



Towards an Aged Care Pricing Framework Consultation Paper

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August 2022

Independent Health and Aged Care Pricing Authority



IHACPA

Towards an Aged Care Pricing Framework Consultation Paper – August 2022

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Abbreviations

Abbreviations	Full term
ABF	Activity based funding
ACFR	Aged Care Financial Report
ACFI	Aged Care Funding Instrument
AN-ACC	Australian National Aged Care Classification
BCT	Base Care Tariff
BDF	Basic daily fee
CHSP	Commonwealth Home Support Programme
DAP	Daily accommodation payments
HCP	Home Care Packages
IHACPA	Independent Health and Aged Care Pricing Authority
IHPA	Independent Hospital Pricing Authority
MMM	Modified Monash Model
MPS	Multipurpose service
NATSIFACP	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
NEP	National efficient price
NHRA	National Health Reform Agreement
NWAU	National weighted activity unit
QFR	Quarterly Financial Report
RAD	Refundable accommodation deposit
RUCS	Resource Utilisation and Classification Study
STRC	Short-term Restorative Care Programme
UOW	University of Wollongong

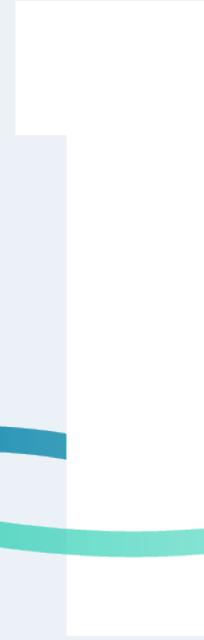
Glossary

Term	Description
Activity based funding (ABF)	A system of funding service providers whereby they are paid for the number and characteristics of people that they provide services to.
Activities of daily living	Self-care tasks that include, but are not limited to functional mobility, bathing and showering, dressing, self-feeding, personal hygiene and grooming and toileting.
Additional service fee	Additional hotel-type services offered by an aged care provider and paid for by the resident. These services may include things like a preferred brand of toiletries, access to paid TV services, or arranging a hairdresser.
Aged Care Financial Report (ACFR)	<p>The ACFR enables the Commonwealth Government to collect approved provider data (and parent entities where applicable).</p> <p>Residential aged care providers report:</p> <ul style="list-style-type: none"> • income and expenses on care services and other activities, for each individual facility • approved provider level balance sheet, income statement and cash flow statement (non-government) • a residential aged care segment note covering all residential services • an Annual Prudential Compliant Statement.
Aged Care Funding Instrument (ACFI)	Residential aged care providers currently use ACFI to claim residential care subsidy for each resident that permanently enters their care, based on their assessment of the resident's ongoing care needs.
Australian National Aged Care Classification (AN-ACC) system	Consists of the AN-ACC assessment, AN-ACC casemix classification and AN-ACC funding model.
Basic daily fee (BDF)	<p>The BDF is paid by all residential aged care residents and is independent of income or assets. It is paid by the resident to cover hotel services such as meals, electricity, cleaning, maintenance and laundry.</p> <p>The BDF is set at 85 per cent of the basic aged care pension and changes with the pension amount in March and September every year.</p> <p>The BDF is also payable by people with a Home Care Package. It is set at 15.68 to 17.50 per cent of the single basic age pension, depending on the Home Care Package level.</p> <p>Some people may be eligible for financial hardship assistance with their BDF.</p>
Basic Daily Fee Supplement (BDF Supplement)	<p>The Commonwealth Government provides BDF Supplements for eligible aged care providers. The 2021 BDF Supplement supports aged care providers to deliver better care and services to residents, with a focus on food and nutrition.</p> <p>From 1 July 2021 eligible residential aged care providers who have entered into an agreement with the Department of Health and Aged Care (known as an undertaking) have been receiving an additional \$10 per day, per resident.</p> <p>The 2021 BDF supplement is available to eligible:</p> <ul style="list-style-type: none"> • residential and respite aged care services • flexible care services that are Multipurpose services (MPS) • services providing residential care under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP).

Best-practice or normative pricing	A pricing approach focused on ensuring sufficient funding to achieve desirable or required standards. In the case of residential aged care, this approach recognises that prices should be set at a level that enables the required care, quality and safety standards to be met.
Commonwealth Home Support Programme (CHSP)	CHSP provides entry level support for older people who need some help to stay at home, maintain their independence and keep them as well as possible.
Cost-based pricing	A pricing approach focused on alignment to the actual costs of care delivery. This approach would not necessarily account for the achievement of required care, quality and safety standards if it is based on cost data from services not meeting these standards or standards have increased since the collection of cost data.
Daily accommodation payments (DAP)	Instead of a lump-sum residential accommodation deposit (RAD), residents can pay a rental-style DAP. This DAP is calculated by applying the maximum permissible interest rate, set by the Commonwealth Government, to the RAD associated with the accommodation.
Extra services	Some residential aged care rooms have extra service status. This means that they can charge residents a regular extra service fee to provide residents with a bundle of higher standard hotel-type services. Examples include specialised menus, higher quality linen or particular room furnishings.
Home Care Packages (HCP)	<p>HCP provide support to older people assessed as having more complex needs to help them stay at home, going beyond supports provided through the Commonwealth Home Support Programme. Approved aged care service providers work with people receiving care to plan, organise and deliver HCP.</p> <p>Services can include:</p> <ul style="list-style-type: none"> • help with household tasks • equipment • minor home modifications • personal care • clinical care such as nursing, allied health and physiotherapy services. <p>There are four levels of HCP to provide support from basic to high care needs.</p> <p>HCP funding comprises the Commonwealth Government subsidy and any applicable supplements, as well as basic daily fees, income-tested care fees and amounts for additional care and services paid by the person receiving care.</p>
Living Longer Living Better reforms	The Commonwealth Government's Living Longer Living Better reforms came into effect in June 2013. The package provided \$3.7 billion over five years as part of a 10-year plan intended to build a more sustainable, better, fairer, person-centred and nationally consistent aged care system. This included providing more home care and support, improving access to residential care, more support for people with dementia and strengthening of the aged care workforce. ¹
Means-tested care fee	The government's daily basic subsidy for a resident's care, currently determined relative to the resident's ACFI class, is reduced by a means-tested care fee paid to the facility by residents, based on their income and assets. There are significant financial safeguards for residents, imposed by the government, including annual and lifetime caps on means tested care fees payable by residents.
Modified Monash Model (MMM)	A geographical classification system that categorises metropolitan, regional, rural and remote locations into seven levels according to geographical remoteness and population size.

¹ Legislated Review of Aged Care 2017

Multipurpose service (MPS)	The MPS program provides integrated health and aged care services to regional and remote communities in areas that cannot support both a separate aged care home and hospital.
National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)	The NATSIFACP provides Commonwealth Government funding for aged care services to deliver culturally appropriate care to older Aboriginal and Torres Strait Islander peoples and allow them to remain close to home and community. Most of these services are in rural and remote areas.
National weighted activity unit (NWAU)	In the context of aged care services, an AN-ACC NWAU is a measure of relative price. An NWAU of 1.2 means that the price of the activity is 20 per cent higher than the national residential aged care price. An NWAU of 0.5 means that the price is 50 per cent lower than the national price.
Person/people receiving care	A person who receives aged care or support services in their own home or in a residential aged care facility. This care may include support to take part in social activities, help with physical tasks and/or medical and personal care.
Refundable accommodation deposit (RAD)	Residents can pay a lump-sum for their accommodation in the form a RAD, which provides a significant source of funding for capital investment and acts as an interest-free loan to providers. The RAD is fully refundable to the resident when they leave the provider or is returned to the estate if they pass away.
Residential aged care	Personal and/or nursing care that is provided to a person in a residential aged care service in, which the person is also provided with accommodation that includes meals, cleaning services, furniture and equipment. The residential aged care service must meet certain building standards and appropriate staffing in supplying that care and accommodation.
Resource Utilisation and Classification Study (RUCS)	<p>The RUCS is a national study that was commissioned by the Commonwealth Department of Health and Aged Care to inform the development of future funding models for residential aged care in Australia. The overall aims of the RUCS were to:</p> <ul style="list-style-type: none"> • Identify the clinical and need characteristics of aged care residents that influence the cost of care (cost drivers) • Identify the proportion of care costs that, on average, are shared across residents (shared costs) relative to those costs related to individual needs (individual costs) • Develop a casemix classification based on identified cost drivers that can underpin a funding model that recognises both shared and individual costs • Test the feasibility of implementing the recommended classification and funding model across the Australian residential aged care sector.
Schedule of Specified Care and Services	The care and services that aged care homes must provide to any resident as needed, under the Quality of Care Principles 2014 .
Viability and Homeless Supplement	This supplement supports providers who specialise in caring for people who were homeless, or at severe risk of becoming homeless at the time they entered permanent residential care.



Introduction

1. Introduction



1.1 Background

Introduction to the Independent Health and Aged Care Pricing Authority

The Independent Health and Aged Care Pricing Authority (IHACPA) is an independent government agency. It was established and originally named the Independent Hospital Pricing Authority (IHPA) under the *National Health Reform Act 2011* (Cwlth) (the Act), as part of the [National Health Reform Agreement](#) reached by all Australian governments in 2011.

IHACPA was established to promote improved efficiency in, and access to, public hospital services through the provision of independent advice to Australian governments. IHACPA achieves this by developing and implementing robust systems to support activity based funding (ABF) for those services.

Since its establishment in 2011, IHACPA's primary function has been to determine an annual national efficient price (NEP) for public hospital services. The NEP is a major determinant of the level of Commonwealth funding for public hospital services and provides a price signal or benchmark for the efficient cost of providing public hospital services.

The Pricing Authority, IHACPA's Board, consists of a Chair, Deputy Chair and up to seven other members. The Pricing Authority holds the determinative powers under the Act.

Response to the Royal Commission into Aged Care Quality and Safety

Among the 148 recommendations of the [Royal Commission into Aged Care Quality and Safety](#) (the Royal Commission) were recommendations to establish an independent pricing authority for aged care services.

The *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (Cwlth) includes amendments that expanded the remit of the existing IHPA and renamed it to become IHACPA.

Commencing 12 August 2022, Schedule 8 amended the Act, the *Aged Care Act 1997* and the *Quality and Safety Commission Act 2018* to expand the functions of a renamed **IHACPA** to include the:

- provision of advice on **healthcare pricing** and **costing** matters
- provision of advice on **aged care pricing** and **costing** matters
- performance of **certain functions conferred by the *Aged Care Act***.

