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A funding model for the residential aged care sector. The Resource Utilisation and Classification Study: Report 5

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A funding model for the residential aged care sector. The Resource Utilisation and Classification Study: Report 5

Abstract
This is one of a series of reports that presents the results of an important national study commissioned by the Department of Health (the Department) to inform the development of a new funding model for residential aged care in Australia. The purpose of this report is to provide an outline of the key design features of the proposed new funding model. Also discussed are the anticipated impacts of the model for both government and the aged care sector, and a recommended approach to implementation.

Keywords
classification, 5, utilisation, report, resource, sector., care, aged, residential, model, funding, study:

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AN-ACC: A funding model for the residential aged care sector

The Resource Utilisation and Classification Study: Report 5

February 2019

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This series of papers reports on different aspects of a major national study into needs, costs and classification of residential aged care called the Resource Utilisation and Classification Study (RUCS). The RUCS was undertaken during 2018.

This report (Report 5) provides an overview of the recommended AN-ACC funding model.

A summary of the overall RUCS work program and associated reports is provided in Appendix 1.

Report 1: The Australian National Aged Care Classification (AN-ACC)

Report 2: The AN-ACC assessment model

Report 3: Structural and individual costs of residential aged care services in Australia

Report 4: Modelling the impact of the AN-ACC in Australia

Report 5: AN-ACC: A funding model for the residential aged care sector (this report)

Report 6: AN-ACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations

Report 7: AN-ACC Technical appendices

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Abbreviations

ABF	Activity Based Funding
ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
ADL	Activities of daily living
AN-ACC	Australian National Aged Care Classification
CDC	Consumer directed care
CF	Compounding factors
DEMMI	De Morton Mobility Index
DHS	Department of Human Services
DVA	Department of Veterans' Affairs
IHPA	Independent Hospital Pricing Authority
the Department	Commonwealth Department of Health
MMM	Modified Monash Model
NWAU	National Weighted Activity Unit
RACF	Residential Aged Care Facility
RCS	Resident Classification System
RUCS	Resource Utilisation and Classification Study

Glossary of Terms

Aged Care Funding Instrument (ACFI)	The existing resource allocation instrument used to determine care subsidies in Australian residential aged care.
Australian National Aged Care Classification (AN-ACC) system	Consists of the AN-ACC assessment, AN-ACC casemix classification and AN-ACC funding model.
Casemix	A system that allocates service recipients into classes. Care recipients within a class will have similar clinical attributes and their care will involve similar levels of resource consumption.
Fixed care costs	The costs of care-related services that are not driven by the care needs of individual residents but by care costs consumed equally by all residents plus facility characteristics. These include the costs of shared care and a proportion of the costs of facility management, care co-ordination, administration and education. In a blended funding model these costs are funded through a fixed payment per day for each facility type.
Hotel costs	The non-care related costs of providing accommodation within an aged care facility. These include catering, cleaning, laundry, maintenance and utilities. These costs are out-of-scope for the Commonwealth subsidy and generally funded through resident contributions. Hotel costs are out of scope for this analysis.
Individual care	Care that is tailored to the needs of an individual resident. Differences in individual care time between residents are likely to be associated with differences in assessed function, cognition, behaviour and health status.
Modified Monash Model	A geographical classification system based on population data that categorises metropolitan, regional, rural and remote into seven levels according to geographical remoteness and town size.
National Weighted Activity Unit (NWAU)	In the context of this study, a measure of relative price. An NWAU of 1.2 means that the price of the activity is 20% above the national average. An NWAU of 0.5 means that the price is 50% below national average.
Permanent resident	A person who enters residential aged care as their ongoing place of residence.
Residential aged care	Personal and/or nursing care that is provided to a person in a residential aged care service. In addition to care, 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 the provision of that care and accommodation.
Respite care	Short term care for a person within a residential care facility for short periods of time on a once-off or regular basis. The main purpose of respite is to provide relief for the usual carer.

Shared care	Care that is not tailored to individual resident needs and that all residents generally benefit from equally. This includes activities such as general supervision in common areas, night supervision clinical care management and quality activities and incidental brief interactions with residents.
Variable costs	The costs of providing care that is in response to the assessed care needs of individual residents. These costs include a proportion of care staff salary costs that relate to individual care (as opposed to shared care) and the related costs of clinical supplies. In a blended funding model these costs are funded based on the casemix class of the resident.

Key Messages

- This is the fifth in a series of reports on the Resource Utilisation and Classification Study (RUCS). This volume describes the proposed new Australian National Aged Care Classification (AN-ACC) funding model.
- The AN-ACC funding model is based on a number of key design principles:
  - Resident assessment for funding to be separated from resident assessment for care planning purposes, with assessment for funding to be undertaken externally.
  - A fixed payment per day for the costs of care management and care that is shared equally by all residents.
  - A variable payment per day for the costs of individualised care for each resident based on their AN-ACC casemix class.
  - A one-off adjustment payment for each new resident that recognises additional, but time-limited, resource requirements when someone initially enters residential care.
- The AN-ACC system is associated with a number of new concepts in residential aged care funding:
  - An activity based funding (ABF) approach similar to the national hospital funding model.
  - The AN-ACC classification system with 13 classes based on those attributes of residents that drive their care needs and associated costs.
  - Six different rates for the fixed payment per day that reflect structural cost differences between different facility types. Funding is allocated through a base care tariff.
  - The assignment of National Weighted Activity Units (NWAUs) to the adjustment payment, each AN-ACC class and each base care tariff.
  - The setting of a single national care price. This is the price of an NWAU of 1.00.
- An implementation strategy is recommended that includes:
  - Gradual and progressive implementation over a two year period with the AN-ACC class and funding allocated for all new residents and for any resident requiring reassessment after a single start-date.
  - The use of stop loss protections and the time-limited continuation of some subsidies to ensure that facilities do not experience sudden losses of income.
  - A communication strategy and change management plan suitable for the introduction of significant reform.
  - Further studies to be conducted relating the components of the funding model not yet addressed.

1 Introduction and background

This is one of a series of reports that presents the results of an important national study commissioned by the Department of Health (the Department) to inform the development of a new funding model for residential aged care in Australia. The overall aim of the Resource Utilisation and Classification Study (RUCS) was to:

- 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 are shared across residents (shared costs) and the proportion that are 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.
- Develop a new funding assessment that efficiently allows for each resident to be assigned to a payment class based on their needs.
- Test the feasibility of implementing the recommended classification and funding model across the Australian residential aged care sector.

Further details regarding the four separate RUCS studies and the other reports in this series are provided in Appendix 1.

The purpose of this report is to provide an outline of the key design features of the proposed new funding model. Also discussed are the anticipated impacts of the model for both government and the aged care sector, and a recommended approach to implementation.

