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| State or territory: | New South Wales |
| Organisation name: (Enter N/A if this does not apply to you) | Uniting NSW.ACT |
| Your role: (Enter N/A if this question does not apply to you) | Head Finance Strategy |
| Which statement best describes your involvement with aged care? | I work for a major residential aged care provider |
| What perspective do you represent? | Aged care providers |
| If you work for a residential aged care provider, what type of organisation do you represent? | Not-for-profit |
| Are you located in a rural or remote area? | Yes |
| Are you a member of, or do you represent or provide specialist care to any of the following groups? (tick multiple) | Culturally and linguistically diverse communities, People with dementia, People experiencing or at risk of homelessness, LGBTIQ+ people |
| Have you heard of the Independent Health and Aged Care Pricing Authority (IHACPA) or the Independent Hospital Pricing Authority (IHPA) prior to this public consultation? | Yes |
| How did you hear about this consultation? | Department of Health and Aged Care Newsletter Alert |

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| What, if any, may be the challenges in using the Australian National Aged Care Classification (AN-ACC) to support activity based funding (ABF) in residential aged care? | AN-ACC allocations are based on RUCS studies pre COVID and -substantial changes in aged care that have evolved due to COVID and -service delivery has evolved due to continuing changes in quality standards -on going technological changes have changed service delivery -consumers have responded to residential aged care due to the Aged Care Royal Commission. The RUCs studies raised concerns that some of their data and recommendation were based on a limited sample size. The limited RUCs sample size voiced in RUCs Volume 3 page 14 stated the sample size for the MMM3 to MMM 5 categories was too small and the results should be treated with caution. We know that regional areas are challenged in obtaining staff and do so at additional expense. Some of our regional services attract agency staff only by offering accommodation. For smaller services (less than 30 beds) a fixed cost aligned to MMM7 fixed costs was identified in the RUCs study. This has not flowed through into ANACC (apart from remote services). Smaller services have yet to come to grips with the impact of the 24/7 RNs. ABF needs to look at regulatory imposts when driving efficiency. ABF for hospitals appears to support smaller hospitals funding funded, ANACC has only taken a size of service approach for remote services, and then only for the fixed component of ANACC. The use of the MMM categories has been shown to create problems in the distribution of health workforce, and has required a process of exemptions from the MMM framework. No exemption process for a regional site with a designated MMM has been developed for aged care. A town of more than 5,000 people moves from MMM 5 to MMM 4 regardless of the characteristics of the town. Proximity to larger cities creates challenges for resourcing, increasing the cost of labour. An MMM 4 service (in a town of 6,600 residents) can have a higher cost of labour than an MMM 5 service in a town of 400 residents. ANACC (RUCs) is restricted to an analysis of the resourcing for what has been defined as “direct” care. The adequacy of the definition that has be re-defined for ANACC remains disputed, direct care is defined as rostered face to face care (but, employed allied health practitioners or specialists who are not on a roster are not included). This approach is maintenance of the resident in their current condition, rather than one of achieving consumer directed outcomes. We are yet to determine if the funding (proportions) proposed under AN-ACC for each class is an adequate reflection of resource requirements. The assumption of ANACC is that (apart from palliation) mobility is the primary driver of driver of resource allocation, with the applied factor finessed by the degree of comorbidities. Being mobility focussed, the design work for home care funding has not adopted the ANACC framework. We are not sure that this failure to align the drivers for the two funding systems will produce the best outcomes for consumers or for government policy. There may be merit in the IHACPA looking at pricing drivers that could be applied to both home care and residential aged care. |