IHACPA's expanded role in providing independent aged care pricing advice will aim to ensure that aged care funding, including through the new classification system for residential aged care and respite care, the Australian National Aged Care Classification (AN-ACC), is directly informed by the actual costs of delivering care.

IHACPA will provide advice to inform Commonwealth Government (Government) decisions on the costing and pricing of aged care services from 1 July 2023.

1.2 Purpose of the Pricing Framework for Australian Aged Care Services

The Pricing Framework for Australian Aged Care Services (the Pricing Framework) will be the key policy document for IHACPA in aged care. It will underpin IHACPA's approach to providing aged care costing and pricing advice to the Government. It will guide how IHACPA develops pricing advice. It will also outline how any required pricing adjustments are developed to account for unavoidable cost variations faced by providers in delivering services for some groups of people receiving care.

IHACPA will seek to support a range of policy objectives through the Pricing Framework, including enabling aged care providers to deliver the person-centred, quality care expected by the community and improving the safety, efficiency and sustainability of the aged care system. Some objectives may be achievable in the short-to medium-term. For example, prices that sufficiently fund uplifts in the required daily care minutes for aged care residents. Other objectives, such as improved efficiency of the system, are longer-term objectives. The pricing principles, outlined in Chapter 5 of this paper, signal IHACPA's commitment to transparency, fairness and accountability in forming pricing advice.

1.3 Consultation to develop a new Pricing Framework for Australian Aged Care Services

The development of the Pricing Framework will be informed by feedback to this consultation paper. IHACPA is committed to ongoing, open and transparent consultation with a broad range of stakeholders in the aged care system.

This consultation paper is the primary mechanism for all stakeholders to provide input into the development of the Pricing Framework and provides an opportunity for public consultation on:

- the pricing principles, which will underpin the Pricing Framework
- the key challenges for aged care costing and pricing, and how to best address them in the development of the Pricing Framework
- the mechanisms that support ABF in aged care.

This consultation paper focuses on the AN-ACC assessment and funding model in the context of residential aged care and residential respite care. Some feedback will be particularly relevant for the initial development of costing and pricing advice, especially submissions on options and evidence for an indexation methodology. However, stakeholder responses will inform a five-year vision for the Pricing Framework and aged care costing and pricing development.

The Government is also developing reforms to home care services. IHACPA is expected to provide costing and pricing advice relating to these services after reforms take effect. IHACPA intends to undertake future public consultation on the costing and pricing of home care services, to support their incorporation into the Pricing Framework.

1.4 Submissions

IHACPA is calling for submissions on this consultation paper until 14 October 2022.

A series of consultation questions that ask for feedback on the specific challenges and options have been included in relevant sections of this paper.

While feedback is welcome on any issue, it is of particular value to receive views on the consultation questions in this paper. Stakeholders are encouraged to focus on questions and issues relevant to them and do not need to answer every question.

IHACPA is focused on ensuring that submissions are representative of the whole system and the community. IHACPA therefore seeks submissions reflecting the diversity of stakeholders, including people receiving care, their representatives and a wide range of organisations, roles, backgrounds and perspectives.

All submissions will be published on the IHACPA website unless respondents specifically identify any sections that they believe should be kept confidential due to commercial or other reasons.

A consultation report summarising the submissions received will also be published in early 2023.

The key dates for this consultation process are:

Process	Date
Release of the consultation paper	16 August 2022
Submissions close	5pm AEDT on 14 October 2022
Release of a consultation report consolidating stakeholder feedback	Early 2023
Pricing Framework for Australian Aged Care Services 2023–24 published	Early 2023

Have your say

- Submissions close at **5pm AEDT on 14 October 2022**.
- Submissions can be:
 - Completed via the [online questionnaire](#)
 - Emailed to submissions.ihacpa@ihacpa.gov.au
 - Mailed to:
PO Box 483
Darlinghurst NSW 1300
- All submissions will be published on the [IHACPA website](#) unless respondents specifically identify sections that they believe should be kept confidential due to commercial or other reasons.
- The Pricing Framework for Australian Aged Care Services 2023–24 will be published in early 2023.

Enquiries

- Enquiries related to this consultation process should be sent to: submissions.ihacpa@ihacpa.gov.au



Overview of the Independent Health and Aged Care Pricing Authority and its role in aged care

2. Overview of the Independent Health and Aged Care Pricing Authority and its role in aged care



The Independent Health and Aged Care Pricing Authority (IHACPA) is an independent government agency. It was established under the *National Health Reform Act* (Cwlth) (the Act) in 2011. Originally named the Independent Hospital Pricing Authority (IHPA), it was created to contribute to significant reforms to improve Australian public hospitals by implementing national activity based funding (ABF). ABF enables hospitals to be funded for the number and type of patients they treat and increases transparency in the delivery and funding of public hospital services across Australia.

Over this time IHACPA has promoted increased efficiency in, and access to, safe and high-quality public hospital services. This has been achieved primarily by providing independent, impartial and evidence-based advice to governments in relation to the efficient costs of such services. IHACPA has also developed and implemented robust and transparent costing, pricing and classification systems aimed to drive standard practices towards quality and efficiency, to support ABF for these services.

The recent passage of the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (Cwlth) by the Australian Parliament saw IHPA expand and be renamed to IHACPA, becoming responsible for providing advice on costing and pricing matters in aged care.

The Commonwealth Minister for Health and Aged Care will in turn determine the price for aged care services. The Commonwealth Government (the Government) and Department of Health and Aged Care (the Department) will continue to be the system operators and responsible for the funding of aged care and aged care policy.

2.1 The role and function of the Independent Health and Aged Care Pricing Authority in hospital pricing

IHACPA classifies hospital activity and each year delivers a national efficient price (NEP) for ABF services, and a national efficient cost (NEC) for block-funded services.

ABF has promoted transparency, standardisation and benchmarking of public hospital practices across different types of care. These include acute, subacute and non-acute, emergency, non-admitted and mental health care services. It allows system and hospital managers to identify inefficient, unsafe and lower quality care, manage costs and optimise resource allocation with a view to both efficiency and improved patient and consumer outcomes. On this basis, IHACPA works with the Government, state and territory governments and stakeholders to promote patient and consumer outcomes and hospital efficiency.

2.2 The role and function of the Independent Health and Aged Care Pricing Authority in aged care

The established expertise of IHACPA in ABF for public hospital services provides a strong foundation for its expanded role in aged care. However, IHACPA acknowledges the need to ensure its aged care costing and pricing advice is developed specifically for the aged care system. IHACPA is committed to transparency and accountability in making impartial, evidence based and timely policy decisions that are appropriate for the aged care system.

The role of IHACPA within the aged care system will be to provide annual advice on aged care pricing matters to the Commonwealth Minister for Health and Aged Care, in particular:

- Provide annual aged care pricing advice about methods for calculating amounts of subsidies and supplements to be paid for residential aged care, residential respite care and home care. This will involve advice on the costs of care and how changes in the costs of care should be considered in Government funding decisions.
- Review data, conduct studies and undertake consultation for the purpose of providing aged care pricing and costing advice and/or healthcare pricing and costing advice
- Perform such functions as are conferred by the *Aged Care Act 1997* or the *Aged Care (Transitional Provisions) Act 1997*
- Perform other functions relating to aged care (if any) specified in regulations
- Do anything incidental or conducive to the performance of the above functions.

The passage of the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (Cwlth) also saw the transfer of functions from the former Aged Care Pricing Commissioner to IHACPA. IHACPA therefore has the power to approve prices for residential aged care accommodation and extra services.

IHACPA may also:

- benchmark cost and activity data within the aged care system over time
- give consideration to the impact of wage increases on costs, only where these have been determined by the Fair Work Commission.

IHACPA activities relating to home care costing and pricing will be established after the future reforms take effect.

The Government may request that IHACPA considers and provides advice on other aged care matters, as appropriate.

2.3 The Pricing Authority

The Pricing Authority, IHACPA's Board, holds the determinative powers under the Act. For functions relating to public hospitals, the Pricing Authority approves the NEP Determination each year, as well as any other materials required to support the national ABF system.

For functions relating to aged care, the Authority will approve the advice provided to the Commonwealth Minister for Health and Aged Care.

The Pricing Authority consists of a Chair, Deputy Chair and up to seven other members. The composition of the Pricing Authority is expected to change following amendments to the Act to reflect the expanded functions.

The Pricing Authority is supported by a Chief Executive Officer, who is responsible for the day-to-day running of IHACPA.