The AN-ACC funding model described in this report addresses a number of weaknesses in the current Aged Care Funding Instrument (ACFI) system. The AN-ACC system provides funding transparency by focusing on what actually drives the need for care and best predicts resource use. This results in more funding equity and improved operational efficiency. In addition, the AN-ACC system enables greater consumer choice by not being prescriptive in the specific care activities that are funded. These are all major deficits in the current ACFI system.

In considering the results and recommendations included in this report, it is necessary to distinguish between three key ideas:

Cost

The cost of care for people living in residential aged care is in scope for RUCS. Capital accommodation and 'hotel' services are out of scope, as is respite care for non-permanent residents.

Funding (payment) model and policy

Funding and payment issues are in scope. The role of the RUCS research team is to develop the funding model and provide policy advice on its potential implementation.

Price

Price is out of scope for RUCS as price is ultimately a decision for payers (both government and consumers). But the RUCS has generated significant evidence that can aid decision-making about pricing.

2 Overview of the proposed AN-ACC funding model

The AN-ACC funding model is similar to the activity based funding (ABF) system that is in place across the health system nationally. Although this approach is best known in its application in the acute hospital sector, it is an eminently flexible approach that has been successfully applied in subacute and non-acute care as well as non-admitted and community based care systems nationally and internationally. It has also been successfully implemented in the disability and education sectors.

The key characteristics of activity based funding systems are:

- A classification system with classes that describe the characteristics of those receiving care.
- Classes that are both clinically meaningful and resource homogeneous. This allows them to be used for funding purposes as well as providing a base for measuring the outcomes of care.
- A payment model in which there is an explicit relationship between cost and price informed by regular costing studies.
- National weighted activity units (NWAU) for all classes based on cost relativities between classes and a single price across all care activities.

All of these characteristics are incorporated in the proposed model with some additional concepts that are required for application in the aged care sector. An important difference between the hospital system and residential aged care is the fact that the care home is the usual residence of the person receiving care. In the funding context, the major implication is that there are accommodation costs that are met by residents themselves.

Another important difference is that, in residential care, about half of all care costs are for services to which everyone in the facility shares equally. The other half are delivered to meet the care needs of an individual resident.

The AN-ACC payment model, therefore, includes two main components. The first is a standard per diem ('fixed care') payment to cover the costs of ensuring capacity and providing the care that all residents receive equally. The second is a variable payment that covers the costs of individualised care for residents. The fixed care payment is based on characteristics of the facility and the variable payment is based on the AN-ACC class assigned to each resident following an independent care needs assessment.

2.1 Key elements of the AN-ACC assessment and funding model

The AN-ACC assessment and funding model is based on six key design elements:

1 Resident assessment for funding to be separate from resident assessment for care planning purposes.

2 Assessment for funding purposes to be undertaken by external assessors capturing the information necessary to assign a resident to a payment class.

3 Assessment related to care planning to be undertaken by the residential aged care facility based on resident needs and underpinned by consumer directed care (CDC) principles.

4 Provision of a one-off adjustment payment for each new resident that recognises additional, but time-limited, resource requirements when someone initially enters residential care.

5 A fixed payment per day for the costs of care that are shared equally by all residents. This may vary by location and other factors.

6 A variable payment per day for the costs of individualised care for each resident based on their AN-ACC casemix class.

The AN-ACC model is a streamlined model that does away with many of the separate adjustments and supplements used in the past. It is administratively simple yet it represents a more sophisticated approach to funding that is based on evidence of cost and cost drivers. The model is discussed in detail in Section 3 below.

3 Detailed description of the AN-ACC funding model

Under the AN-ACC funding model, the subsidies payable to homes for the care of residents incorporate three components:

- a base care tariff (for the fixed care component)
- a variable payment (for the individual care needs of the resident as determined by the resident's AN-ACC class)
- a one off adjustment payment for residents when a resident enters residential aged care.

For funding purposes a common unit, known as the NWAU, is used across all three components. The NWAUs that are applied in the funding model are relative values that determine the amount paid for each component — with an NWAU of 1.00 being a single measure of price that represents the national average. This allows payments to be weighted to reflect the variation in the costs of providing care due to the different individual care needs of residents and different structural characteristics of care homes. For example, an NWAU of 1.2 means that the price paid is 20% above the national average; while an NWAU of 0.5 means that the price is 50% below national average.

The daily subsidy is calculated by multiplying the total NWAU (the care home's base care tariff NWAU plus the resident's AN-ACC class NWAU) by the single NWAU price. The national NWAU price is set by the Commonwealth. The one off adjustment payment is a standard rate which is also calibrated to the NWAU.

Each of the components of the AN-ACC funding model is further detailed below.

3.1 The base care tariff (fixed care)

The base care tariff is included in the funding model for two key reasons. The first is to recognise the fact that a large proportion (approximately 50%) of care costs within a facility are driven not by the individual care needs of the residents but by care delivered equally to all residents. The second is to provide stability in the funding model, where 50% of the facility funding is fixed regardless of changes in the individual resident care needs profile and, for some facilities, regardless of changes in occupancy.

The base care tariff covers fixed care costs. These include activities such as clinical supervision and training, facility clinical management and shared care activities such as night supervision and resident observation during social activities and meal times. These costs are considered fixed (at least within a defined period) as they do not change significantly with changes in individual resident care need or with small changes in occupancy. For example, the costs of a night supervisor are fixed and are determined by the overall number of residents rather than the needs of a specific resident. Fixed care costs have been found in the RUCS to be determined by structural characteristics of the facility including size, geographic location and service specialisation (see Report 3).

Aged care homes will receive a per diem base care tariff payment for all resident care days within the funding period and this payment will be standard across Australia for all facilities that meet the conditions for a particular base care tariff. These base care tariffs are mutually exclusive and each facility will only qualify for payment under a single tariff.[1] The base care tariff levels have been set based on the fixed costs of care analysis (see Report 3). This analysis found that, with some very notable exceptions, most facilities across the country report very similar fixed care costs per day.

The structural factors that are associated with significant increases in fixed care costs per day are remote and very remote facilities that provide indigenous care services, non-indigenous remote services that have less than 30 beds and specialised services to homeless people. Remoteness has been defined using the Modified Monash Model (MMM) a standardised measure of geographic isolation on a scale of 1 to 7. The MMM value of 1 represents the most urbanised parts of the country and, at the other end of the scale, the facilities with an MMM value of 7 are the most remote.

Each of the base care tariffs and their associated NWAUs are included in Table 1.