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| What, if any, concerns do you have about the ability of AN-ACC to support long-term improvement in the delivery of residential aged care in Australia that is efficient, sustainable and safe? | AN-ACC is a funding formula for a subset of residential aged care operations, direct care. To ensure the residential aged care is sustainable at a provider level the returns of all of the operations of residential aged care providers needs to be reviewed. To ensure sustainability at a government funding level, the interplay between home care, aged care and the health system need to be reviewed. Current benchmarking shows cross subsidy from accommodation returns to hotel services and at times a cross subsidy from accommodation to care. The result is an accommodation result that does not support redevelopment, and for most providers a negative result (depreciation is not covered). Until a breakeven (at least) is achieved on care and hotel services, and accommodation provides a return to capital that can support borrowing, residential aged care will not be sustainable. Recommendation 45 of the Aged Care Royal Commission and the Government's response is required to be put in place to provide adequate accommodation returns The Government will work with the aged care sector and relevant stakeholders to develop a reformed Residential Aged Care Accommodation framework, to commence from July 2024. The framework will include: Reforms to residential aged care accommodation funding to better reflect the capital cost of accommodation. If the Authority has a role in sustainability why are all of the revenue levers not in the Authority's remit? The aged care system currently has a number of price restrictions that prevent a greater consumer contribution. |
| What, if any, additional factors should be considered in determining the AN-ACC national weighted activity unit (NWAU) weightings for residents? | -The ANACC weighting for a resident is determined by assessment using a predefined range of instruments. The shadow assessment phase of ANACC showed the challenges in the class definition – dementia was upgraded as a cost driver. The class definitions are a average of the presenting needs at a point in time – we are yet to see the rate of change in ANACC class due to increases in resident acuity (and reassessment). Components of the assessment may be a better driver for resource allocation, but to adopt this approach envisages a system drowning in reporting requirements of individual residents and a system where reassessment is infrequent. -Because ABF is being measured as a service average there is concern about the composition of a service's average (number of residents not yet assessed, number of respite, beds off line for refurbishment etc). -The adequacy of the respite funding levels needs to be verified by actual data. -There is a concern that the current NWAU is a plug figure back worked off the (Budget) spend envelope applied to the fixed and variable costs of ANACC. Pricing proposals can only be viewed in the context of the available funds and it is expected the price will become a proportion to drive allocation, unless pricing is developed in the context of the available funds. -The proportion of residents in each of the ANACC classes will change as providers seek to support those with higher acuity. It is probable that as a greater proportion of aged care residents are in a higher class, we may need to see a recasting of the proportion of ANACC allocated to each class or a reduction in the NWAU. |

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| What should be considered in developing future refinements to the AN-ACC assessment and funding model? | Why are there no expected fixed costs (one off adjustment component) for the admission of respite clients? Why is palliation only defined as occurring before entry into a service (palliation funding is not possible once a person had been admitted to a service?) Why is resourcing for palliation only funded if identified before admission. The RUCs study showed the proportion of residents moving to palliation between assessment and reassessment. As an efficiency outcome, will we know what improvements in care are achieved when we move from 200 to 215 minutes per resident per day? How will this be identified? How are innovations to be funded? Innovations require risk capital and can result in quality or efficiency improvements. The principles support innovation, but services need a return to be able to fund innovation. Why is ANACC care defined as only rostered face to face? Do other forms of care not achieve quality outcomes? The drivers for overheads and management cost have not been identified. A quantum of cost subjectively allocated will have impacts on the accuracy of overall costs. Increased reporting and compliance time has not been funded and it is anticipated the needs of IHACPA will provide additional reporting (and system development) cost. |
| What, if any, changes do you suggest to the proposed principles to guide the development and operation of the Pricing Framework for Australian Aged Care Services? | It is challenging to see how the following Principles will be achieved: -Access to care. Not stated in the description under “access to care” is the proposal that the care is consumer directed care, according to their desired outcomes of consumers not what is being offered by the service. -Access to care. People of low means can have difficulty finding care in some markets. How will the pricing system address low means if accommodation pricing is not in scope? -Quality of care: we appear to be driving pricing analysis off what is currently supplied and off the quality of current operations. The Royal Commission criticized what is currently being provided. Recommendation 115 recommended the Pricing Authority should commence studies on the cost of providing high quality care. Pricing should ensure quality by establishing prices based on resourcing required to achieve quality. -Quality Care: Is there a debate needed on what the Aged Care Quality Standards minimum standards are? Do we need to determine what are core and not core services and whether consumer contributions are required for non-care services? Is the discussion regarding core and non core services a consumer driven discussion? -Fairness. The cost of acquiring services varies across Australia. MMM is a blunt tool and ABF looks to be efficiency driving through averages. Fairness may require layers of averages according to location. -Fairness. There appears to be little discussion about thin markets. The debate continues around how far a community should have to drive to residential access aged care. Small towns can only operate as small, aged care services. There needs to be analysis on the cost of the “minimum” roster the size of a service and the funding required. |

