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Aged Care Update: A new funding for model for nursing and personal care in residential aged care

The case for replacing the current arrangements for funding nursing and personal care in residential aged care, which are based on annually indexed prices set by government and assessments by providers of each resident's care needs using the Aged Care Funding Instrument (ACFI), is overwhelming.

Since the introduction of ACFI in 2008, funding for personal care and nursing has been prone to pronounced volatility from year to year, with average annual real increases in funding per resident per day ranging between 2.1 per cent and 8.1 per cent. In addition, annual indexation of prices was withheld by government on two occasions in order to reclaim some of the growth, and there have been ad hoc one-off injections of funding when government moves to reclaim or stall funding growth have 'over-shot' and resulted in a large proportion of providers operating at a loss.

Such short-term volatility is detrimental for financial management and budgeting for both providers and governments, and cannot be explained by fluctuations in average resident care needs. It also poses risks for consistency in service quality.

The funding volatility that has been experienced largely stems from the subjectivity involved in administering the ACFI. Subjectivity has generated ongoing tensions between the understandable focus by providers on maximising ACFI funding, to the point where ACFI now supports an industry of specialist ACFI assessors, and governments wishing to curtail funding increases that they consider do not reflect the extent of changes in resident acuity implied by the funding increases.

As well as funding volatility, the indexation applied annually to prices has been substantially below wage movements in other sectors, and substantially below Fair Work Australia's annual minimum wage adjustments. For example, ACFI indexation since 2008-09 was half the movement in the wage price index for the health care and social assistance sectors (17% compared with 35%). By discounting indexation in this way^[1], successive governments have been extracting an annual productivity dividend from the sector and applying it to their bottom line.

Productivity improvements are expected in all sectors of the economy, and aged care is not an exception. However, it is not possible for providers to deliver the extent of cost

reductions expected under the current indexation arrangements while at the same time responding to rising community expectations about quality of care and quality of life outcomes (noting that in a competitive market, productivity gains are reflected in service improvements as much as cost reductions), as well as be competitive in the labour market for skilled staff and reward staff for the important role they perform.

Recent analysis undertaken by the Korn Ferry Hay Group on behalf of the Government's Aged Care Workforce Strategy Taskforce highlighted that personal care workers in residential care and home care are being under-rewarded by 15 per cent against the average for similar work value roles in other sectors.

Responding to these flaws in the current funding model, a [new resident classification tool and funding model](#) has been proposed by the Department of Health, substantially based on analysis and developmental work undertaken by the Australian Health Services Research Institute (AHURI) at the University of Wollongong. The new model is an adaptation of the activity based funding/case mix approach developed and used over several decades for the public hospital system.

The main features of the proposed new funding model are:

- Separation of assessment for funding for nursing and personal care and assessment for care planning, with the former conducted by independent external assessors and the latter by providers.
- A new resident classification tool (the AN-ACC) which groups residents that incur similar costs for delivering personal and nursing care into one of 13 classes, for which different price weights apply.
- A fixed payment per resident per day for aged care homes to cover shared care costs and a variable payment per day for the costs of individualised care for each resident according to their classification. There is capacity for the fixed payment to vary according to remoteness, size of service and specialisation (Indigenous and homeless residents), but on average the two components each represent about 50 per cent of funding for each aged care home.
- A one-off adjustment payment for each new admission that recognises the additional, but time-limited, costs of settling in a resident when they first enter an aged care home.
- Annual costing studies to provide data on cost movements, including labour market-based wage increases and changes in service scope and delivery practices.

The AN-ACC resident classification tool

The [Resource Utilisation and Classification Study \(RUCS\)](#) that underpinned the development of the new [AN-ACC](#) identified that the most significant attributes of residents that drive their care needs and associated costs are admission for palliative care, mobility, function (the ability to manage activities of daily living), cognition, ability to communicate and behaviour.

Reflecting the above, the 13 classes of the AN-ACC comprise one class for residents who have a palliative care plan developed by an appropriate medical practitioner on admission to the aged care home, and 12 other classes distributed across three branches distinguished by resident mobility (independent, assisted mobility and not mobile). Within each branch, residents are classified according to cognitive ability, functional ability, risk of pressure wounds and technical nursing requirements, and the presence of compounding factors.

A trial of the new funding model involving a sample of aged care homes will be conducted by the Health Department over about six months, starting in the second half of 2019. The target date for the new funding model is July 2021.

The proposed new funding model has many potentially positive aspects, including

external assessment (allowing providers to focus on assessment for care planning purposes and removing the need for external auditing), a resident classification system with significantly fewer classes, recognition of time-limited adjustment costs incurred on admission, no requirement for reassessment if a resident's wellbeing is improved, recognition of higher fixed costs for certain services according to their remoteness, size and specialisation and, most importantly, the provision for annual independent costing studies to inform future prices.