Table 1 Base care tariffs and NWAUs

Base care tariff	Facility description	Base care tariff NWAU
1	Indigenous, MMM=7	1.80
2	Indigenous, MMM=6	0.78
3	Non-indigenous, MMM=6-7, < 30 beds	0.68
4	Non-indigenous, MMM=6-7, 30+ beds	0.52
5	Specialised homeless	0.92
6	All other residential aged care facilities (RACFs)	0.49

The tariffs in Table 1 have been calculated based on a rate ***per occupied bed day*** for the non-remote facilities (Tariffs 5 and 6) and on ***approved bed days*** for those classified as remote (MMM 6 and 7).[2]

This feature of the base care tariff payment recognises that remote facilities tend to be the smallest and at risk of low and variable occupancy levels. With small local feeder populations, they are less likely to have a waiting list to draw from when a bed becomes

[1] Where a facility potentially qualifies for two base care tariffs (e.g. a specialised homeless facility in MMM 6-7) it will be paid on the basis of whichever tariff is higher.

[2] The RVU (cost) statistics reported in Report 3 are based on occupied bed days for all facilities (include facilities located in MMM 6 and 7). In contrast, NWAU statistics used in the funding model are based on occupied bed days for MMM=1-5 and on capacity (approved beds) for MMM 6 and 7. If NWAU for remote facilities were to be based on occupancy rather than capacity, the NWAU would have to be recalibrated (increased) based on the RVU for occupied bed days rather than approved bed days.

available. Being small, these facilities suffer the largest percentage loss of income if funding is based on occupancy and beds are vacant for any substantial period.

3.2 The individualised care (variable) payment

The individualised care or variable payment is paid in addition to the base care tariff and relates to the tailored care received by residents. This payment recognises the costs associated with the care of residents with different needs for assistance with activities of daily living and clinical or social support. The variable payment is based on the AN-ACC class assigned for each resident (see Figure 1).

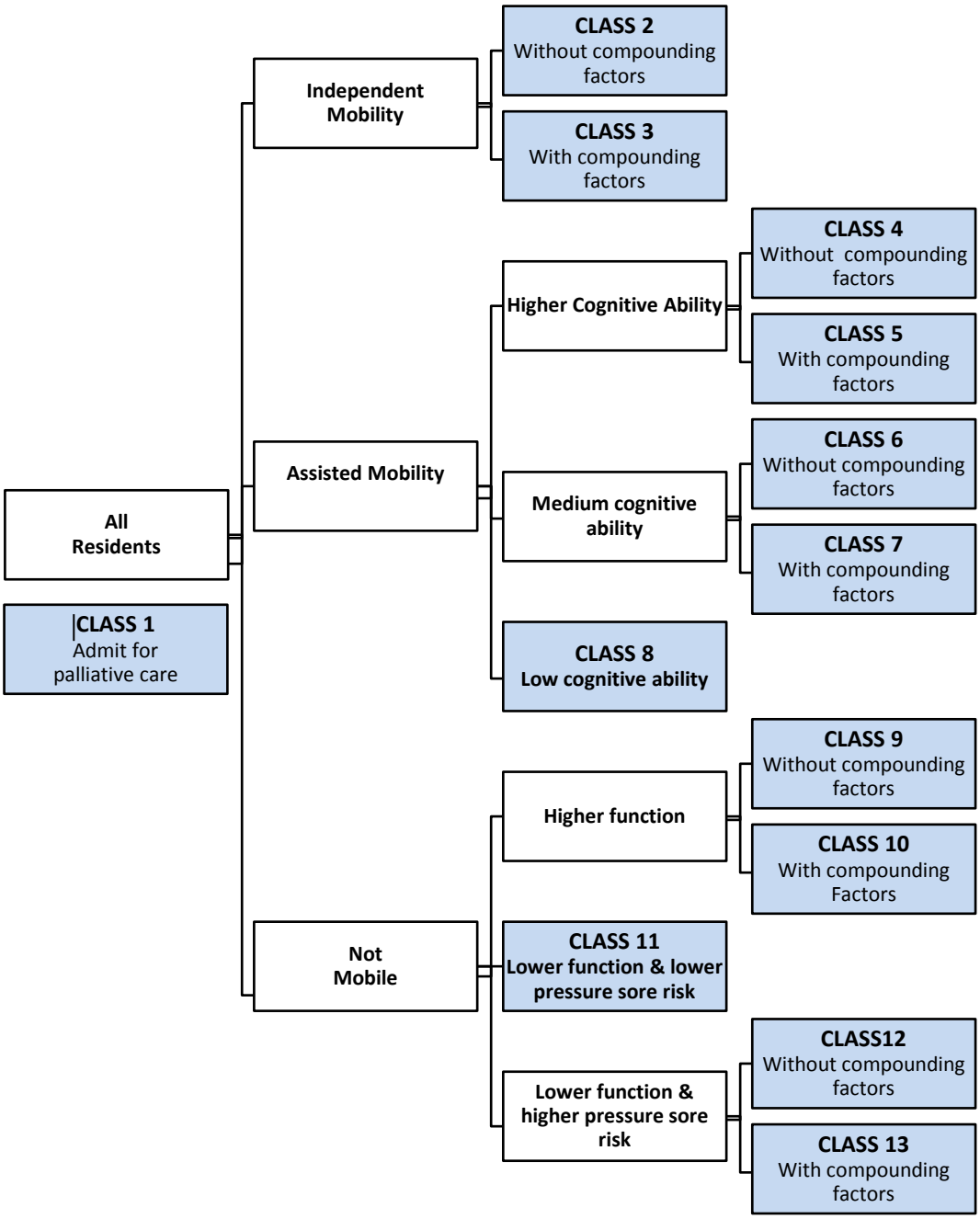
The AN-ACC classification system was developed with expert clinical input and was based on an intensive classification development study. Each resident was assessed using a standardised tool and care staff collected data on the time (in minutes) that they spent delivering care to each individual resident. The classification system is a branching model which enables the factors that drive care cost to be addressed interactively rather than operating in isolation. For example, two residents have cognitive impairment. One resident is mobile. The other is not. While they both have cognitive impairment, they have very different care needs. In the current ACFI system, cognition and mobility are each considered separately. In the AN-ACC, they are considered in combination. This issue is discussed in detail in an earlier report on options and recommendations for future funding models for residential aged care that was completed by AHSRI.[3]

In the AN-ACC funding model, the AN-ACC class is assigned based on an assessment conducted by an independent assessor who is not employed by the care home, using the AN-ACC Assessment Tool. The AN-ACC assessment process is described in detail in Report 2.

The branching model of the AN-ACC Version 1.0 is presented in Figure 1.

[3] McNamee J, Poulos C, Seraji H et al. (2017) *Alternative Aged Care Assessment, Classification System and Funding Models Final Report.* Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

Figure 1 The Australian National Aged Care Classification (AN-ACC) Version 1.0



Each of the AN-ACC classes is assigned an NWAU, with NWAUs calculated based on the relative cost of delivering care to residents within the class. Table 2 includes the NWAU for each class in Version 1.0 of the classification system.