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| What, if any, additional principles should be included in the pricing principles for aged care services? | None. The 3 sets or principles are comprehensive. |
| What, if any, issues do you see in defining the overarching, process and system design principles? | The operation of the principles is not elaborated on in subsequent sections of the discussion paper. An example is innovation. The current experience is that innovations need margin to fund the innovation and support the business case. There is no clarity as to whether the pricing proposals will allow margin, or whether we are now looking at a pricing framework that seeks to break even on care. |
| What, if any, concerns do you have about this definition of a residential aged care price? | The time lag from collection of data to impact on price is a concern. The hospital activity-based system appears to have a two year delay. Concerns previously expressed (in the above) are that the price is based on current practices and current levels of care, it is not a price reflecting the "required level of care". There are concerns that prices proposed can only be funded if the total funding is sufficient to cover the pricing. Are we looking at an allocation methodology to be applied to available funds? |
| What, if any, additional aspects should be covered by the residential aged care price? | The pricing activity should cover care, hotel services and accommodation. Failure to do so does not recognise the cross subsidies required at times to ensure sustainability. The premise of the care pricing is that care is a discrete function performed by specialist staff and those staff are not able to perform any cleaning or other hotel services functions. The Royal Commission called for smaller personalised models of care. The smaller models of care enable care staff to act in a household context – performing more than care functions. If an artificial separation of function has to be advised based on estimations, data quality will be poor. |
| What, if any, concerns do you have about the proposed pricing approach and level of the residential aged care price? | The discussion thus far has drawn a nexus between ANACC case mix and by implication minutes of care per resident per day. In reassuring the sector on the adequacy of ANACC funding to cover minutes it set out analysis showing that the average minutes required per class is covered by just 78% of the proposed ANACC funding https://www.health.gov.au/sites/default/files/documents/2022/08/what-are-care-minutes.pdf. At the time this was presented the StewartBrown allocations placed all overheads into care and the total funding proposed to be received under ANACC would not have covered care costs. As required by the QFR overheads are now being allocated to care, hotel services and accommodation but the allocation methodology remains unclear and will result in inconsistent comparisons. |

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| How should 'cost-based' and 'best practice' pricing approaches be balanced in the short-term and longer-term development path of the Independent Health and Aged Care Pricing Authority (IHACPA)'s residential aged care pricing advice? | Normative pricing is essential. It needs to be understood why the quality of aged care delivered might be below community expectations. Normative pricing will quantify the shortfall. Government will be better informed. |
| What should be considered in the development of an indexation methodology for the residential aged care price? | If pricing is based on cost data, it is possible to predict cost trends – forecasts could drive price rather the indexation methodologies. The COPO/COPE method was derived to create efficiency in the delivery of government funded services, but when applied to aged care it has an impact on quality and service sustainability. Increased staff time and wage costs under COPO indexation has resulted in a steady reduction of EBITDA per bed. If we are to see indexation it needs to be in the context of the increased staffing and quality of staffing required. 24/7 RNs will be a major impost. In the STARs discussions thus far, it has been proposed that services delivering the required minutes per resident per day would achieve 3 out of 5 stars. Excellence would be a quantum greater than the required minutes. Average funding cannot create excellence in minutes per resident per day. |
| What, if any, additional issues do you see in developing the recommended residential aged care price? | Assessment of the EBA/EAs in place provide improved insight into wage expectations rather than the FWC decisions. |

