CATHOLIC HEALTH
Australia

PROPOSAL FOR A NEW RESIDENTIAL AGED CARE FUNDING MODEL

RESPONSE TO CONSULTATION PAPER

Introduction

CHA considers that the case for replacing the current funding model for personal and nursing care in aged care homes, which is based on the Aged Care Funding Instrument (ACFI) administered by providers, is overwhelming.

Since the introduction of ACFI in 2008, funding for personal and nursing care has been prone to pronounced volatility from year to year, with average annual real increases in prices ranging between 2.1% and 8.1%. In addition, on two occasions, annual indexation of prices was withheld by government in order to reclaim some of the growth.

Such short-term volatility is detrimental for financial management and budgeting for both providers and governments.

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%).

While productivity improvements can be expected in all sectors of the economy, and aged care is not an exception, it is not possible for providers to deliver the extent of cost reductions expected under the current funding arrangements while at the same time;

- responding to rising community expectations about quality of care and quality of life outcomes (noting that in an open and competitive market, productivity gains are reflected in higher quality services as much as cost reductions);
- being competitive in the labour market for skilled staff; and
- rewarding 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% against the average for similar work value roles in other sectors.

CHA supports the view of the former Minister for Aged Care that the proposed AN-ACC classification and funding model is a superior model than the current ACFI, while acknowledging that further analysis, testing and fine tuning is required before the AN-ACC can be implemented.

The following addresses the questions raised in the Department of Health's consultation paper, as well as other issues.

Question 1: Are there any risks or benefits of the proposed funding model that have not been identified?

CHA supports the three-component structure proposed for the new funding model – a fixed payment per occupied bed for shared care costs, a variable payment for individual resident care costs and an adjustment payment for settling-in on admission. However, CHA offers the following additional comments:

a) CHA notes that, as is the case with ACFI, there is no incentive under the new funding model for providers to move away from a **dependency model**. CHA members note that it is more costly to actively provide 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.

   CHA members also note that the proposed classes and price weights under the new model seem to reflect the current aged care system, much of which still has a dependency focus to the provision of personal and nursing care. For example, of the 775 residents that were reassessed under the RUCS after 4-6 months, only six had participated in a structured reablement or restorative care program during that period.

   On this basis, CHA members are concerned that the new model will not deliver the same funding currently available under ACFI to support a reablement/social engagement approach, consistent with the new Quality Standards. Accordingly, CHA recommends that the trial includes a selection of aged care homes that pursue a structured reablement approach to test whether the new classification tool and NWAU price weights disadvantages them compared with ACFI, and hence compromises their capacity to continue to deliver a reablement approach.

b) CHA is concerned that treating the **adjustment payment** as a one-off payment compromises the exercise of consumer choice and control, a principle that underpins the direction of current reforms.

   The one-off nature of the payment could present a barrier for admitting residents wishing to change homes because of changed family circumstances, dissatisfaction with the quality of care in their current home or who have to move from a home that does not provide 'ageing in place' or does not cater for certain high needs residents. Aged care homes are not all the same.

   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 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.

   Similarly, introducing specific accountability provisions for acquitting the adjustment payment would constitute unnecessary and costly regulation.

Finally, CHA notes that it is not unusual for providers to use contracted allied health professionals as part of a multi-disciplinary approach to care planning.

c) CHA notes that the number of **MMM 4 and 5 services** included in the RUCS was very small, raising a concern from our members with regional services that base care tariffs using data drawn from this small sample may not be indicative of the cost structures incurred by MMM 5 and 6 services. For example, there are services that fall within MMM 4 and 5 that can be more than two hours from the nearest large urban centre, and as a result incur similar fixed costs as more remote services - albeit not to the same extent, but materially more than services in larger urban centres.

   CHA strongly urges therefore that further analysis is undertaken of regional services using a larger sample before the base care tariff regime for the new funding model is finalised.

d) CHA notes that the AN-ACC is intended to focus on the functional consequences of underlying health conditions, such as **dementia**, rather than have separate classes for particular health conditions. As a result, the intention of the new classification system is that the functional consequences of dementia are measured and incorporated into each classification.

   CHA is concerned however that this approach, in practice, may result in dementia specific facilities receiving significantly lower funding than under ACFI. In this regard, CHA's attention has been drawn to the results of a dementia specific facility whose residents were assessed as part of the RUCS where 60% of the residents were assessed as class 6 and below, and 30% were assessed as independent. This spread of residents across the classes would result in a significant funding reduction for this dementia specific facility.