Nevertheless, there are aspects of the proposed model that warrant comment or further consideration, including as part of the trial.

A dependency-based model

The 13 classes and associated price weights of the AN-ACC were developed following activity based costing studies of a sample of aged care homes. There is a concern that the proposed classes and price weights may be based on a sample that reflects the dependency model of care that has been a feature of the current aged care system. Looking forward, to achieve the improved quality of life outcomes and person-centred care envisaged under the new quality Standards, it will be essential for residents and their families that the assessment tool and price weightings support a wellness promoting approach that fosters mobility and social inclusion activities, rather than a narrow personal care and clinical nursing approach.

Accordingly, it will be essential for the new model to recognise the additional cost of actively providing encouragement, management, activities and the skilled staff to mobilise frail residents with the potential to be mobilised, and to keep them mobilised and socially engaged.

An important aspect of the trial will be to ensure that the new model does not financially disadvantage providers that have been developing a wellness promoting approach to aged care.

Annual costing study to inform prices

From the perspective of the future viability of quality aged care services, the most important consideration in assessing any new model is the extent to which it can result in future prices (funding) that reflect movements in care-related costs and, importantly, rising community expectations about quality of life outcomes based on a person-centred care and wellness approaches, consistent with the new quality Standards.

Therefore, CHA strongly supports the proposal in the new funding model for annual costing studies that will provide data on cost movements, such as wage increases and service improvements, to inform prices for the following year. Using annual costing studies to inform prices will mean that the funding model need no longer be hostage to an indexation formula, and in particular the current onerous indexation formula which has constrained prices.

While prices would continue to be set by government, it is essential that the costing studies be undertaken by an independent body that is also responsible for recommending prices based on transparent analysis of the costing studies. The Independent Hospital Pricing Authority, which performs this role for the public hospital and health sector, provides the precedent for aged care to follow.

This approach offers the potential to move away from the current productivity harvesting focussed indexation arrangements, and instead to focus more of the cost of providing aged care services in a competitive service environment that meet the new quality Standards.

External assessment

To be successful, the external assessment process will need to be independent, undertaken by appropriately credentialed assessors, result in consistently accurate and timely assessments and reassessments, and have the trust of providers. It is proposed that assessors be drawn from professional groups whose undergraduate degree includes function and mobility as a core component, such as registered nurses, occupational therapists and physiotherapists.

Putting in place a sufficient external assessor workforce will be a major challenge in order to achieve timely assessments and reassessments, while not withdrawing skilled professionals from direct aged care provision, noting that the current assessor and ACFI auditing workforce is drawn from a wider range of occupations. This is a matter that will need to be taken into account when evaluating the trial.

The efficiency of the external assessment process will also be influenced by the reassessment triggers that are included in the model. While reducing the number of classes will help in this regard, there is also a need to strike a sensible balance between ensuring additional funding as a resident's needs increase and not generating excessive reassessment requests. Given that significant changes in care needs can occur at any time, it would seem that a threshold increase in payment would be the most appropriate trigger for reassessment.

With regard to the potential for unnecessary requests by providers for reassessments, the Government could signal a preparedness to introduce charges if excessive reassessment requests eventuates, such as applying a charge after a set number of failed assessment requests over a given period.

There is scope for the trial to test different reassessment triggers and protocols.

The work currently underway in the Department of Health to develop streamlined eligibility assessment arrangements across all aged care will also need to be taken into account. At this stage, it is unclear how the AN-ACC assessors will be integrated into the wider eligibility and assessment function that incorporates ACATs and the Regional Assessment Services, and which body or bodies will be performing the eligibility and assessment role across all aged care. The critical importance of an efficiently functioning and trusted independent eligibility and funding assessment process for government, consumers and providers across all aged care cannot be overstated.

The one-off adjustment payment on admission

There is a concern that the proposal to treat the adjustment payment as a one-off payment will compromise the exercise of consumer choice and control as it may discourage the admission of residents wishing to change homes. There are a variety of reasons for changing aged care homes, including dissatisfaction with the quality of care in their current home and changed family circumstances, or having to move from a home that does not provide 'ageing in place' or does not cater for certain high needs residents.

It is also the case that providers will incur settling-in costs for residents who are relocating, including familiarising them with new staff, a new environment, new residents and new arrangements. It has been suggested that these costs would be minimised if the relocating resident brings documentation from the previous home. The experience with care documentation for residents transferring from hospital suggests that this is a problematic assumption. Moreover, the scope of the documentation may be limited by the model of care used in the previous home, and therefore be of limited use.