2.4 Advisory committees and working groups of the Independent Health and Aged Care Pricing Authority

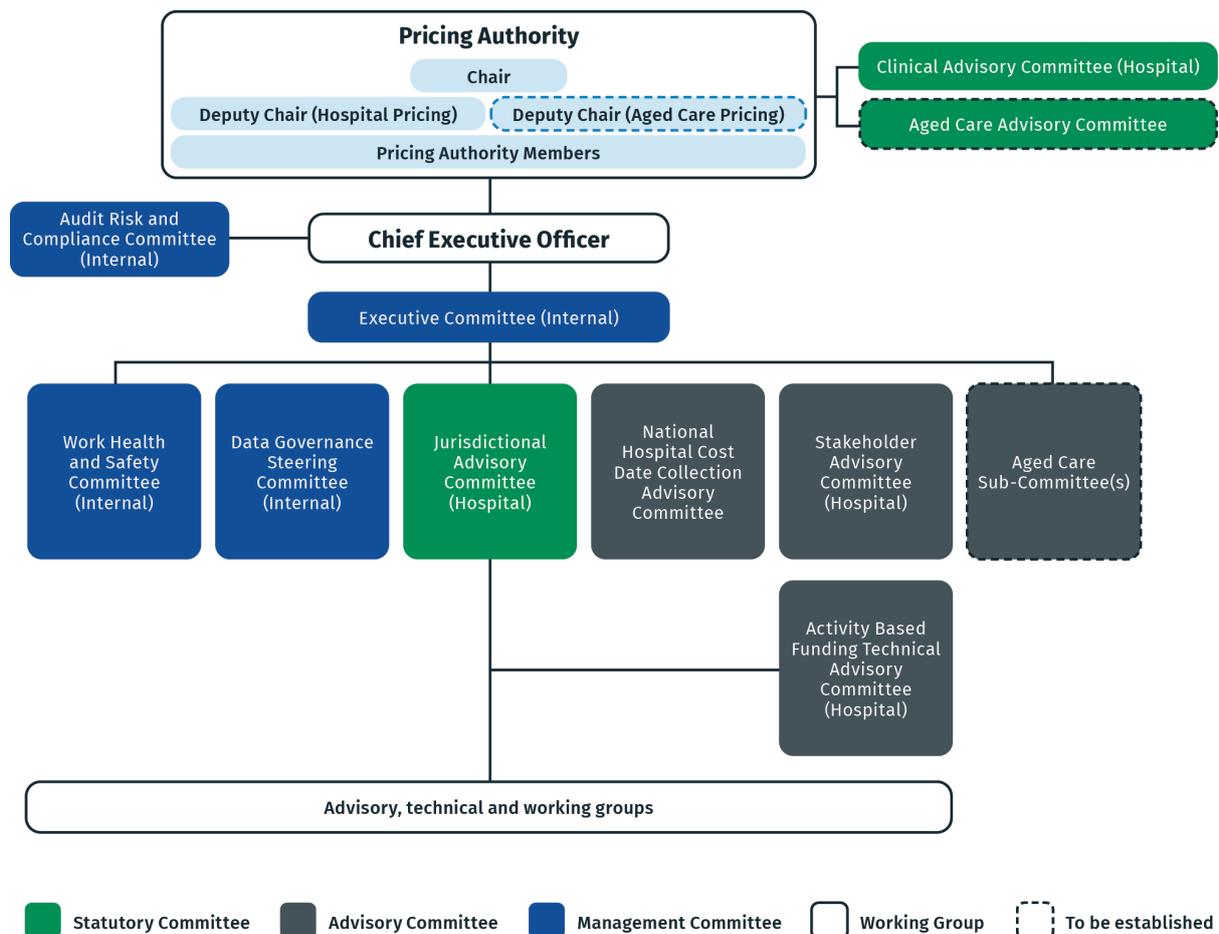
IHACPA relies on significant input from stakeholders to ensure that its classification systems, counting and costing rules, and pricing models, are robust, appropriate and respond to changes in the system.

To support its public hospital services work, IHACPA has a range of statutory committees, advisory committees and working groups that allow stakeholders, technical experts, clinicians, and health care consumers to contribute to its work program. New committees will be established to extend this structure and approach to IHACPA's aged care functions.

IHACPA's statutory committees will be the Clinical Advisory Committee and Jurisdictional Advisory Committee (both relating to hospital pricing) and an Aged Care Advisory Committee.

Additional sub-committees relating to aged care will be established. IHACPA will ensure that membership represents the different provider types operating in the system and the diversity of stakeholders and perspectives.

Figure 1: The intended IHACPA management, committee and working group structure



3



Overview of the aged care system

3. Overview of the aged care system

3.1 The Australian aged care system

The Australian aged care system provides subsidised care and support, through a range of services, to people who can no longer live without assistance. Access is determined by assessed needs and is provided across:

- different settings – in people’s homes, the community and in residential aged care homes
- a range of services – assistance with everyday living activities, equipment and home modifications, personal care, health care and accommodation
- a wide variety of providers – including not-for-profit, for-profit and government providers of various size.

Aged care services are funded by the Commonwealth Government (the Government), state and territory governments, and individuals, with the Commonwealth being the primary funder and regulator of the system.

In 2020–21, total government expenditure on aged care services was \$23.6 billion, and 98.5 per cent of this was Commonwealth spending. Residential aged care accounted for \$14.3 billion (60 per cent) of this expenditure. Resident contributions (excluding lump-sum deposits) represent approximately 27 per cent of total residential aged care provider revenue.²

The *Aged Care Act 1997* and the *Aged Care Quality and Safety Commission Act 2018* (Cwlth) set out the legislative framework for the funding and regulation of aged care services. The main bodies responsible for regulation and compliance of the provision of aged care services are the:

- Department of Health and Aged Care (the Department) – responsible for policy and compliance with the *Aged Care Act 1997*.
- Aged Care Quality and Safety Commission – the national end-to-end regulator of aged care services. The Commission is responsible for granting approval for providers to deliver aged care services, administering the Serious Incidents Response Scheme and reducing the use of restrictive practices.

More broadly, several government agencies, departments and stakeholders are responsible for the delivery of safe, quality and efficient care within the system.

The aged care system is primarily segmented into three areas of care delivery:

- Home Care including the Commonwealth Home Support Programme and Home Care Packages
- Short Term Care including Short-term Restorative Care, Transition Care and Respite
- Residential Care.

² Australian Institute of Health and Welfare GEN Aged Care Data

Commonwealth Home Support Programme

The Commonwealth Home Support Programme (CHSP) provides basic services to help older people to live independently at home.

The CHSP is intended to provide entry-level and relatively low-intensity support for older people who require minimal assistance to continue living in their home and participating in the community.

CHSP providers receive Commonwealth funding through grant agreements to provide subsidised services to older people. People receiving care under CHSP are expected to contribute to the cost of their care if they can afford to, with the cost depending on the type of support required and the CHSP provider.

Home Care Packages

Home Care Packages (HCP) provide support to older people assessed as having more complex needs to help them stay at home, going beyond supports provided through the CHSP. Approved aged care service providers work with people receiving care to plan, organise and deliver HCP.

There are four levels of HCP to provide support from basic to high care needs.

HCP funding is comprised of Government subsidy and any applicable supplements, as well as basic daily fees (BDF), income-tested care fees and amounts for additional care and services paid by the person receiving care.

Reforms to home care

The final report of the Royal Commission into Aged Care Quality and Safety (the Royal Commission) recommended a new aged care program to assist older Australians with staying in their homes for longer. The Government is developing reforms to home care that are expected to consolidate a number of existing programs under a single assessment and funding model.

Respite Care

Respite care is an alternative care arrangement with the aim of providing the carer or the person receiving care a temporary break from the usual care arrangement.

Respite care is funded by the Government across a range of programs, including:

- Commonwealth Home Support Programme
- Home Care Packages
- Residential aged care.

Government funded residential respite care can also be provided through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and multipurpose services (MPS).

The Government currently funds residential respite through subsidies and supplements that are paid to the provider. Respite funding is currently assessed and provided separately to the Aged Care Funding Instrument (ACFI).

The Government has developed a new funding model for residential respite care to align it to the new Australian National Aged Care Classification (AN-ACC) funding model to be used in residential aged care. The new funding model for residential respite will be implemented alongside the AN-ACC funding model.

Residential aged care

The Government currently controls the levers available to influence the financial sustainability of the system and the supply of residential aged care through:

- establishing the price a provider receives
- determining the types of resident contributions that can be charged
- controlling the number of subsidised aged care places.

Residential aged care funding is made up of:

- the ACFI Government subsidy and any means-tested care fees payable by residents
- the BDF payable by all residents
- accommodation payments or contributions paid by the resident plus any Government accommodation supplements
- other applicable Government supplements
- fees paid by the resident for extra and additional services.

As part of the reforms to residential aged care, the new AN-ACC funding model subsidy will replace the ACFI subsidy.

3.2 Current residential aged care classification and pricing

Government funding of residential aged care is largely determined by the ACFI. The ACFI assesses the core care needs of permanent residents in an aged care home to allocate funding according to their required supports. An ACFI assessment is conducted by the aged care provider and is based on twelve questions across three domains – activities of daily living, behaviour and complex health care. Domain scores are additive and determine the daily basic subsidy payable to the provider.

3.3 Other components of funding for residential aged care

Accommodation payments and supplements

On 1 July 2014, the Government introduced refundable accommodation deposits (RAD) and daily accommodation payments (DAP), as part of the Living Longer Living Better reforms:

- **Refundable accommodation deposits** – Residents can pay a lump sum for their accommodation in the form of a RAD, which provides a significant source of funding for capital investment and acts as an interest free loan to providers. The RAD is fully refundable to the resident when they leave the provider or is returned to the resident's estate if they pass away.
- **Daily accommodation payments** – Instead of a lump-sum RAD, residents can pay a rental-style DAP. This DAP is calculated by applying the maximum permissible interest rate, set by the Government, to the RAD associated with the accommodation.
- **RAD and DAP** – The resident can elect to pay a combination of a RAD and DAP.

Accommodation payments are means-tested and individuals with income below certain thresholds are not required to make an accommodation contribution. For these individuals, the Government contributes the full accommodation cost on behalf of the resident through an accommodation supplement. Other residents may pay a means tested contribution that is supplemented by Government funding. A range of Government accommodation supplements are based on ministerially determined rates.³

³ Department of Health, 2017-18 Report on the Operation of the Aged Care Act 1997

3.4 Royal Commission into Aged Care Quality and Safety

The [Royal Commission](#) was established in 2018. Its purpose was to protect and improve the safety, health, wellbeing and quality of life of people receiving Government funded aged care in response to systemic issues in funding, policy, culture and operation. A final report was delivered on 26 February 2021, which made 148 recommendations for the reform of the aged care system.

In response to the Royal Commission's findings, the Government has commenced a range of reforms to the aged care system, including to improve the quality and safety, sustainability, workforce and governance of residential aged care services.

The Royal Commission identified that one of the key limitations of the aged care system is the funding model, with funding levels that are based largely on historical precedents and ad hoc decisions, which bear little direct relevance to the actual cost of delivering care. A new funding model for aged care was therefore determined to be important in driving a transparent, accessible, sustainable and affordable aged care system.

The Royal Commission recommended that a pricing authority be established that is independent from the aged care system and Government. It also recommended that the primary approach for funding aged care services be based on the volume of activity each provider performs, using activity based funding (ABF), and, where practicable, based on a national efficient price (NEP). This approach should be supplemented by block funding in cases where ABF is impractical or inappropriate.

In response to the findings of the Royal Commission, the Government has implemented an independent process to advise the Government on aged care pricing issues. These will include the new AN-ACC funding model for residential aged care, the new residential respite funding model and home care pricing. This has been delivered through the expansion and renaming of the existing Independent Hospital Pricing Authority to take on aged care costing and pricing functions.

The Independent Health and Aged Care Pricing Authority (IHACPA) will inform Government funding decisions by providing advice on residential aged care, including residential respite care, on an annual basis starting from 1 July 2023. IHACPA activities relating to home care pricing are anticipated to be established after future reforms take effect.

The establishment of IHACPA's aged care costing and pricing functions will enable aged care funding decisions to be informed by regular costing studies and independent, evidence-based advice on contemporary cost structures and care delivery models.

IHACPA's work in this area will support and complement broader aged care reforms and improvements occurring across the system.