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| What, if any, changes are required to the proposed approach to adjustments? | The Base Care Tariffs are presented in the discussion paper as being inefficient. Adjustments based on the characteristics of a person receiving care are generally preferred to facility related adjustments. This is because adjustments related to individual people receiving care are more clearly outside the control of a particular service or type of provider. Facility based adjustments risk enshrining existing facility-related inefficiencies, even though those inefficiencies may be shared across all facilities of a particular type. The rationale for the BCTs was fixed versus variable costs. The costs of care-related services that are not driven by the care needs of individual residents but by care costs consumed equally by all residents plus facility characteristics. These include the costs of shared care and a proportion of the costs of facility management, care co-ordination, administration and education. In a blended funding model these costs are funded through a fixed payment per day for each facility type. https://www.health.gov.au/sites/default/files/documents/2019/12/resource-utilisation-and-classification-study-rucs-reports-report-3-structural-and-individual-costs-of-residential-aged-care-services-in-australia_0.pdf If we are to move away from the BCT the validity of using ANACC as the basis of costing is questioned – the RUCs recommendations are based on apportionment of the variable costs after determining the fixed component. RUCs identified higher levels of cost for certain geographies or types of services. If Activity Based Funding fails to accommodate the increased cost in these areas we will see an increase in the number of smaller regional providers closing. This outcome would appear to be contrary to the access principle. Funding should support appropriate access to aged care services. Individuals should have access to care that is not unduly delayed by availability, access to assessment, location or other factors |
| What, if any, additional adjustments may be needed to address higher costs of care related to the resident characteristics? | ANACC classes are an average of individual client profiles. Analysing the relative component of each profile clinical of each resident by geography and service size/design/age needs would help understand higher costs of individual residents, but could not be carried out as a provider exercise (the Department of Health has the profiling data). |
| What evidence can be provided to support any additional adjustments related to people receiving care? | Existing benchmarking shows variance between the costs incurred by metropolitan, inner and outer regional providers (on a cost per bed per day basis). ANACC profile adjusted data by region will enable additional adjustments. |
| What should be considered in reviewing the adjustments based on facility location and remoteness? | Wage costs and consumable costs and possibly occupancy. Suggested earlier, the size of service is also a factor to be considered. It was presented earlier that location/remoteness by MMM is not necessarily a suitable basis for analysis. The costs experienced by services are not driven solely by definitions such as “within 10kms of a town with a population of 5,000 or more”. |

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| What evidence can be provided to support any additional adjustments for unavoidable facility factors? | The financial data will provide insight into a “minimum roster”, e.g. the minimum staff on duty overnight as a factor of the number of beds/wings in a service. ANACC requirements such as 24/7 RNs regardless of occupancy further drive this. |
| How should any adjustments for quality and safety issues be considered in the long-term development path of AN-ACC and the associated adjustments? | IHACPA may need to develop a forecasting capacity for the cost of quality and safety changes. If we wait until service providers have provided the service according to amended quality and safety requirements, providers will see a further reduction in sustainability – or IHACPA may need to recommend one off payments as a result of cost variances observed. |
| Should hotel costs be incorporated into the AN-ACC funding model and what should be considered in doing this? | Yes. All hotel costs should be included. Accommodation returns (return to capital) should also be included. |
| What should be considered in future refinements to the residential respite classification and funding model? | Respite comes with high administration costs – setting up residents in systems for short term stays. An overhead component for all respite residents, regardless of clinical need should be considered. An improved level of case mix assessment and therefore class variance may benefit respite. |
| What are the costs associated with transitioning a new permanent resident into residential aged care? | Work needs to be undertaken to process flow the workload for new admissions. The process flow needs to include issues such as means testing adjustments, default DAP payment until a decision is made by the resident as to whether a RAD or a DAP will be paid long term, and if a RAD is to be paid, the follow up on ensuring completion (often RAD payment is subject to house sales). |
| How might workforce challenges present in the implementation and refinement of AN-ACC for the aged care system? | Staff availability, use of agency staff, applications for exemptions for RNs do, and will all impact the comparability of the cost of service provision. The impact will be more noticeable in some areas more than others (taken from our own experience over 76 sites in NSW and the ACT). |
| What areas should be included in the proposed five-year vision for IHACPA’s aged care pricing advice? | Residential aged care and home care need to have aligned pricing bases. The failure to develop home care pricing based on ANACC principles is understandable but will create major impediments in government aged care policy and will skew consumer choice. The correct pricing signals need to be sent if we are to encourage more home care and higher acuity residential aged care. The cost of care and consumer expectations change rapidly – we need annual normative cost of care reviews. |

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| What would be considered markers of success in IHACPA's aged care costing and pricing work? | Services make sufficient return that redevelopment can be funded by external borrowings and innovation can be funded. |
| Other comments | NULL |
| Please indicate if there are specific sections of your submission that you wish to remain confidential and the reasons for this. | NULL |
| I consent to IHACPA contacting me for further information or clarification about my submission. | Yes, I consent |
| Timestamp | 44848.63611 |