CHA also notes that the scope for abuse of the adjustment payment by providers orchestrating resident transfers in order to maximise funding from adjustment payments is negligible. Residents and their families will only consider relocation when necessary, and security of tenure provisions also act against unwarranted moves.

Accordingly, CHA considers that the policy case for making the adjustment payment a one off payment is not compelling.

Services with higher fixed shared care costs

The proposed model recognises that the proportion of fixed shared care costs increases with remoteness, facility size of less than 30 beds in remote locations and the provision of care for Indigenous and homeless people. Accordingly, the proposed new funding model would provide a higher fixed payment for these homes. It also proposes that payment for small remote services should be based on the number of beds in the service, not occupied beds, because small changes in occupancy can have a proportionally bigger impact on smaller services than on larger services.

The additional funding for fixed shared care costs targets remote and very remote services. A case for additional funding can also be made for outer regional services that incur similar fixed costs due to remoteness from larger urban centres.

Transition issues

A key consideration for both providers and government is the arrangements for transitioning from ACFI to the new funding model. The transition poses considerable implementation and financial risks for both.

In principle, CHA would support the AHURI option of switching all residents, new and existing, to the new model from a set date. However, noting that RUCS found that a significant proportion of residents would be eligible for re-assignment to a higher class within a short period, the re-assessment process would need to be achieved in a short time frame in order to avoid revenue risks for providers. This may not be possible because of workforce constraints. The proposed trial should provide guidance in this regard.

The option of grandfathering existing residents for a transition period (two years has been suggested) also poses financial (and service quality) risks for providers and consumers if residents remain on grandfathered funding rates despite increased care needs. Grandfathering also increases risks and costs associated with running parallel payment systems.

Another factor that aged care providers will need to weigh is the inevitability that there will be 'winners and losers' across aged care homes under the proposed new model compared with funding they receive under ACFI, though the fact that about half of each aged care home's funding will be a fixed payment per resident may help reduce the scope for differences.

In order to soften the impact on providers who may receive less funding under the new model, it is proposed that 'stop/loss' provisions would apply for a period (two years) if the revenue reduction exceeds 5%. Arguably, the proposed threshold of 5% is too high, especially in the current environment where the majority of providers are under financial pressure. A 5% revenue reduction would drive many providers into negative financial performance territory, or further into negative territory. A 'stop/loss' threshold should not exceed 2%, with the precise figure and timeframe reviewed at implementation time in the light of the overall financial performance of the sector at the time. Any threshold could also apply at the approved provider level, rather than to individual services.

Developing and implementing a payments system for the new funding model is another source of implementation risk for government and providers. The new payments system will need to be tested before it is introduced.

Residential respite services

The proposed new funding model does not apply to residential respite care.

Despite the significant increase in demand for respite care that has accompanied the increase in the supply of home care packages, the planned further significant expansion in the supply of packages, and the significant reforms to the aged care system overall, the funding arrangements for residential respite have not changed.

The opportunity should be taken now to extend/adapt the new funding model for permanent residential care to residential respite. The shortcoming of the current funding arrangements for residential respite are discussed by CHA [here](#).

Accommodation costs and expenses of daily living

It is noteworthy that the proposed model will address only personal care and nursing costs. Funding for accommodation costs and daily living expenses will continue to be funded under separate arrangements.

Accommodation payments for non-supported residents (essentially self-funded retirees) are negotiated between each resident and provider, subject to regulatory oversight by the Aged Care Pricing Commissioner. The government accommodation subsidy for supported residents who are unable to meet their accommodation costs (mainly non-home owning pensioners and residents with a 'protected person' still living in the former residence) is determined by government having regard to the accommodation prices for non-supported residents set by the market.

In contrast to accommodation prices, funding for living expenses (the basic daily fee) is capped for all residents at 85 per cent of the single age pension. This cap on living expenses limits living standards that can be supported in aged care homes which, along with funding for personal care and nursing, has implications for residents' quality of life. The *Legislated Review of Aged Care 2017* recognised this limitation by recommending the uncapping of the basic daily fee for non-supported residents, subject to regulatory oversight by the Aged Care Pricing Commissioner.

[1] Indexation for wages in aged care is based on the dollar increase in the national minimum wage (determined annually by Fair Work Australia) expressed as a percentage of the latest available estimate of average weekly ordinary time earnings (AWOTE) published by the Australian Bureau of Statistics. Because AWOTE is more than double minimum wages, the effect of this formulation is to apply a discount on the actual growth of minimum wages.

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.

You can read previous [Aged Care Updates here](#).