   It is unclear to what extent dementia specific facilities were included in the RUCS. However, given the above example, CHA considers that the trial include a representative sample of dementia specific services because, depending on the financial impact, it has the potential to influence dementia care and the availability of dementia services.

e) The additional funding required for **base care tariff 1-5 homes** should not be met through a re-distribution from within existing Budget forward estimates by re-directing funding across shared care and individual care, or re-directing funding from base tariff 6 homes. Additional Budget funding should be included under the new model from the outset to cover the additional costs incurred by higher base care tariff homes that has been identified by RUCS.

f) Because of the growing consumer demand for **residential respite services**, especially as the availability of home-based services expands, CHA recommends that the new funding model be extended to residential respite, including provision for an adjustment payment.

g) CHA observes that it is potentially misleading to refer to the 'base care tariff' as a 'fixed' component as it varies according to occupancy (except for a limited number of MMM 6 and 7 services and homeless services). As an alternative, when used, the 'fixed' reference could include 'per occupied bed' as a qualification.

Question 2: Are the resident assessment and classification processes appropriate?

The following provides comments on aspects of the proposed resident assessment and reassessment processes.

a) CHA agrees that the external assessors should be independent. The legislative basis or authority that establishes their independence needs to be clarified. CHA also supports the proposals for ensuring comprehensive and specialised training of assessors to ensure consistency of assessment, and the proposal that the credentialing of assessors be based on qualifications in registered nursing, occupational therapy and physiotherapy.

b) As well as inter-rater consistency, it is important for the successful operation of the system that assessors accurately assess the care needs of each person.

   CHA notes that, even though assessments are intended to use a range of strategies, including observation, conversation and key informants (including family, carers, friends, staff and external health providers), the initial piloting of the tool indicates that an assessment can be completed in about an hour.

   CHA members are concerned that a one hour 'snap-shot' assessment may not be representative of an individual's needs which can manifest differently over a relatively short period of time, including the time of day when the assessment is undertaken. CHA notes that providers will be tempted to do their own assessment of each prospective resident before admission if they are not confident of the independent assessor's assessment.

   Confidence in the independent assessment is vital to achieving the objectives of the new model. Accordingly, CHA considers that this aspect be monitored as part of the trial, and if established as a problem, that alternative arrangements be considered e.g. the provision for reviews or for reassessments to be undertaken by the provider, subject to audit.

c) CHA notes that the NWAU price weights for Class 1 (admit for palliative care) and Class 13 are the same. CHA also notes that the evidence base for setting the price weight for Class 1 was not extensive, and that the relativities may change in the light of ongoing review and new information.

d) While acknowledging the importance of a professional, credentialed and skilled assessor workforce, CHA members are concerned that establishing the assessor workforce may be at the expense of skilled staff to work in aged care, especially registered nurses and physiotherapists, noting that the current assessor and validation workforce is drawn from a wider range of occupations. This is another matter that will need to be taken into account in assessing the trial, and when implementing the new funding model.

e) The development of streamlined eligibility assessment arrangements across all aged care that is currently underway 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, 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.

f) Timeliness of assessment and re-assessment will be essential to the efficient operation of the system. In this regard, it is important that the trial includes a trial of using internet-based assessment, targeting rural and remote communities in the first instance.

Question 3: Are the proposed re-assessment triggers appropriate? If not, why not?

CHA notes that the reassessment triggers proposed by ASHRI are designed to allow a person to be assigned to a higher paying class if their needs change significantly due to either a deterioration over time or as a result of a specific event that results in a significant change e.g. following a period of hospitalisation.

The AHURI study indicates that many residents undergo significant change in only a matter of months. For example, by using an increase in individual care payment of more than 10% as the trigger for movement to a higher payment class, 23% of the AHURI study group were re-assigned to a higher class over a short period. This suggests that a time-based threshold may not be appropriate, and suggests instead that a significant change in needs, which can take place over a short time, would be a more appropriate trigger.

CHA is also concerned that the proposed period of hospitalisation, five days, may be excessive, and it is unclear why five days was chosen. CHA notes that the target length of stay for public hospitals in most jurisdictions for benchmarking purposes is four days, making the five day threshold a high threshold. While a lower threshold (two days) is proposed if an anaesthetic is used, there are conditions such as a stroke of heart attack that do not involve an anaesthetic, but which may trigger significant care need changes.

CHA suggests that two days of hospitalisation be considered as a trigger. This would not mean that a reassessment will always be requested after two days of hospitalisation, but would cover instances when there has been a significant change following a short hospitalisation.

Other triggers similar to hospitalisation that could be considered include a case conferencing event with the family or significant other, or a medical officer's review of care needs.

Question 4: Are there other factors that should be considered for inclusion as reassessment triggers?

CHA members consider that the need for palliation and a significant deterioration in cognition should be triggers for reassessment, noting that significant decline can occur over a short period.

Question 5: Should the Commonwealth consider the introduction of reassessment charges for services that trigger unnecessary reassessments?

Assessments and reassessments should be free of charge for both consumers and providers.