The most costly residents (on a daily basis) with an NWAU of 0.96 are those who either enter the facility specifically for palliative care (Class 1) or are not mobile, have lower levels of function, higher risk of pressure sores and other compounding factors such as

behavioural issues (Class 13). The least costly residents are those who are independently mobile without compounding factors (Class 2).

Table 2 AN-ACC Version 1.0 NWAUs

AN-ACC class	Resident description	AN-ACC NWAU
Class 1	Admit for palliative care	0.96
Class 2	Independent without CF	0.18
Class 3	Independent with CF	0.30
Class 4	Assisted mobility, high cognition, without CF	0.20
Class 5	Assisted mobility, high cognition, with CF	0.36
Class 6	Assisted mobility, medium cognition, without CF	0.34
Class 7	Assisted mobility, medium cognition, with CF	0.47
Class 8	Assisted mobility, low cognition	0.51
Class 9	Not mobile, higher function, without CF	0.52
Class 10	Not mobile, higher function, with CF	0.83
Class 11	Not mobile, lower function, lower pressure sore risk	0.80
Class 12	Not mobile, lower function, higher pressure sore risk, without CF	0.78
Class 13	Not mobile, lower function, higher pressure sore risk, with CF	0.96

CF = Compounding Factors

3.3 The AN-ACC assessment

The AN-ACC assessment model is underpinned by the principle of separating assessment for funding purposes from assessment for care planning purposes. Assessment for comprehensive care planning would continue to be undertaken within care homes by staff who know their residents well. Assessment for funding would be conducted externally.

This is a significant change from the current approach to assessment using the ACFI. The ACFI model involves staff within the residential aged care facilities assessing each resident and submitting the results to the Commonwealth for funding purposes. The assumption in this process is that the home uses that same information for both funding and care planning purposes.

The AN-ACC assessment for funding purposes focuses on the drivers of cost. This is a fundamentally different type of assessment to one that would be undertaken for care planning. The AN-ACC assessment is designed to be robust and concise and able to be completed by an external expert clinician who is not familiar with the resident.

The AN-ACC funding assessment would be undertaken within four weeks of entry into care. Depending on circumstances, this could be an assessment prior to entry (with the assessment occurring in a health facility or in the person's home) or within the first four weeks after the people has moved into the care home.

To ensure that there are no incentives for preferential resident selection by the care home, it is proposed that, where the AN-ACC assessment for funding is undertaken prior to entry, the care home not be advised of the specific AN-ACC class assigned. The home would, however, receive the relevant aged care assessment team (ACAT) and referral information as they do now. The only information restriction would be the specific AN-ACC class.

If the AN-ACC assessment is undertaken after entry, the recommended entry payment default is Class 2, the lowest payment class. Payments may then be retrospectively adjusted back to the date of entry, as required, once the assessment is undertaken and the correct class assigned.

In the interests of sector education, engagement and transparency it is proposed that aggregated, de-identified data captured in the AN-ACC assessment be released annually in the form of a public report on the needs of residents in the residential aged care sector.

This annual public report will also act as an independent monitoring system on the changing needs of aged care residents. This is a fundamental requirement for system-level planning.

3.3.1 AN-ACC reassessment protocols and class reallocation

The design and implementation of the funding model should allow for a person to be assigned to a higher paying class if their needs change significantly either due to deterioration over time or as a result of a specific event. At the same time, the model should not create incentives for frequent unnecessary reassessments. This should be easier to achieve with the new funding model as the individualised payment represents, on average, only half the daily payment and there are many fewer classes. There is therefore less incentive and scope to change class. The fixed care payment is set at the facility level and does not change as the result of a reassessment.

It is proposed that the funding model include no formal requirement for reassessment of residents. If the capability of the resident improves after entry into care home, there is no requirement for them to be reassessed or assigned to a lower paying class and the payment rates should not change. This will provide explicit incentives for high quality care with a focus on restorative care and reablement.

A number of conditions have been identified, however, where resident care needs are likely to increase significantly and where a reassessment and class reallocation would be appropriate. The threshold for a reassessment is that the home anticipates that the person's individualised payment would increase by more than 20% of the national average payment per day. This would involve, in most cases, the movement of the resident within the AN-ACC classification from one major branch to another (e.g. independent mobility to assisted mobility). The three conditions set out below were found to most frequently result in a

significant change in resident care need in the reassessment study (see Report 2). As such, they are proposed as triggers for homes to request a reassessment.

Significant hospitalisation

A home may request a reassessment if the resident has been hospitalised for five days or more or, in the case of a patient who has a general anaesthetic, two days or more. As reported in the assessment report (Report 2), other significant events captured in the national reassessment study did not significantly result in a change of class.

Significant change in mobility

A home may request a reassessment if the resident's mobility has changed such that they move between the three mobility branches in the AN-ACC (i.e., from independent/assisted to assisted/non-mobile as measured by the De Morton Mobility Index (DEMMI).

A standard time period for reassessment

A home may request a reassessment after a specified period for any resident who is becoming progressively more frail and/or whose health status is gradually deteriorating. This period should be 12 months for classes 2 to 8 and six months for classes 9 to 13.

+++

In requesting a reassessment, the onus will be on homes to only select residents for reassessment whose individualised payment would be expected to increase by more than 20% per day (i.e. an overall funding threshold of 10% per day as the fixed care payment does not change with a change in AN-ACC class). The Department may choose to introduce reassessment charges for any home that routinely triggers unnecessary reassessments.

3.4 Adjustment payment on entry into residential aged care

An important feature of the proposed AN-ACC funding model is the inclusion of a one-off adjustment payment for each resident when they first enter residential aged care. This one-off adjustment payment recognises that there are additional, but time-limited, resource requirements when someone initially enters residential care.

The time-limited additional costs incurred when residents first transition into care relate to the following activities:

- time spent getting to know the resident and their family
- individualised care planning
- behaviour management
- health care assessments
- facilitating health care arising from assessments (including pain management, dental care, palliative care and other issues that need attention)
- developing an advanced care directive in partnership with the resident and their family.

This one-off payment relates only to an initial admission into residential aged care. An adjustment payment would not be payable if a resident transfers between homes. Consistent with principles of consumer-directed care, needs assessments and care plans should follow the resident if they move between facilities.

It is critical that aged care providers be held accountable to ensure that this adjustment payment is actually used for the intended purpose and not simply added to the bottom line. Nor should it be allowable for adjustment planning to be contracted out to third party providers.

