than filling out paperwork'.

To date, we have seen the welcome removal of building certification in residential aged care and the decision to remove key personnel reporting once it is prioritised in a crowded legislative agenda.

We have also seen ongoing work to reduce administration around financial reporting through the introduction of an attested (rather than audited) Comprehensive Financial Report to replace several existing reports. The full benefit of a Comprehensive Financial Report will be realised in the medium term, the time required to adapt Standard Business Reporting to the aged care sector. Selected participants in the South Australian Innovation Hub will also have the opportunity to gain five-year accreditation from the Aged Care Quality Agency.

Meanwhile, the sector was invited in 2014 to provide input to a Red Tape Reduction Action Plan that was being drafted by the Aged Care Sector Committee. The sector awaits the release of, and action on, the many worthwhile measures contained in the Plan.

Quality indicators

Minister Fifield announced in 2014 that three quality indicators - pressure injuries, unplanned weight loss, and use of physical restraint - will be introduced for residential aged care in 2015. These quality indicators were selected, in part, based on experience in the Victorian health sector.

A national pilot of the first three indicators will commence in early 2015, with national implementation planned to commence with data collections from July 2015 and publication on My Aged Care. The aim of the pilot is to work with providers to test and refine the data collection processes and analysis, and to confirm the data specifications that underpin the indicators. A

cross-section of providers is being invited to participate in the pilot.

It is also planned to develop and pilot a consumer experience/quality of life indicator during 2015.

The indicators will be voluntary and will not be used as benchmarks for which there is a pass/fail rating. A question that remains to be answered is whether an independent and expert body will be engaged to manage the collection and analysis of the data.

Reforms scheduled for 2015

2015 will see the implementation of the final tranche of LLLB reforms. Most of these have been the subject of separate Aged Care Updates in the second half of 2014. To recap, the major changes in 2015 are:

- The replacement of the HACC program, the National Respite for Carers Program, Day Therapy Centres and the Assistance with Care and Housing for the Aged program under a new consolidated Commonwealth Home Support Program (CHSP) in all states except Victoria and Western Australia. Negotiations with Victoria and Western Australia are continuing, with the likelihood that Victoria will join the new CHSP before Western Australia.
- The creation of Regional Assessment Services designed to ensure consistent eligibility and needs assessments under the CHSP, including the introduction of an electronic client record for each care recipient. The existing ACATs will be progressively integrated into the Regional Assessment Services.
- The introduction of a consistent fees policy to apply for all recipients of care and support under the CHSP.

The Department of Social Services is embarking on an extensive Roadshow to brief stakeholders on these changes. Details on the Roadshow can be **accessed here**.

Aged care reform beyond 2015

The Coalition's election platform stated that the Productivity Commission report Caring for Older Australians should continue to inform future policy direction, and that the Coalition would prioritise future reform with the sector by negotiating a Healthy Life, Better Ageing Agreement.

The sector is aware that the Aged Care Sector Committee has been working with the government to draft such an Agreement that will contain principles to guide the next stage of reforms. Its release is awaited. There will be more on this subject in a future Aged Care Update when the document is released.

In the meantime, it is worth highlighting again Minister Fifield's speech in November 2014 to the Committee for Economic Development of Australia (CEDA). In his speech, the Minister invited the sector to engage in a 'conversation' about how we might 'move closer towards the vision of greater consumer choice, of the money following the individual and of business freed up to do what they do best', which he characterised as a consumer-driven system.

The Minister's speech makes the general direction of reform, if not the specifics and the timing, fairly clear. We can also expect that the guiding principles in the Agreement referred to above will embody the sentiments in the Minister's CEDA speech.

For those who have not read the Minister's CEDA speech, it may be accessed at **this link**.

Disclosure Statement: The author of Aged Care 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