With regard to the potential for unnecessary requests by providers for reassessments, CHA considers that the Government should signal its preparedness to introduce charges for reassessments (or similar options) if provider behaviour results in excessive and unreasonable requests. In the event of excessive requests by providers for reassessments, an alternative option may be to apply a reassessment charge after a set number of failed reassessment requests over a given period.

But in the first instance, however, it would be appropriate for Government to signal an intention to monitor and assess provider reassessment request behaviour.

Question 6: Should there be a requirement for re-assessment in the proposed funding model?

Consistent with a focus on wellness and quality of life outcomes, CHA considers that there should not be a requirement for re-assessment in the new funding model, noting that maintaining mobility and social engagement incurs ongoing costs.

Question 7: What are your views on an annual costing study to inform price?

From the perspective of the viability of quality aged care service provision, the most important consideration in assessing the new model is the extent to which it can result in prices (revenue) that reflect movements in care-related costs and, importantly, meet rising community expectations about quality of life outcomes based on greater involvement of allied health professionals and social engagement activities.

CHA supports the proposal that the new funding model include annual independent costing studies that will provide data on cost movements, such as wage increases and service improvements, to inform prices for the following year. While annual prices will be set by government, price setting should be based on a transparent analysis and recommendations made by an independent body. The Independent Hospital Pricing Authority, which performs this role for the public hospital and health sector, provides the precedent for aged care to follow.

With the expansion of home-based care, access to respite services will become increasingly important to consumers and the aged care sector. It is important that the annual costing studies include respite care.

Question 8: What are the risks and benefits of rolling the viability supplement into the fixed payment NWAUs?

The main benefit of rolling the viability supplement into the fixed payment NWAU is that it becomes subject to the regular costing studies. Therefore any increases in the NWAU would flow to the base shared-care tariff that includes the viability supplement. There would also be administrative benefits.

CHA understands that there will be scope under the new model to change RVUs in response to costing studies. As a result, there is a risk that, for a given NWAU, this may result in a re-distribution of funding across classes and base tariffs. As a result, changes in RVUs in favour of base tariffs for rural and remote services may be resisted by other sectors of residential care unless the cost of any changes is met by an increase in overall funding.

There is also a risk that relates to the loss of visibility by removing the supplement. Loss of a separate funding mechanism (a specific purpose supplement) may reduce the potential for cases to be argued specifically for smaller rural and remote services, noting that the viability supplement covers the cost of daily living expenses as well as care-related costs. Scale and geography also impacts daily living expenses. History tells us that successive governments have been quite responsive to submissions that make a case for increasing the viability supplement.

CHA also understands that the ABF arrangements for public hospitals include significantly modified arrangements for small rural services.

Accordingly, CHA considers that this aspect would benefit from a clearer exposition of how rolling the viability supplement into the NWAU arrangements would work in practice.

Question 9: What are the risks and benefits of rolling the homeless supplement into the fixed payment NWAUs?

CHA notes that rolling the homeless supplement into the NWAU arrangements raises similar issues as for the viability supplement.

Question 10: Which transition option do you prefer? Why?

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 two year transition period also poses financial (and service quality) risks for providers and consumers.

With regard to the proposed 'stop/loss' provisions, CHA considers that the proposed threshold of 5% is too high. Especially in the current environment, 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 amount reviewed at implementation time in the light of the overall financial performance of the sector at the time. Any threshold could also apply to providers, rather than individual services.

Question 11: Are there any other approaches that should be considered?

An option that has been mentioned for consideration to effect a quick transition is to use a mapping approach to translate existing ACFI assessed residents to the new AN-ACC. This might help reduce the window required for reassessing existing residents.

Question 12: What are the implications of ceasing ACFI assessments in relation to care planning activities?

Ceasing ACFI assessments (and the need for validation processes), in theory, will enable skilled resources to focus exclusively on care planning, rather than assessing for both care planning and funding purposes.

However, the extent to which this happens in practice will depend on the level of trust that providers have in the funding assessments undertaken by the external assessors. The implication is that Government will need to ensure that the external assessment processes are well resourced by professional and credentialed assessors in order to deliver consistently reliable, trusted, timely and accurate assessments.

Question 13: Do you support the development of a best practice needs identification and care planning assessment tool for use by residential facilities?

While noting that such tools already exist and are extensively used, CHA would not object to the Government funding research aimed at developing a new tool for use in the Australian context that takes into account rising community reablement and quality of life expectations. However, CHA considers that providers should have discretion to choose their preferred assessment tool for care planning.

Question 14: Do you support a requirement for care planning assessments to be undertaken at least once a year for all residents, with outcomes discussed with residents and carers?

CHA considers that such a requirement would be consistent with the current practices of most providers, and should be a matter that is monitored by the new Aged Care Quality and Safety Commission.

Catholic Health Australia

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