This is a significant payment to give homes the capacity to work individually with every resident and their family to ensure that the resident subsequently receives the care that meets their needs and aspirations. The Commonwealth, working through the Department of Health and the Aged Care Quality and Safety Commission, will need to build strong accountability into the system to ensure that these goals are met.

3.4.1 The rate of the adjustment payment

Analysis of resource utilisation data collected in the first RUCS provided clear evidence that costs are indeed higher in the initial adjustment period. These additional costs vary slightly by AN-ACC branch and the adjustment period is longer for some classes than for others. However, these variations are not sufficient to justify different adjustment payments.

Instead, one adjustment payment is proposed for all branches and for all classes (including the palliative care class). Based on the resource utilisation data collected in Study One, this adjustment payment covers an average adjustment period of 16 weeks. It should be noted, however, that 16 weeks is an average and not expected to be the length of the adjustment period for all residents. This is a one-off lump sum adjustment payment to cover the whole initial adjustment period and which is to be paid in the month that the resident enters care.

The adjustment payment is 5.28 NWAUs.

3.5 The AN-ACC price

The price is set by the Commonwealth as funder. It is the standard national price for an AN-ACC NWAU value of 1.00.

While AN-ACC Version 1.0 has been designed specifically for residential care, the AN-ACC has the potential for progressive expansion across the whole aged care sector. If this were to occur, other AN-ACC classes would be progressively added to cover community aged care with the price for each new class also expressed as an NWAU.

4 The AN-ACC funding calculation

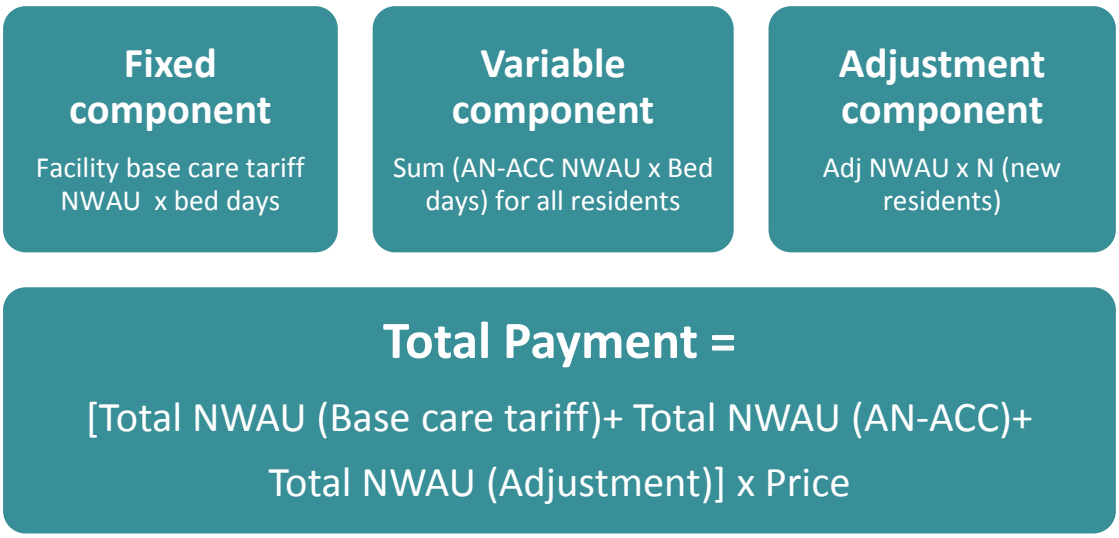
The funding amount allocated under the AN-ACC model is based on a simple calculation. The total resident care bed days to be funded are converted into NWAU weighted care days and the total weighted days figure is multiplied by the standard NWAU price per day. As noted earlier, the total weighted care days comprises three components. A summary of these components and an explanation of the total NWAU calculation is provided below.

Components of the AN-ACC funding model

- **The total base care tariff NWAU**. This is the standard daily bed day tariff determined for each different type of facility related to fixed care costs. This tariff is paid for every resident bed day in the funding period.
- **The total AN-ACC NWAU**. This is the variable component based on the AN-ACC class for each resident in care. This accounts for the variable care costs for residents with different individual care needs. An AN-ACC NWAU is assigned for each resident bed day based on the resident AN-ACC class. The total AN-ACC NWAU for the facility is the sum of NWAU across all residents for their total of days of stay within the funding period.
- **The total adjustment NWAU**. This is an additional calculated NWAU set at a standard rate for each new resident admitted for the first time during the funding period.

To determine the total funding allocation for a specific period, the total of these three component NWAU values is multiplied by the AN-ACC price.[4] Figure 2 provides an illustration of the model funding calculation.

Figure 2 Calculation of AN-ACC total funding based on NWAU and price



[4] The price is set by the Commonwealth government (funder) and is the price paid for one NWAU.

This funding concept is best illustrated by example. The scenarios below are provided to illustrate the effect of the funding model for different types of facilities and for residents different care needs represented by the AN-ACC class. In practice the total NWAU would be calculated for all resident bed days across the facility which would then be multiplied by the single price.

Imagine that the Commonwealth determined that the Commonwealth subsidy for an NWAU of 1.00 would be $100 per day.[5] In this example, the following rates would be payable:

> ***Resident in a very remote (MMM=7) facility with indigenous specialisation is assigned to Class 13. That is, the resident is non-mobile, with low function, at high risk of a pressure sore and with other compounding factors***

Base care tariff = 1.80 x $100 = $180 per day

AN-ACC funding = 0.96 x $100 = $96 per day

Total NWAU = 1.80+0.96 = 2.76

Total funding = $276 per day

> ***Resident in a RACF that receives base care tariff 6 and who is in Class 2. That is, the resident is a home in a non-remote area and the resident is independent and without compounding factors***

Base care tariff = 0.49 x $100 = $49 per day

AN-ACC funding = 0.18 x $100 = $18 per day

Total NWAU = 0.49+0.18 = 0.67

Total funding = $67 per day

The consolidated table of NWAUs for Version 1.0 of the AN-ACC funding model is included in Appendix 2.

[5] $100 has been used in this example to make it easy to understand the idea. There is no intention to suggest that the Commonwealth would pay this as a subsidy.

5 Commonwealth payments and supplements under the new AN-ACC funding model

Under the current ACFI system a number of additional supplements and funding adjustments are applied for specific conditions. These adjustments relate to differences between facilities and residents that are not able to be addressed by the ACFI model.

The fact that the AN-ACC model is more explicitly aligned with the different drivers of cost, and funds costs that relate to facility and resident characteristics through separate mechanisms, enables several current funding adjustments to be incorporated into the core model. However some require further investigation. These are discussed below.

5.1 Payments related to facility characteristics

Viability supplements

The viability supplement is currently paid to remote and regional facilities based on the understanding that the overall costs of operations for these facilities is higher than in metropolitan areas. The fixed care cost analysis found that there are clearly higher costs of providing care in remote facilities that are not related to the care needs of individual residents.