4

A new funding approach for residential aged care

4. A new funding approach for residential aged care

Consistent with the recommendations of the Royal Commission into Aged Care Quality and Safety (the Royal Commission), the Commonwealth Government (the Government) has commenced funding reform of residential aged care, transitioning to a system of activity based funding (ABF). This will draw on concepts from the implementation of ABF in Australian public hospitals but will need to be designed specifically for the aged care system. The new funding approach will account for, and reflect, the dynamic nature of the system.

Under ABF, providers will be funded based on the number of residents and the type of care they require. This aims to provide a transparent, fair, equitable and predictable approach to funding that is informed by the cost of care delivery.

The key building blocks for a successful ABF system are:

- a robust **classification system** to allow residents to be grouped in a manner that is both relevant to care and resource homogenous
- nationally consistent **activity data**
- nationally consistent **cost data** at a resident level
- **pricing of services** that is regularly updated to reflect the latest cost and activity data.

4.1 Classification systems

Classifications comprise codes that provide clinically meaningful ways of relating the types of residents receiving care to the resources required to deliver that care. As such, classification systems enable the bundling of various care services into predefined classes. This allows the output of service providers to be measured, then informs pricing, funding, budgeting and benchmarking.

The Independent Health and Aged Care Pricing Authority (IHACPA) will aim to support a nationally consistent method of collecting data and classifying all types of aged care residents, their care, and associated costs. This will support the development of classification systems that effectively group residents with similar care needs. This enables pricing to be more closely aligned to the actual care costs for residents in each group.

In 2017, the Commonwealth Department of Health and Aged Care (the Department) commissioned the University of Wollongong (UOW) to develop a new classification system for residential aged care residents in Australia. This followed a number of reviews, which concluded that the existing funding instrument, the Aged Care Funding Instrument (ACFI), was not effectively distinguishing and grouping residents according to their different care and assistance requirements, and the variable costs associated with these different needs. This meant that ACFI funding was not closely aligned to the actual cost of care for residents.

To develop the classification, UOW undertook a series of four discrete but associated studies during 2017 and 2018, known collectively as the Resource Utilisation and Costing Studies (RUCS). These studies trialled different resident assessment approaches and collected information on relative resource utilisation and costs across a wide range of residential aged care facilities.

Figure 2: The series of Resource Utilisation and Costing Studies conducted by UOW



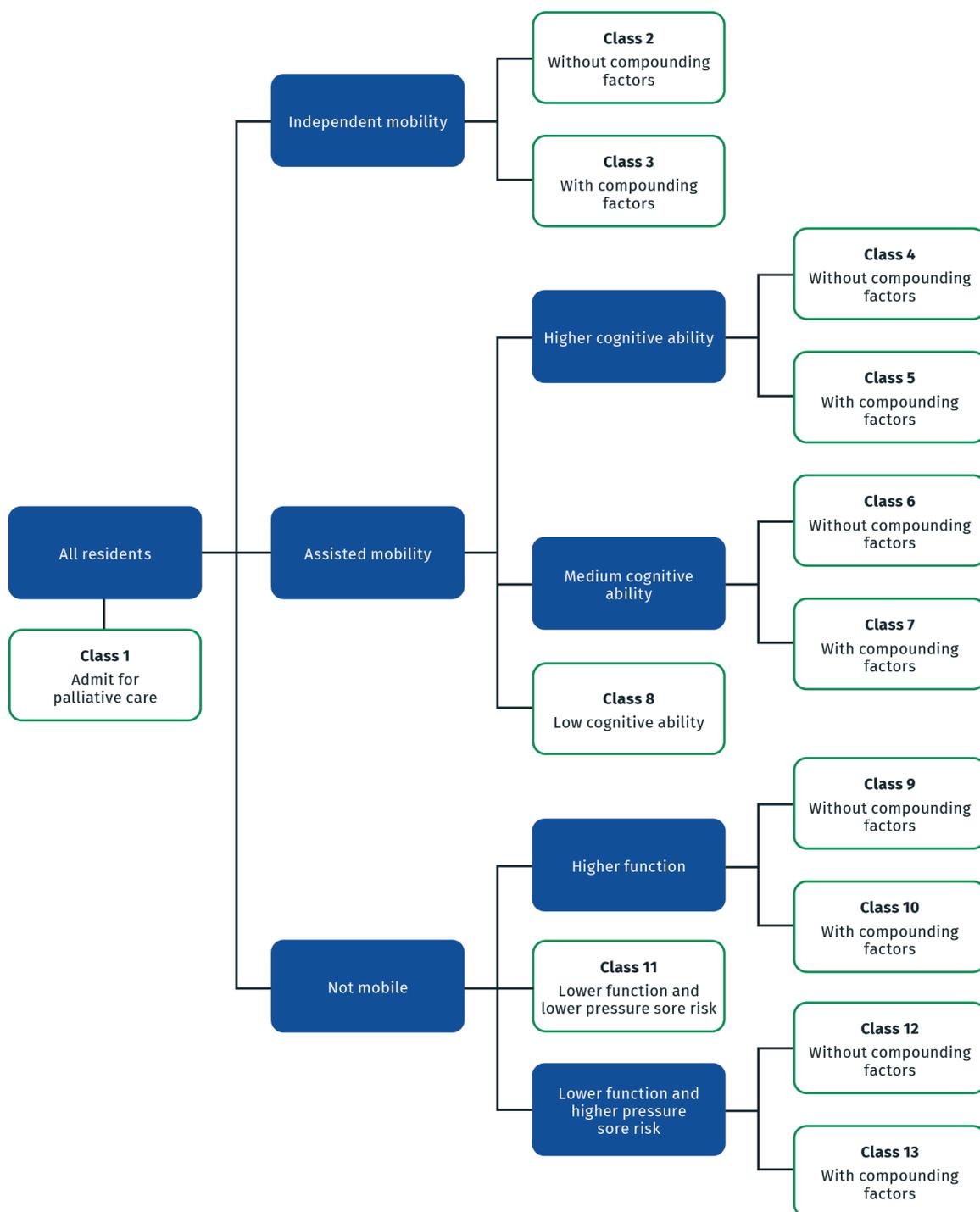
The result of this work was the Australian National Aged Care Classification (AN-ACC) assessment and funding model. This includes a tool that combines multiple assessment instruments, including the de Morton Mobility Index, the Australian Modified Functional Independence Measure, Resource Utilisation and Braden Scale, and assesses residents based on compounding factors. Based on the scores and outcomes of the assessment instruments, residents are assigned into one of 13 classes. The AN-ACC branching algorithm is pictured in Figure 3.

A key part of the reforms to residential aged care funding is the introduction of independent assessments of residents. Independent assessors will use the AN-ACC assessment tool developed by UOW to evaluate a resident's functional, cognitive and physical capabilities.⁴

The Government will also determine how assessments are undertaken, reviewed, and the requirements for re-evaluation.

⁴ [Department of Health and Aged Care AN-ACC Reference Manual and AN-ACC Assessment Tool](#)

Figure 3: Australian National Aged Care Classification (AN-ACC) structure and classes



More detailed information about AN-ACC is available from the [Department of Health and Aged Care](#) and reports relating to the RUCS and subsequent development of the AN-ACC is available from the [UOW website](#).

Initial price weights for each class have been developed by the Department to support the current shadow assessment period and implementation of AN-ACC. Following the commencement of funding through AN-ACC from 1 October 2022, IHACPA will be tasked with refining the classification system over time based on evidence, stakeholder feedback and cost data as it becomes available.

4.2 Activity data

Under the AN-ACC funding model, activity data from residential aged care providers will be reported to the Government. This will include data on the assessed AN-ACC classes of the residents as well as demographic and facility data. This data will form the basis of AN-ACC daily basic subsidies paid by the Government to providers. It will also be used for other reporting requirements.

IHACPA will utilise this data in the development of costing and pricing advice and the refinement of AN-ACC over time. This activity data will help identify relevant cost drivers, such as the costs related to a particular AN-ACC class or remote facilities.

4.3 Costing data

A fundamental change to the pricing approach for residential aged care services will be moving from the ACFI indexation-based pricing model (described in section 3.2) to one more directly informed by the actual costs of delivering care to residents.

The collection of cost data in Australian hospitals has a long history. The National Hospital Cost Data Collection was established in the late 1990's and has evolved into a comprehensive collection of patient level costs from a very large sample of public hospitals.

In contrast, there is not a history of resident level cost information that has been collected systematically and consistently in the aged care system. A series of costing studies will be required to support future classification and pricing refinement. This will be a multi-year and multifaceted process where costing practices and datasets grow and are refined overtime.

Prior to the passage of enabling legislation, the Department commissioned IHACPA to conduct costing studies to support the future refinement of aged care pricing. The Residential Aged Care Pilot Costing Study commenced in November 2021. Due to the restrictions on aged care facilities as a result of coronavirus disease 2019, the study was suspended in January 2022 and then recommenced in May 2022. The pilot study tested a number of approaches to collecting cost data from residential aged care facilities. Several technology options to relate staff time to the care of individual residents (that will form the basis of cost allocation to residents) have been trialled during the study.

Based on the lessons learned from this pilot study, IHACPA expects to commence a more comprehensive costing study later in 2022. This study will aim to collect cost data from a wide range of facilities. This is important in ensuring that a representative sample of cost data is collected to enable IHACPA to confidently determine any cost differentials by facility size, type or location, as well as any cost differentials associated with specific resident groups and AN-ACC classes.

In addition to this, IHACPA will also utilise the Aged Care Financial Report (ACFR) and the new Quarterly Financial Report (QFR) data to support costing and pricing work.

4.4 Pricing

The design of the pricing model is a foundational part of any ABF system. The pricing model provides the incentives in the system (for example, improving technical efficiency) and distributes financial risk between residential aged care providers and the payers (in this case the Government and aged care residents).

The core AN-ACC pricing model outputs are a national recommended residential aged care price and the price weights, also called national weighted activity units (NWAU). An AN-ACC NWAU is a measure of relative price. For example, an NWAU of 1.2 would mean that the price of the AN-ACC class is 20 per cent higher than the national residential aged care price. An AN-ACC of 0.5 means that the price is 50 per cent lower than the national price.

As part of their work for the Department, UOW calculated initial AN-ACC NWAU for each of the 13 classes using the data collected in the various stages of the RUCS. AN-ACC NWAU reflect the relative cost of delivering care per bed day to residents within the class, with classes 1 and 13 including residents requiring the most costly care.