Within remote facilities there are also further additional costs related to the provision of specialised indigenous services and small facility size. The base care tariff in the AN-ACC funding model addresses the additional fixed care-related costs for remote and indigenous facilities.

Higher hotel costs are also addressed by the viability supplement but these costs are not care related. They are thus out of scope for the AN-ACC funding model.

The current viability supplements that relate to additional care costs may be discontinued once the AN-ACC model is introduced. However, the additional structural costs associated with hotel-type services would still need to be addressed.

Adjusted Subsidy Reduction

This subsidy reduction is currently applied to services operated by state or territory governments. A sample of government-run facilities was included in the AN-ACC fixed cost analysis and the raw cost results for these facilities were analysed. Those facilities reported substantially different costs and care staff mix and data and were therefore excluded from further analysis. The review of raw cost data for these facilities did not support the continuation of the adjusted subsidy reduction. It is proposed that this subsidy reduction be discontinued and the care homes be funded in the same way as non-government facilities.

Homeless Supplement

A homeless supplement of $16.16 per day is currently paid to facilities that provide specialised services to homeless people. This payment recognises that there are costs of providing care in these facilities that are driven by structural factors and the model of care

rather than the individual residents' need for activities of daily living (ADL) and clinical support.

The results of the AN-ACC classification study (see Report 1) are consistent with this. It found that the care needs of residents in these specialised facilities are different and not well captured through standard measures of physical mobility and related domains. An important finding is that a significantly greater proportion of care costs in specialised facilities for homeless people are shared care rather than individualised care.

In consequence, the fixed care cost analysis found that there are additional costs for homeless care that are facility-related. This has resulted in an increased base care tariff for facilities providing these services in the AN-ACC model.

The current homeless supplement may be discontinued once the AN-ACC model is introduced as the appropriate funding is included in the base care tariff.

5.2 Payments related to resident characteristics

All of the following supplements and subsidies relate to the characteristics of individual residents in care. For each of these items there were insufficient numbers of residents within the study sample to be able to fully understand the costs and therefore to recommend a funding approach under the AN-ACC model. A recommended course of action is proposed for each of the supplements and subsidies below.

Daily residential respite subsidies: Respite care was not in scope for the AN-ACC study with respite residents excluded from the resource utilisation and classification development study. A RUCS supplementary study on respite care is required. The goal of such a study would be to assess respite residents using the AN-ACC assessment tool, to allocate respite residents to one or more AN-ACC classes and to determine the NWAU or NWAUs that should apply to respite care.

There are currently two subsidy rates for respite care; $46.74 for low care and $131.05 for high care needs. For high care respite an additional supplement is paid to facilities when specified proportions of approved respite care services are provided. Given that specific respite care data were not collected as part of the RUCS, there is no justification to change current funding arrangements in the short-term.

Oxygen Supplement: The current supplement of $11.57 is allocated to address the costs of the additional staff time and materials associated with delivering technical nursing care to residents requiring oxygen. It is proposed that grandparenting arrangements be introduced for current recipients.

It is also proposed that a supplementary costing study be undertaken to determine the costs of care associated with oxygen, whether or not these costs are covered by the AN-ACC class, and whether an additional payment should be continued.

If additional funding is justified, this should be calibrated to the NWAU value and added to the AN-ACC NWAU for each eligible resident. The additional funding would then be incorporated into the AN-ACC variable payment.

Enteral Feeding Supplement: There are currently two separate subsidy rates for enteral feeding; a daily payment of $18.33 for bolus delivery and $20.59 for non-bolus. As with the oxygen supplement, grandparenting arrangements should be introduced until a supplementary costing study is completed to identify both the cost of materials and the technical nursing care costs for these residents.

Any justifiable additional funding for enteral feeding, identified as a result of a supplementary study, should also be calibrated to the NWAU value. As with the oxygen supplement, this would then be added to the resident AN-ACC NWAU for inclusion in the AN-ACC variable payment

Veterans' Supplement: This supplement of $7.08 per day is paid for veterans who have a mental health condition which Department of Veterans' Affairs (DVA) has determined is related to their service in the defence forces. This supplement is in recognition of the increased cost of mental health care and to ensure that their mental health condition does not act as a barrier to accessing appropriate aged care.

The RUCS did not capture data on the mental health needs of veterans within residential facilities or the care provided specifically to veterans. It is therefore proposed that grandparenting arrangements be introduced for current recipients in the initial implementation.

A RUCS supplementary study should be undertaken with a focus on mental health services and services provided to veterans. This study would identify any costs associated with mental health care for veterans and inform future decisions regarding this supplement.

RCS payments for grandparented residents: The continued payment of residential care subsidies based on a Resident Classification System (RCS) involves only those residents who were in care prior to the introduction of the ACFI in 2008. With the transition to the ACFI, grandparenting arrangements were introduced whereby existing residents continued to be funded under the RCS.

It is proposed that resident assessment, classification and subsidy payments transition from the ACFI to the AN-ACC over a two year period (see Section 6). To ensure that the bulk of care funding is transitioned to AN-ACC within the transition period, current residents should be reassessed using the AN-ACC assessment tool and assigned to an AN-ACC class as their care needs change. Any resident still funded under the RCS after the two year transition period should be reassessed and funded under AN-ACC and their RCS-based funding ceased.

Resident specific subsidy reductions: There are a number of subsidy reductions related to resident factors such as compensable status and means testing. The RUCS did not capture any specific cost data for residents that would inform changes to these subsidy reductions. It is proposed that these reductions be retained in the initial implementation and reviewed in a supplementary costing study.

6 AN-ACC Implementation

The introduction of the AN-ACC represents very real funding reform and significant change for the Australian aged care sector. This new approach will be associated not only with changes in the funding allocation for care homes but with the introduction of new terms and concepts. However commonplace they are within health, these concepts are new and very different to those currently used in aged care.

The successful introduction of these reforms will require a significant change management strategy including education, clear communication and a transition plan.

The implementation should commence with a single starting date across the system but with progressive transition in terms of the actual funding impact. This gradual implementation is required to address key concerns around funding stability. There should be 'no surprises' during transition for either the Commonwealth or for providers.

The AN-ACC funding model does not, per se, determine the size of the residential aged care funding pool. Rather, the Commonwealth determines the total system-level funding pool and the price of an NWAU of 1.00.

However, irrespective of the size of the funding pool, there will inevitably be a redistribution of funding with some increases and decreases across facilities. The recommended implementation program is that the transition to full AN-ACC funding occurs over a two year period with stop-loss protections in place to ensure that no facility experiences sudden loss of income. At the end of this two year period, care homes will have a further six months to transition all remaining residents to the AN-ACC system.