UOW also found that different characteristics of facilities affected their costs. For example, rural and remote facilities often have higher costs. To capture this within the AN-ACC funding model, they introduced Base Care Tariffs with AN-ACC NWAU values reflecting the relative cost of different types of facilities.

Furthermore, RUCS found that a resident's initial admission was associated with additional one-off costs. These have been accounted for through the introduction of AN-ACC NWAU for a one-off adjustment payment.

Bringing these three components together, the total AN-ACC NWAU per resident per day comprises:⁵

1. **Fixed component:** called the Base Care Tariff (BCT), this is paid at the facility level and dependent on the specific characteristics of the facility such as its location and resident specialisation.
2. **Variable component:** based on the resident's AN-ACC class.
3. **Adjustment component:** additional funding for residents on their initial admission to services.

The calculation is shown in Figure 4 and AN-ACC NWAU values for these components are provided in Figure 5.

Separately to the RUCS study and design of the residential aged care AN-ACC funding model, the Department have developed a new residential respite funding model that is aligned to the AN-ACC and will replace the current Respite Subsidy and Respite Supplement (including the respite incentive).⁶

There are three respite classes reflecting residents who are assessed to be independently mobile (Class 101), have assisted mobility (Class 102) or limited mobility (Class 103). Residential respite funding will comprise a fixed component that is the same as the BCT for permanent residents and a variable component according to their respite class. Unlike permanent residential aged care, there is no initial entry payment for respite care as this cost has been reflected in a higher daily rate.

The Department has also introduced default classes for residents. These will be used for new residents who have not yet had their AN-ACC assessment completed. The default classifications are:

- Class 98: Residents entering permanent care to receive palliative care.
- Class 99: Residents entering for permanent care (other than entry for palliative care)
- Class 100: Residents entering for respite care.

Once assessed, the resident's actual classification will replace the default classification and payment will be adjusted and backdated to 1 October 2022 or the resident's date of entry, whichever is later.⁷

The components of AN-ACC NWAU for both permanent and respite residential aged care are summarised in Figure 5.

To calculate the total payment per resident per bed day, the total AN-ACC NWAU is multiplied by the residential aged care price. The Government has determined that the first residential aged care price for an AN-ACC NWAU of 1.00 will be \$216.80 per day. IHACPA will provide advice to the Government on a recommended residential aged care price for the AN-ACC NWAU value of 1.00, to be used from 1 July 2023.

⁵ [Department of Health and Aged Care – How do I calculate my AN-ACC care funding?](#)

⁶ [Department of Health and Aged Care – How do I calculate my residential respite funding under AN-ACC?](#)

⁷ [Department of Health and Aged Care – What is AN-ACC and how will it work?](#)

Figure 4: Components of the AN-ACC NWAU per resident per day

Total AN-ACC NWAU per day =

Fixed Component (facility Base Care Tariff) + Variable Component (resident's AN-ACC class) +
One-off Adjustment (on initial admission)

Figure 5: Components and calculation of total AN-ACC NWAU^{8,9}

<p>Fixed Component</p> <p>(Facility Base Care Tariff AN-ACC NWAU multiplied by the number of bed days*)</p>	+	<p>Variable Component</p> <p>(AN-ACC Class NWAU multiplied by bed days aggregated across all residents)</p>	+	<p>One-off Adjustment</p> <p>(AN-ACC NWAU multiplied by the number of new permanent residents)</p>																																																																						
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #e1f5fe;"> <th style="text-align: left;">BCT Eligibility</th> <th style="text-align: left;">AN-ACC NWAU</th> </tr> </thead> <tbody> <tr><td>Standard MMM 1–4</td><td>0.49</td></tr> <tr><td>Standard MMM 5</td><td>0.55</td></tr> <tr><td>Specialised Homeless</td><td>0.92</td></tr> <tr><td> Standard</td><td>0.68</td></tr> <tr><td> MMM 6–7, <30 beds</td><td>0.68 for first 29 beds,</td></tr> <tr><td> Standard</td><td>0.52 for beds 30+</td></tr> <tr><td> MMM 6–7, 30+ beds</td><td></td></tr> <tr><td>Specialised Indigenous</td><td>0.78</td></tr> <tr><td> MMM 6</td><td></td></tr> <tr><td>Specialised Indigenous</td><td>1.80</td></tr> <tr><td> MMM 7</td><td></td></tr> </tbody> </table>	BCT Eligibility	AN-ACC NWAU	Standard MMM 1–4	0.49	Standard MMM 5	0.55	Specialised Homeless	0.92	Standard	0.68	MMM 6–7, <30 beds	0.68 for first 29 beds,	Standard	0.52 for beds 30+	MMM 6–7, 30+ beds		Specialised Indigenous	0.78	MMM 6		Specialised Indigenous	1.80	MMM 7			<table style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #e1f5fe;"> <th style="text-align: left;">Class</th> <th style="text-align: left;">AN-ACC NWAU</th> </tr> </thead> <tbody> <tr><td>1</td><td>1.00</td></tr> <tr><td>2</td><td>0.19</td></tr> <tr><td>3</td><td>0.31</td></tr> <tr><td>4</td><td>0.21</td></tr> <tr><td>5</td><td>0.37</td></tr> <tr><td>6</td><td>0.35</td></tr> <tr><td>7</td><td>0.49</td></tr> <tr><td>8</td><td>0.54</td></tr> <tr><td>9</td><td>0.54</td></tr> <tr><td>10</td><td>0.87</td></tr> <tr><td>11</td><td>0.83</td></tr> <tr><td>12</td><td>0.81</td></tr> <tr><td>13</td><td>1.00</td></tr> <tr><td>98 (Default)</td><td>1.00</td></tr> <tr><td>99 (Default)</td><td>0.54</td></tr> <tr><td>100 (Default)</td><td>0.404</td></tr> <tr><td>101 (Respite)</td><td>0.304</td></tr> <tr><td>102 (Respite)</td><td>0.404</td></tr> <tr><td>103 (Respite)</td><td>0.864</td></tr> </tbody> </table>	Class	AN-ACC NWAU	1	1.00	2	0.19	3	0.31	4	0.21	5	0.37	6	0.35	7	0.49	8	0.54	9	0.54	10	0.87	11	0.83	12	0.81	13	1.00	98 (Default)	1.00	99 (Default)	0.54	100 (Default)	0.404	101 (Respite)	0.304	102 (Respite)	0.404	103 (Respite)	0.864		<table style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #e1f5fe;"> <th style="text-align: left;">Description</th> <th style="text-align: left;">AN-ACC NWAU</th> </tr> </thead> <tbody> <tr><td>New permanent entrant adjustment funding</td><td>5.28</td></tr> <tr><td>New respite entrant adjustment funding</td><td>0.00</td></tr> </tbody> </table>	Description	AN-ACC NWAU	New permanent entrant adjustment funding	5.28	New respite entrant adjustment funding	0.00
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*For Standard Modified Monash Model (MMM) categories 6–7, Specialised Indigenous MMM 6 and Specialised Indigenous MMM 7, the facility BCT is calculated per bed (operational places only, excluding provisionally allocated places). For Standard MMM 1–4, Standard MMM 5 and Specialised Homeless services groups, it is calculated per occupied bed.

⁸ [Department of Health and Aged Care – How do I calculate my AN-ACC care funding?](#)

⁹ [Department of Health and Aged Care – How do I calculate my residential respite funding under AN-ACC?](#)

The following examples illustrate how the total payment per resident per bed day is calculated using AN-ACC NWAU and the residential aged care price.

Example 1

Resident in a standard metropolitan facility (MMM 1) is assigned to Class 4 (Base care tariff AN-ACC NWAU = 0.49; AN ACC Class NWAU = 0.21). That is, the resident has assisted mobility and high cognition, without compounding factors.

$$\text{Total AN-ACC NWAU} = 0.49 + 0.21 = 0.7$$

$$\text{Total AN-ACC Daily Basic Subsidy} = 0.7 \times \$216.80 = \$151.76 \text{ per day}$$

On admission into the aged care facility, an additional 5.28 AN-ACC NWAU would be paid to support the adjustment of the resident into the home.

$$\text{One-off adjustment component} = 5.28 \times \$216.80 = \$1,144.70$$

Example 2

Resident in a very remote facility (MMM 7) with Indigenous specialisation is assigned to Class 13 (Base care tariff AN ACC NWAU = 1.80; AN-ACC Class NWAU = 1.0). That is, the resident is non-mobile, with low function, at high risk of a pressure sore and with other compounding factors.

$$\text{Total AN-ACC NWAU} = 1.80 + 1.0 = 2.80$$

$$\text{Total AN-ACC Daily Basic Subsidy} = 2.80 \times \$216.80 = \$607.04 \text{ per day}$$

On admission into the aged care facility, an additional 5.28 AN-ACC NWAU would be paid to support the adjustment of the resident into the home.

$$\text{One-off adjustment component} = 5.28 \times \$216.80 = \$1,144.70$$

Example 3

A respite resident in a standard facility with MMM category 5 is assigned to Respite Class 102 as they have assisted mobility (Base care tariff AN-ACC NWAU = 0.55; AN ACC Respite Class NWAU = 0.404).

$$\text{Total AN-ACC NWAU} = 0.55 + 0.404 = 0.954$$

$$\text{Total AN-ACC Daily Respite Subsidy} = 0.954 \times \$216.80 = \$206.83 \text{ per day}$$

There is no one-off adjustment component for the respite resident.

4.5 Care requirements

The AN-ACC funding model incorporates a care minute requirement based on the resident's AN-ACC class. This will require the system to deliver an average of 200 minutes per resident per day, based on care provided by registered nurses, enrolled nurses and personal care workers, including an average of 40 minutes of registered nurse time per day. This care minute requirement is mandatory from 1 October 2023 but is reflected in the initial AN-ACC prices to support uplifts in care minutes from 1 October 2022.

The required care minutes are expected to increase to an average of 215 care minutes per resident per day, including an average of 44 minutes of registered nurse care, from October 2024.

At the resident level, the required minutes reflect the varying care needs across AN-ACC classes of differing complexity. The variation in target care minutes by AN-ACC class is shown in Figure 6 and Figure 7. At the facility level, this results in a care minute target that is adjusted according to the number and AN-ACC classes of residents at the facility. For example, a facility with mainly higher needs residents will have a higher average care minute target than a facility with mainly lower needs residents.

Providers already report their care staffing minutes by facility in their annual Aged Care Financial Report. From 1 October 2022, this will move to quarterly reporting as part of the new QFR. Data from the QFR will be used to determine each facility's performance against their care minutes requirements, including when these become mandatory from 1 October 2023. Reporting on care minutes will also be one of the measurable indicators used to inform a new star rating system on the My Aged Care website. This will be introduced from December 2022.

A resident's care minutes are determined by their current AN-ACC class. Any shift in class and funding level is accompanied by a change in the required care minutes that must be provided by the facility. As a result, funding should remain closely aligned to the care that is required and provided. The Government has included additional funding, intended to cover the cost of the uplift in average care minutes, in the calculation of the AN-ACC residential aged care price of \$216.80.

Figure 6: Daily care minute targets for each AN-ACC class, based on an average 200 care minutes per resident per day¹⁰

AN-ACC class	Total Care Minutes	Registered Nurse Care Minutes
Class 1	284	53
Class 2	135	32
Class 3	157	34
Class 4	139	30
Class 5	169	39
Class 6	166	35
Class 7	189	37
Class 8	200	38
Class 9	200	44
Class 10	261	52
Class 11	254	41
Class 12	250	42
Class 13	284	53

Figure 7: Daily care minute targets for each residential respite class, based on an average of 200 care minutes per resident per day¹¹

Respite class	Total Care Minutes	Registered Nurse Care Minutes
Class 101	151	34
Class 102	185	39
Class 103	282	49

¹⁰ [Department of Health and Aged Care – How do I calculate my care minutes targets?](#)

¹¹ [Department of Health and Aged Care – How do I calculate my care minutes targets?](#)

4.6 Implementation timeframes

Following passage of the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (Cwlth), the new AN-ACC assessment and funding model will be used to fund residential aged care homes from 1 October 2022.

The initial policy settings, classification, and pricing approach have been developed by the Department. This includes the AN-ACC funding model starting price of \$216.80, which was announced in the Federal Budget 2022–23.

IHACPA will provide pricing advice to the Commonwealth Minister for Health and Aged Care in early 2023. This will be used to inform residential aged care funding from 1 July 2023.

Next steps

The ongoing implementation of ABF in residential aged care will be an extended, multi-year process involving evolution and refinement. This will ensure the classification and pricing model are responsive to improving data collections and developments in aged care over time. IHACPA will work alongside stakeholders to:

- develop, review and refine the Pricing Framework for Australian Aged Care Services 2023–24
- review the distribution of residents across AN-ACC classes to provide advice on the aged care starting price and AN-ACC NWAU weightings
- conduct cost studies to gather the relevant data required to make appropriate adjustments
- review and refine the cost components in the AN-ACC funding model including those involving Indigenous status, MMM classifications, homelessness and other identified adjustment categories
- explore future areas of reform and priority and consider how these can be appropriately captured in classification, costing, pricing and funding model development.

The stages of review will inform an increasingly mature and nuanced funding and classification model.

? Consultation questions

- What, if any, may be the challenges in using AN-ACC to support ABF in residential aged care?
- 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?
- What, if any, additional factors should be considered in determining the AN-ACC NWAU weightings for residents?
- What should be considered in developing future refinements to the AN-ACC assessment and funding model?



Principles for activity based funding in aged care

5. Principles for activity based funding in aged care

5.1 Understanding the Independent Health and Aged Care Pricing Authority's pricing principles

The design of an activity based funding (ABF) system includes many foundational decisions that must be made early on. For example, the classification system to be used and how resident assessments will take place. There are also a number of ongoing considerations and various competing policy priorities to consider.

The emphasis on certain criteria must balance proposed policy objectives, directions and preferences. This consultation paper has approached the task of ABF system design by first articulating a set of principles to inform design choices.

Three types of principles have been articulated:

- overarching principles that express the overall policy intent of ABF
- principles to guide ABF processes
- principles to inform detailed system design choices.

The Independent Health and Aged Care Pricing Authority (IHACPA) will need to balance a range of policy objectives, including promoting the resident-centred, quality care expected by the community, improving the sustainability of the aged care system and increasing efficiency over time. The pricing principles signal IHACPA's commitment to transparency and accountability as it undertakes its work. This is the overarching framework within which IHACPA will make its policy decisions.

5.2 Overarching principles

The overarching principles articulate the policy intent behind the introduction of funding reform for aged care services.

There are five proposed overarching principles central to the design of ABF systems:

- **Access to care** – 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.
- **Quality care** – Care should meet the Aged Care Quality Standards and aim to deliver outcomes that align with community expectations.
- **Fairness** – ABF payments should be fair and equitable, including being based on the same price for the same service across government, private and non-for-profit providers of aged care services. This should also recognise the legitimate and unavoidable costs faced by some aged care providers.
- **Efficiency** – ABF should ensure the sustainability of the aged care system over time and optimise the value of the public investment in aged care.
- **Maintaining agreed roles and responsibilities** – ABF design should recognise the complementary responsibilities of each government agency and department in the funding and management of aged care services, as well as providers in delivering aged care services.

IHACPA's role as part of the aged care reforms will be to provide pricing and costing recommendations to the Commonwealth Government (the Government). The Government will ultimately determine the prices and funding of residential aged care.

In parallel to funding reform, other reforms are being introduced to aged care. These changes signal an intent from the Government to improve safety, care, accessibility, and efficiency. As the system operator, the Department of Health and Aged Care (the Department) is responsible for the viability of the reforms in aged care safety and quality.

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) highlighted that previous arrangements have meant that residential aged care services have been funded similarly despite variable resident outcomes. The introduction of ABF contributes to the broader policy intent and should support accessible, high quality and fairly funded aged care services that enable equitable outcomes for residents. ABF should also promote sustainability and value across the aged care system over time.

While the first four principles demonstrate the 'what' and 'how' the system should deliver, the fifth principle articulates the contribution of government departments and agencies in supporting the ABF policy outcomes. ABF sits within a broader context of system reforms to achieve an efficient, quality-based system that is sustainable and person-centred in its approach to funding. This principle also reflects the responsibility of providers in the delivery of services to residents, and the need to support an ABF system that rewards the delivery of high quality, safe and efficient care to residents.

5.3 Process principles

The process principles guide the implementation of ABF and any fixed funding arrangements.

The four proposed process principles are:

- **Administrative ease** – Funding arrangements should not unduly increase the administrative burden on aged care providers.
- **Stability** – The payment relativities for ABF should be consistent over time.
- **Evidence based** – Funding should be based on best available information.
- **Transparency** – All steps in the development of advice for ABF and fixed funding should be clear and transparent.

Whilst the implementation of ABF will result in some initial changes, IHACPA will aim to minimise the additional ongoing impost of any new data collections and costing studies. It is important to note that this concept is not the same as saying ABF will not change organisational requirements in aged care. To respond well to the new incentives, aged care facilities will have to have effective systems of resident care and engagement so that cost and care variations can be identified and analysed to determine underlying causes.

A key purpose of ABF is to better align the price of care to underlying costs and optimise efficiency over time. An ABF system will, by its nature, present providers with a range of incentives that promote achievement of policy objectives over time. The effects of these incentives will be stronger when providers understand them well. Where incentives change frequently, these incentive effects may be attenuated, and providers may struggle to maintain capability to achieve the desired policy intent. There is a need for continuity and predictability in pricing to facilitate effective implementation of ABF across the system. Regular updates must be balanced with the need to achieve stability and consistency over time.

Advice must be determined based on the best quality data available. IHACPA will support pricing recommendations with regular costing studies, and utilise other available, complementary data that can support costing and pricing advice.

Transparency is necessary to ensure providers and the system stakeholders truly understand the policy goals and outcomes required. A commitment to transparency will be central to the pricing principles of IHACPA and a central tenet of ABF.

5.4 System design principles

The system design principles articulate the detailed elements of ABF design.

The six proposed system design principles are:

- **Fostering care innovation** – Pricing of aged care services should respond in a timely way to the introduction of evidence based, effective new technology and innovations in the models of care that improve resident outcomes and service efficiency.
- **Promoting value** – Pricing should support innovative practices and systems that deliver efficient, person centred care.
- **Promoting harmonisation** – Pricing should facilitate best practice provision of care at the appropriate site.
- **Minimising undesirable and inadvertent consequences** – Pricing should minimise susceptibility to gaming, inappropriate rewards, and perverse incentives.
- **ABF pre-eminence** – ABF should be used for funding aged care services wherever practicable and compatible with delivering value in both outcomes and cost.
- **Recipient based** – Pricing adjustments should be, as far as is practicable, based on characteristics related to people receiving care, rather than those of providers.

Care delivery is not a static system. An efficient system today may not be the most efficient system tomorrow and ABF design must recognise and respond to this. The system should be able to respond to innovation in a timely manner and ABF should accommodate the dynamic nature of care in the aged care system.

To allow a person to be cared for at the most appropriate site, the Government funds aged care services both within a person's home or residential aged care facility. Under the principles of price harmonisation, the funding system should not unduly incentivise the delivery of care at particular sites or in specific settings.

The introduction of a new pricing structure will create new incentives in the management and care of residents. It also comes with risks such as the risk of perverse incentives, which could drive undesirable changes in care practices for financial purposes. ABF design and review must be cognisant of the extent to which perverse responses occur, as this weakens the foundations of the system and the overarching principle of fairness. IHACPA, the Department and other agencies must be conscious of resident outcomes and the impact on care. This includes the shifting of cost, reduced care and detrimental resident outcomes.

The implementation of an ABF system across aged care will be predominately driven by characteristics related to people receiving care, rather than those of a facility. This principle reflects a person-centred approach, funding individual need rather than provider characteristics. Additionally, an ABF model should be impartial to the business and financial structures of providers.

Circumstances may exist where it is not practicable to fund a service through an ABF model. In such instances, a funding model that reflects the different cost structure of care delivery may be more appropriate. For example, fixed funding may be more appropriate for small providers in remote and regional areas, and aged care services for Aboriginal and Torres Strait Islander peoples. It may also be appropriate to fund certain types of services through a fixed funding approach. It is critical to ensure that ABF maintains pre-eminence and any divergence from funding under this model be transparent and evidence based.

Consultation questions

- 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?
- What, if any, additional principles should be included in the pricing principles for aged care services?
- What, if any, issues do you see in defining the overarching, process and system design principles?



Developing aged care pricing advice

6. Developing aged care pricing advice

The two core elements of the Australian National Aged Care Classification (AN-ACC) funding model are the AN-ACC national weighted activity unit (NWAU) values and the residential aged care price.