At the start of the two year period funding arrangements for all residents (both ACFI and RCS funded) will be grandparented. From that date all new resident assessments and reassessments for funding will be conducted using the AN-ACC tool and AN-ACC funding will be allocated. This includes existing residents being reassessed and transitioned to AN-ACC funding as their care needs charge. The important implication is that there would be no further ACFI assessments, reassessments, reporting or validation from the AN-ACC start date.

This progressive introduction means that at the end of the two year period there should be very few residents to be reassessed for funding under the AN-ACC in the additional six month transition period.

6.1 Implications for the sector

Fixed care and variable payments

The blended funding model, which pays at a fixed rate for shared care and care management costs and at a variable level based on resident care needs, will provide more certainty and stability for facilities. This is particularly important for small remote facilities with variable occupancy where the fixed care payment is recommended to be on the basis of bed capacity rather than occupancy.

Stop-loss thresholds and transition payments

As noted above, no home should experience the sudden loss of significant income as the result of the new funding model. To ensure that this is the case both gradual transition and stop-loss measures are recommended.

The gradual transition to full AN-ACC funding will occur over a two year period with the new funding allocation only relating to new residents arriving after the implementation start date or on the basis of reassessment as care needs change. This allows the facility to understand the funding impact without experiencing the full effect of the changes immediately. If the funding level is to be reduced under the new model, the facility will be able to use this time to make the necessary adjustments. The supplements that are currently in place will also be retained during this period and only modified or removed based on new cost evidence.

The stop-loss mechanism is an additional safeguard to ensure that any significant reduction in funding as a result of the AN-ACC model will be experienced gradually giving the homes some time to adjust.

The stop-loss threshold should be 5%. Any income reduction less than this will be carried by the home. Any loss greater than 5% will make a home eligible for a transition payment up to the 95% threshold for the two year transition period.

This threshold applies at the level of the home as a whole rather than the individual resident. Every home will have some residents who attract more funding under AN-ACC than ACFI and others who would attract less. The transition payment strategy applies only to homes where the net effect is negative for the home as a whole.

Given that implementation of AN-ACC will be incremental, homes cannot apply for a transition payment until at least 25% of their residents have transitioned to AN-ACC funding.

It will also be the case that many facilities will be allocated a higher level of total funding under the AN-ACC model. These facilities will receive the AN-ACC based funding allocation for new residents from the implementation start date and as existing residents are reassessed. No facility level funding adjustments will be made for these facilities and they will retain the full value of increases due to AN-ACC funding.

Care planning assessments

Although AN-ACC assessments for funding will be undertaken by clinicians who are external to the facility, detailed assessments for care planning remain the responsibility of the residential aged care facility. Savings that may be realised by facilities no longer undertaking internal ACFI assessments should be redirected towards improvements in individualised care planning that involves best practice needs identification and consumer choice.

6.2 Implications for government

The AN-ACC funding model is designed as a funding distribution model which applies price weightings (NWAU) to different types of facilities and residents. It does not determine the

price that the Commonwealth pays. The price is a policy decision for government. The government could decide to implement the AN-ACC funding system so that it is cost neutral at the system level. Likewise, the government could use the AN-ACC to distribute a growth budget.

Either way, this is a significant reform process for government which will require upfront investments to introduce changes in the information systems, payment processes, policies and, potentially, legislation. There will be some opportunities to offset some of these costs through the system efficiencies of the AN-ACC model. An example of this is that the new costs of operating the AN-ACC assessment workforce should be offset by reduced government investment in audit and compliance functions.

The gradual transition process will also enable the government to make the necessary adjustments to the model over the first two years. Although the stop loss payments will increase the cost of funding in the short term, the impact will lessened by the gradual funding transition, particularly where facilities would be entitled to higher subsidies under the AN-ACC.

There is likely to be little or no impact for the jurisdictions as a result of the introduction of the external assessment model. The role of the ACAT program is likely to be unchanged as they may still retain role of 'gatekeeper' to aged care across the community and residential services.

Annual costing studies to inform price

Government subsidies for residential aged care are a policy decision of government. Under the proposed new funding model, the government makes an annual determination about the funding price determined based on a costing study. This price would be standard across fixed care and individualised components of the funding model and the adjustment payment. For funding allocation purposes, this price is the value of an NWAU of 1.00.

This model is based on the precedent established by the national hospital funding model. In this model, there is an explicit relationship between cost and price and the price is set based on a program of annual costing studies. In the hospital context the price is termed the 'National Efficient Price' and the results of the costing study in one year are used to inform the price and the NWAUs for different types of care in the following year.

In the annual costing study for residential aged care, the proportion of costs that relate to services provided to all residents (fixed care) versus the relative costs of care provided to residents in different care need groupings (individualised care) would be identified. Whereas for hospital services the Independent Hospital Pricing Authority (IHPA) sets the price equal to the 'efficient cost', in the aged care sector the price should be informed by cost but also include a reasonable return on investment.

If this approach is adopted, the Department of Health or the IHPA could be tasked with undertaking a national costing study each year with the Commonwealth using those results to inform the residential aged care price for the following year. This concept of cost informing price also delivers a system that is self-regulating and creates minimal incentives

for gaming. (i.e. if residents are assessed as being in a high paying AN-ACC class but do not receive high cost care, the average cost of the high paying class, hence the future payment, may be reduced.)

Assessment workforce

The AN-ACC model involves the development of a workforce of accredited assessors who are external to the aged care homes. This requires an AN-ACC assessment workforce model and strategy which includes systems for recruitment, training, credentialing and ongoing professional support. The AN-ACC workforce requirements are discussed in Report 2.

Information technology

The IT system to support the AN-ACC funding system needs to be determined by the government. The AN-ACC assessment can be recorded by the assessor using a paper or digital form. Either way, the results of each assessment then need to be fed into a software 'grouper', a software program that assigns each resident to one of the thirteen AN-ACC classes. The grouper should be installed and managed centrally within the Department of Human Services (DHS), either integrated within the DHS system or as a standalone system that may transfer data to the DHS payment system.

Although the volume of assessment and compliance related data required to be collected under the AN-ACC model is substantially less than under the ACFI system, there will still be information system changes required. The data for each facility will include the AN-ACC assessment data and class assignment, along with the AN-ACC and base care tariff NWAUs.

Once the AN-ACC data are included within the DHS system, the payment mechanism and issues should be managed in the same way as the current system.

Change management and education

As this model represents significant change for the sector, it is critical that planning for change and a communication and education strategy is developed as early as possible.

The government will need to have the systems in place for continuing engagement with the sector and to enable fine tuning of the system over time in partnership with the sector. The ability for the sector to participate in some of the fine tuning decisions will help to build trust, enhance the transparency and promote 'ownership' of the system.