The AN-ACC NWAU values are used to set pricing relativities between AN-ACC classes and facility Base Care Tariff rates based on resident and facility factors. The Independent Health and Aged Care Pricing Authority (IHACPA) will develop recommendations to refine these pricing relativities over time (discussed in Chapter 4).

This chapter focuses on IHACPA's development of a recommended residential aged care price for one AN-ACC NWAU. This price is used to convert AN-ACC NWAU into dollar amounts that are paid to facilities. There are a number of issues that IHACPA will need to consider in preparing this advice for the Commonwealth Minister for Health and Aged Care.

6.1 What is the national residential aged care price?

The terminology of a 'residential aged care price' stems from the use of the term national efficient price (NEP) in the National Health Reform Agreement (NHRA), which underpins the national system of activity based funding (ABF) for public hospitals.

The NHRA does not provide a definition for efficiency, so IHACPA had to determine this. The NEP is currently based on the average cost for an episode of care. In setting the NEP for public hospitals at this point, the Pricing Authority concluded that the average provided a strong incentive for higher cost hospitals or states and territories to focus on improving efficiency. At the same time, the NHRA established the rules by which the Commonwealth Government (the Government) contributes to the funding of public hospitals.

The development of a recommended residential aged care price draws upon the concept of the NEP in that it provides a national benchmark price to support an ABF system. However, there are significant differences between the public hospital and residential aged care systems that require specific consideration. IHACPA therefore proposes a more nuanced approach (compared to an approach based on the average cost) for developing a recommended residential aged care price. This approach is discussed further in Section 6.3.

Providing a recommendation to support a residential aged care price will be an extended process. IHACPA proposes that initial recommendations for the price will reflect the need for facilities to sustainably meet direct care minute requirements as well as other factors required to support minimum care standards and quality improvement. As system reforms and the AN-ACC funding model become embedded across the system over the longer-term, costing data is acquired and technical models are refined, greater focus will be given to improving efficiency in developing a recommended residential aged care price.

Consultation question

- What, if any, concerns do you have about this definition of a residential aged care price?

6.2 What should the price cover?

The recommended residential aged care price is intended to predominantly cover the cost of care. Elements of care in-scope for the price are specified under Part 2 of the Schedule of Specified Care and Services. This includes administrative costs directly related to care.

The Basic Daily Fee Supplement (BDF Supplement) introduced on 1 July 2021 will be rolled into AN-ACC funding from 1 October 2022. This supplementary payment is intended to ensure better care and service provision for residents. IHACPA proposes this is retained in the first recommended residential aged care price for 1 July 2023.

It is also proposed that IHACPA undertake future work to better understand the costs of hotel services, including hotel cost elements covered under the BDF Supplement. This will inform future recommendations around the separation or inclusion of hotel costs as part of residential aged care costing and pricing advice.

Some costs will be excluded from the recommended residential aged care price. These include:

- Capital, depreciation and leasing costs, which are funded through refundable accommodation deposits (RADs) and daily accommodation payments (DAPs).
- Costs for extra services, which are funded through extra service fees.
- Costs for additional services, which are funded through additional services fees.



Consultation question

- What, if any, additional aspects should be covered by the residential aged care price?

6.3 The pricing approach and level

An ABF price can be set using a range of methods. The residential aged care price should reflect the actual cost of care delivery, also known as 'cost-based' pricing. An example of predominantly 'cost-based' pricing is the NEP for public hospital services, which prioritises efficiency through pricing aligned to the average cost of services.

However, IHACPA considers that there are a number of reasons why the recommended residential aged care price will need to account for additional factors beyond the average cost, at least in the short- to medium-term. These include that:

- many aged care providers are currently not meeting minimum care, quality and safety standards and have greater challenges in this respect than public hospitals did upon the introduction of the NEP.
- some aged care providers may face funding challenges arising from reduced economies of scale and their ability to cross subsidise funding differences across residents, whereas state and territory governments are able to balance these risks across their entire network of public hospital services and over time.
- there are a range of prospective funding uplifts that should be incorporated in the price to fund facilities to achieve the minimum standards.
- aged care providers may not currently have the systems and expertise to respond effectively to average cost benchmarking and funding. Even if they do, this could be at the expense of providing high quality and safe care.

For example, there are minimum standards of service and care quality required by:

- The Royal Commission into Aged Care Quality and Safety (the Royal Commission) recommendations
- the BDF supplement
- the Aged Care Quality Standards
- the Schedule of Specified Care and Services ([Schedule 1, Quality of Care Principles 2014](#)).

Pricing that accounts for these elements would utilise elements of 'best practice' or 'normative' pricing.

The 'normative' or 'best practice' approach recognises that prices should be set at a level that enables the required care standards to be met. This contrasts with a purely 'cost-based' pricing approach, which has less regard for the required care standards and may risk pricing that is set too low for providers to fund the necessary standard of care.

The proposed pricing approach therefore combines elements of both 'cost-based' and 'best practice' pricing. This recognises the need for prices to be aligned to the actual cost of delivering care, while also supporting the required uplifts in care minutes and quality arising from the aged care system reforms. For example, prices will need to be sufficient to support minimum care minutes required from 1 October 2023, as well as further increases in required care minutes from October 2024. These approaches are not mutually exclusive and can be adjusted over time to reflect the underlying policy direction.

Consultation questions

- What, if any, concerns do you have about the proposed pricing approach and level of the residential aged care price?
- How should 'cost-based' and 'best practice' pricing approaches be balanced in the short-term and longer-term development path of IHACPA's residential aged care pricing advice?

6.4 Indexation

In developing an annual recommendation to the Government, there is an inevitable delay in the provision of cost data. As a result, IHACPA will need to index prior years' cost data to inform recommendations for the future residential aged care price.

This would enable pricing advice based on historical cost data to account for general increases in the costs of wages, goods and services, as well as specific factors that might cause future prices to be significantly different from the costs reflected in historical data.

IHACPA's proposed approach will include reviewing independent reports, consulting with technical experts, analysing time-series cost data (if available) and comparison to other available data sources to ensure appropriate price indexation rules are established.

Due to the lag in cost data availability, any adjustments to wages made by the Fair Work Commission could take multiple years to be reflected in the cost data utilised by IHACPA in calculating prices. This would result in gaps between the actual costs faced by aged care providers and the residential aged care price until submitted cost data can be included in the new rates. IHACPA will therefore provide advice to the Government that considers the likely impact of Fair Work Commission rulings on wage rates finalised in the prior year. Where a wage determination is made by the Fair Work Commission and takes effect outside of the IHACPA advice cycle, additional advice may be sought from IHACPA by the Government. IHACPA will not assess appropriateness of wages within the aged care system.

Consultation questions

- What should be considered in the development of an indexation methodology for the residential aged care price?
- What, if any, additional issues do you see in developing the recommended residential aged care price?

7



Adjustments to the recommended price

7. Adjustments to the recommended price

7.1 The Independent Health and Aged Care Pricing Authority's approach to adjustments

Ideally, the Australian National Aged Care Classification (AN-ACC) model would account for all resident related characteristics that impact on the cost of delivering care. However, the Resource Utilisation and Costing Studies (RUCS) demonstrated there are key variables impacting the cost of care delivery across both resident and facility characteristics.

Furthermore, some of these cost drivers may not be completely captured within the existing AN-ACC categories and classes.¹²

The premise of activity based funding (ABF) is that the price should not be solely driven by historical costs of delivering care but any adjustments must be evidence based and transparent. Adjustments to the price should be utilised when there is a need to account for legitimate and unavoidable variations in the cost of delivering care. In this context, adjustments refer to additional elements within the funding model aiming to address these cost variations. For example, the existing base care tariffs (BCT) in the AN-ACC funding model aim to address unavoidable facility factors such as rurality and remoteness, or provider specialisations that generally involve higher costs. This concept is distinct from year-to-year refinements to the funding model.

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 implementation of ABF also provides opportunities to develop and include adjustments for quality and safety over time.

? Consultation question

- What, if any, changes are required to the proposed approach to adjustments?

¹² [University of Wollongong - RUCS Report 5: AN-ACC: A Funding Model for the Residential Aged Care Sector](#)

7.2 Adjusting for factors related to people receiving care

During the RUCS conducted by the University of Wollongong, two specific resident related factors were found to significantly impact fixed cost drivers. These were the provision of care to Aboriginal and Torres Strait Islander peoples and people experiencing homelessness.¹³ Despite being related to resident characteristics, these additional costs have initially been captured in AN-ACC through the facility BCT.

This is because the provision of specialist care to Aboriginal and Torres Strait Islander peoples and people experiencing homelessness frequently occurs in combination with other facility characteristics that impact fixed cost drivers. These may include remoteness, size and low bed occupancy.

The AN-ACC model considers the impact of these resident related factors, facilitating adjustments to the fixed BCT component of the payment. The model allows for six categories of resident-related factors that explain variation in fixed costs. Each category has been modelled and found to have a high degree of cost homogeneity within the individual category.

Other funding supplements and adjustments based on specific resident factors under the existing residential aged care funding model include, but are not limited to, supplements for:

- oxygen (primary supplement)
- enteral feeding (primary supplement)
- veterans (services related to mental health)
- hardship.

The Independent Health and Aged Care Pricing Authority (IHACPA) will consider if and how these existing adjustments and supplements should be incorporated into the AN-ACC funding model.

The new funding model must ensure that pricing reflects the cost of the service and is directed towards resident care, in line with the intent of funding and other reforms to the system. It must be determined whether these costs are best reflected under the fixed, variable or adjustment categories of the AN-ACC model.

Consultation questions

- What, if any, additional adjustments may be needed to address higher costs of care related to the resident characteristics?
- What evidence can be provided to support any additional adjustments related to people receiving care?

¹³ [University of Wollongong – RUCS Report 5: AN-ACC: A Funding Model for the Residential Aged Care Sector](#)

7.3 Adjusting for unavoidable facility factors

7.3.1 Location

The RUCS findings highlighted unavoidable facility factors that have a significant impact on the cost of delivering care. In addition to remoteness, low and variable levels of occupancy have significant impacts on the cost of care per bed day. Two adjustments have been included in the AN-ACC model BCT categories to support more stable funding of these facilities.

Firstly, the fixed BCT component of the AN-ACC payment makes adjustment for facilities with Modified Monash Model categories five to seven. This is combined with resident factors where the facility provides specialist care to Aboriginal and Torres Strait Islander peoples.

Secondly, those remote facilities with low and variable occupancy will receive a BCT based on approved beds, rather than per bed day. In combination, these adjustments will provide a degree of block funding that is funding independent of actual activity, while retaining the pre-eminence of ABF and ongoing focus on the efficient funding of aged care.

7.3.2 Costs due to provider structure

A diverse range of providers deliver services across the residential aged care system nationally. These providers include government, not-for-profit and private operators of varied size. Provider type and business structure can have an impact on additional costs in the overall delivery of care.

Under the principles of ABF, IHACPA will be committed to the principles of fairness and transparency. Additionally, an ABF model should be impartial of provider business and financial structures, enabling public-private neutrality in pricing guidance.

Consultation questions

- What should be considered in reviewing the adjustments based on facility location and remoteness?
- What evidence can be provided to support any additional adjustments for unavoidable facility factors?

7.4 Adjusting for safety and quality

The findings of the Royal Commission into Aged Care Quality and Safety (the Royal Commission) highlighted a lack of transparency and accountability with profound consequences for the safety and quality of care for residents. Adjustments for safety and quality through ABF can encourage good quality care, where payment captures not only the cost and complexity of care, but also the safety and quality of care delivered.

For example, IHACPA introduced pricing adjustments for hospital acquired complications.¹⁴ This was done through strong collaboration across relevant agencies, the development of supporting data collections, extensive clinical and stakeholder input and the development of risk-adjusted price reductions that are fair and minimise undesirable consequences.

IHACPA recognises the different structure and nature of the aged care system, as well as the significant and broad range of reforms occurring across the system, present significant challenges for any proposed pricing adjustments for safety and quality.

Any approach would need to align with the existing and future safety, quality and care standards across the system and the regulations around this. In particular, adjustments would need to complement and support the role and work of the Aged Care Quality and Safety Commission and avoid duplication or undue impact on aged care providers. Furthermore, any pricing adjustments for safety and quality would need to consider a wide range of data, information and perspectives, including clinicians, residents, carers and providers.

Due to these reasons and the complexity of the system, a specific pricing approach for safety and quality adjustments could only be introduced in a longer-term, phased way once AN-ACC is well-established. IHACPA therefore invites stakeholder views on this topic and how this may be appropriately incorporated as a long-term objective.

Consultation question

- How should any adjustments for quality and safety issues be considered in the long-term development path of AN-ACC and the associated adjustments?

¹⁴ A hospital acquired complication refers to a patient complication that occurs during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.



Priorities for future developments

8. Priorities for future developments

Future priorities for the Independent Health and Aged Care Pricing Authority (IHACPA), as set by the Commonwealth Government (the Government), include:

- consideration of whether hotel costs could and/or should be incorporated in the Australian National Aged Care Classification (AN-ACC) funding model.
- consideration of the inclusion of Multipurpose Services and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program within the AN-ACC assessment and funding model.
- a residential respite costing study to refine the classification and funding of respite care.
- a costing study to refine the pricing of the initial entry of new residents into residential aged care, and any other key periods in the resident's journey where costs may vary.
- development of costing and pricing advice for home aged care, following future reforms in this area.

8.1 Inclusion of hotel costs in AN-ACC

Hotel costs for residents of aged care homes are currently aligned under the payment of the basic daily fee (BDF). The BDF is up to 85 per cent of the basic aged care pension with all residents required to pay the fee or apply for hardship or alternative payment options. Between 1 July 2021 and 1 October 2022, the Government will provide a BDF supplement of \$10 per resident per day. From 1 October 2022 it will be rolled into AN-ACC funding.

IHACPA will undertake future work to better understand the costs of hotel services, including hotel cost elements covered under the BDF Supplement. This will inform future recommendations around the separation or inclusion of hotel costs as part of residential aged care costing and pricing advice.

If included, the scope of AN-ACC funding across hotel and care would align with [Schedule 1 \(Quality of Care Principles 2014\) – Care and services for residential care services](#).

? Consultation question

- Should hotel costs be incorporated into the AN-ACC funding model and what should be considered in doing this?

8.2 Multipurpose services

Multipurpose services (MPS) provide health and aged care services for small regional and remote communities.

MPS providers receive a combination of funding including:

- a flexible aged care subsidy from the Government for aged care services
- state and territory government funding for health services, capital and infrastructure costs.

A payment agreement covering the aged care funding component of MPS exists between the Government and MPS providers, with most being state or territory governments.

The flexible aged care subsidy for each MPS is calculated based on the number of allocated places, daily funding, including relevant supplement equivalent amounts, and the number of bed days where care has been provided to an individual.

IHACPA will consider whether the AN-ACC model can be appropriately developed to support its use in MPS residential aged care services in the medium- to long-term.

8.3 National Aboriginal and Torres Strait Islander Flexible Aged Care Program

The [National Aboriginal and Torres Strait Islander Flexible Aged Care Program \(NATSIFACP\)](#) provides aged care to older Aboriginal and Torres Strait Islander peoples. These aged care services are mainly delivered in rural and remote areas.

The NATSIFACP is funded by the Department of Health and Aged Care (the Department), subject to parliamentary appropriation.

Payments are provided under a ‘cashed out’ model, based on an agreement with the facility and not on the occupancy of the facility. Aged care providers receive a daily base rate depending on whether the person receiving care is allocated to a Residential High or Low Care place or a Home Care place. Residential aged care providers additionally receive the following supplement equivalent amounts:

- the Veterans’ Supplement
- the Residential Concessional Supplement
- the Respite Supplement
- the Residential Aged Care Viability Supplement.

Residential aged care places under NATSIFACP also receive ‘frailty indexation’, which is a financial supplement provided to address the disparity in funding per residential aged care place funded under the Program as compared with mainstream residential aged care services operating under the *Aged Care Act 1997*.

In addition to the daily funding rate, services with an allocation of home care places may also receive the following supplement equivalent amounts:

- the Dementia and Cognition supplement for home care
- the Veterans Supplement for aged care
- the Home Care Viability Supplement.

¹⁵ [Department of Health and Aged Care – How do I calculate my residential respite funding under AN-ACC?](#)

Annual infrastructure and equipment funding, and emergency funding is also provided.

IHACPA will consider whether the AN-ACC model can be appropriately developed, refined and introduced to fund NATSIFACP services in the medium- to long-term.

8.4 Residential Respite Costing Study

The Department has developed a new residential respite funding model that is based on and aligned to the new AN-ACC funding model for residential aged care.¹⁵ This is detailed in Chapter 4. However, the analysis of residential respite care was out-of-scope of the Resource Utilisation and Classification Studies and the AN-ACC model development. There is a need to undertake a costing study that includes residential respite. This would enable refinement of the AN-ACC funding model for residential respite, to ensure it reflects the actual costs of residential respite care.



Consultation question

- What should be considered in future refinements to the residential respite classification and funding model?

8.5 Review of the one off adjustment for new residents

Residential aged care facilities receive a one-off adjustment payment under AN-ACC to fund the additional costs associated with transitioning a permanent resident into their new care environment. This is currently set at 5.28 national weighted activity units or \$1,144.704 per new resident. IHACPA will undertake work to analyse the costs of this activity, as well as any other key periods in a resident's journey in residential aged care where costs may vary.

Consultation question

- What are the costs associated with transitioning a new permanent resident into residential aged care?

8.6 Home care pricing advice

The Department is developing reforms to home care. A new program is expected to replace the Commonwealth Home Support Programme (CHSP), Home Care Packages (HCP) Program and Short Term Restorative Care (STRC) Programme. Following commencement of the new program, IHACPA will undertake work, including public consultation, to support the provision of pricing advice to the Commonwealth Minister for Health and Aged Care on an annual basis.

8.7 Workforce

IHACPA acknowledges the well-documented challenges faced by the aged care system regarding workforce. The implementation of significant reform across aged care will continue to impact workforce requirements as providers align with changes to delivery of services in all areas.

Workforce is a complex matter and largely the responsibility of the Government and the Department. However, IHACPA will monitor ongoing changes and challenges in this area and be alert to any implications for costing and pricing development.

Consultation question

- How might workforce challenges present in the implementation and refinement of AN-ACC for the aged care system?

8.8 Five-year vision

Developing and refining a pricing framework for aged care services will be an extended and evolving process. Improvements in the quality, safety and transparency of aged care will require robust data, stakeholder engagement, technological enablers, and recognition of the dynamic nature of funding methodologies, policy, costs and aged care system challenges. IHACPA will have a five-year vision to guide sustainable, forward looking and multi-year funding reform to support the delivery of quality care. This vision will be informed by this consultation process, and refined through annual public consultation and regular engagement with stakeholders.

Consultation questions

- What areas should be included in the proposed five-year vision for IHACPA's aged care pricing advice?
- What would be considered markers of success in IHACPA's aged care costing and pricing work?



Consultation process and next steps

9. Consultation process and next steps

The Independent Health and Aged Care Pricing Authority (IHACPA) is calling for submissions on this consultation paper until 14 October 2022.

The key dates regarding this consultation process are:

Process	Date
Release of the consultation paper	16 August 2022
Submissions close	5pm AEDT on 14 October 2022
Release of a consultation report consolidating stakeholder feedback	Early 2023
Pricing Framework for Australian Aged Care Services 2023–24 published	Early 2023

9.1 How your information will be used

All submissions will be published on the [IHACPA website](#) unless you specifically identify any sections that you believe should be kept confidential due to commercial or other reasons.

Your submission will be carefully considered and IHACPA may contact some individuals or entities that make submissions. IHACPA will not contact everyone who makes a submission, but will ensure that all submissions are recorded, reviewed and used to inform the development of the Pricing Framework for Australian Aged Care Services 2023–24.

A consultation report summarising the submissions received will also be published in early 2023.

Have your say

- Submissions close at **5pm AEDT on 14 October 2022**.
- Submissions can be:
 - Completed via the online questionnaire
 - Emailed to submissions.ihacpa@ihacpa.gov.au
 - Mailed to:
PO Box 483
Darlinghurst NSW 1300
- All submissions will be published on the [IHACPA website](#) unless respondents specifically identify sections that they believe should be kept confidential due to commercial or other reasons.
- The Pricing Framework for Australian Aged Care Services 2023–24 will be published in early 2023.

Enquiries

- Enquiries related to this consultation process should be sent to: submissions.ihacpa@ihacpa.gov.au

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Appendix A: Consultation questions

10. Appendix A: Consultation questions

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