This engagement should include strategies for how the AN-ACC data may be used to benefit both the sector and the government. In time, the discussion could extend beyond the allocation of funding to the measurement and review of resident outcomes, the use of data to describe changes in resident profile and predicting future demand.

7 Conclusion

This funding model represents a significant change for the residential aged care sector and planning for its incremental implementation needs to commence as soon as government announcements are made. Initially, this model may be perceived as complex by the sector with a new language and concepts. These concepts are sophisticated. However, they are at the same time clinically meaningful and easily explained.

However conceptually sophisticated, these ABF type models are administratively simple, straightforward and do not require complex information systems. In contrast, the current ACFI system is conceptually straightforward but time—consuming and expensive to administer.

Planning for the technical implementation of the model needs to be accompanied by an investment in change management. The government should enter into a partnership with the sector to implement the new model, recognising that this is in the interests of residents, providers and government.

At the same time, there will inevitably be the need to fine-tune the model as implementation progresses. The Department will need systems in place for sector engagement and consultation as implementation progresses, as well as ongoing access to technical expertise.

As the system becomes embedded the government should both access external, and begin to develop internal, expertise in using the data to better measure the needs of residents and changing needs over time and to review resident outcomes and adverse events. The data should also be used in future planning to predict ongoing demand for residential aged care.

Funding reform is not an end in itself. As well as being a more efficient and equitable funding model, this funding reform provides an important opportunity to drive fundamental improvements in resident experiences and outcomes. It also provides the evidence base necessary to evaluate the value for money that the sector delivers.

Appendix 1

Overview of the Resource Utilisation and Classification Study (RUCS)

In summary, RUCS comprised four separate but closely related studies. Each study included separate data collection and analysis elements that have been synthesised to produce a classification and associated funding model that is suitable for implementation across the Australian residential aged care sector.

- ***Study One – Service utilisation and classification development study***

Study One involved a prospective and comprehensive collection of resident assessment, service utilisation and financial data which was analysed to develop a casemix classification. Study One involved 30 facilities clustered in three geographic regions in Queensland, New South Wales and Victoria.

Study One was completed between October 2017 and October 2018.

- ***Study Two – Fixed and variable cost analysis study***

Study Two involved a larger nationally representative sample of 110 facilities. The purpose of this study was to understand differences in cost drivers between different types of facilities (including facility size, location) as well as differences that may result from seasonal effects. This analysis will inform the design of the funding model. Study Two will examine facility, rather than resident level costs from a nationally representative sample of facilities across Australia.

Study Two was completed between November 2017 and October 2018.

- ***Study Three – Casemix profiling study***

Study Three involved the collection of variables included in the classification from an additional nationally representative sample of 80 facilities. The primary purpose of Study Three was to develop a national casemix profile of residents in aged care in Australia.

Study Three was completed between September 2018 and December 2018.

- ***Study Four – Reassessment study***

Study Four was added to the RUCS work program in mid-2018 in recognition of value that could be added by collecting additional information about the rate and extent of change in residents' care needs over time. Study Four involved conducting re-assessments of approximately 1,000 residents assessed as part of Study One four to six months after their initial assessment.

Study Four was completed between August 2018 and December 2018.

The RUCS reports

Given the complexity of RUCS, it has been written up in a series of reports as follows:

- **Report 1: The Australian National Aged Care Classification (AN-ACC)**

  Report 1 covers the design and conduct of the study undertaken to develop the Australian National Aged Care Classification (AN-ACC) Version 1.0 (Study One). It covers the design and use of the AN-ACC assessment tool and the resource utilisation study undertaken to develop AN-ACC Version 1, including the preparation and analysis of the data collection. It discusses the results, the classification development process and key outcomes including the statistical analysis and clinical validation.

- **Report 2: The AN-ACC assessment model**

  Report 2 presents detailed findings relating to the external assessment tool and assessment process (informed by Studies One, Three and Four). This includes the development of the assessment tool using expert clinical panels and a summary of feedback from assessors regarding the use of the tool and the suitability of individual instruments. The skills and competencies required for the assessment workforce and other implications for implementation of the external assessment model are considered as well as triggers and protocols for reassessment.

- **Report 3: Structural and individual costs of residential aged care services in Australia**

  Report 3 presents the analysis and findings of Study Two which identified the proportions of total care costs that are fixed (including shared care) and variable (relating to individualised resident care). The analysis focused on the differences in fixed costs between different types of facilities, characterised by ownership, size, remoteness and service specialisation. It includes an analysis of the drivers of fixed care costs.

- **Report 4: Modelling the impact of the AN-ACC in Australia**

  Report 4 presents an analysis of modelling the introduction of the AN-ACC across Australia. This is based on the findings of Study Three. The sampling and assessment data collection process and the casemix of residents in aged care across Australia are described. The focus of this report is on modelling the introduction of the AN-ACC to replace the ACFI.

- **Report 5: AN-ACC: A funding model for the residential aged care sector**

  Report 5 presents the design of a new funding model based on the AN-ACC. It includes a consideration of other payment issues such as existing payment supplements, a discussion of incentives in funding model design and key issues in implementing the new model.

- **Report 6: AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations**

  This report syntheses and consolidates the findings presented in other reports and provides a consolidated set of recommendations.

- **Report 7: AN-ACC Technical appendices**

  This report is a series of technical appendices that contain detailed data for reference purposes.

Appendix 2

The consolidated set of AN-ACC Version 1.0 NWAUs

Adjustment payment – payable once for each new resident		
Fund Code	**Description of payment**	**NWAU**
Adj	Resident entering residential care for the first time	5.28
Base care tariff – payable by facility total resident bed days		
Tariff	**Facility description**	**NWAU**
1	Indigenous, MMM=7	1.80
2	Indigenous, MMM=6	0.78
3	Non-indigenous, MMM=6-7, < 30 beds	0.68
4	Non-indigenous, MMM=6-7, 30+ beds	0.52
5	Specialised homeless	0.92
6	All other RACFs	0.49
AN-ACC class payment – payable by bed day for each resident		
Class	**Resident description**	**NWAU**
Class 1	Admit for palliative care	0.96
Class 2	Independent without CF	0.18
Class 3	Independent with CF	0.30
Class 4	Assisted mobility, high cognition, without CF	0.20
Class 5	Assisted mobility, high cognition, with CF	0.36
Class 6	Assisted mobility, medium cognition, without CF	0.34
Class 7	Assisted mobility, medium cognition, with CF	0.47
Class 8	Assisted mobility, low cognition	0.51
Class 9	Not mobile, higher function, without CF	0.52
Class 10	Not mobile, higher function, with CF	0.83
Class 11	Not mobile, lower function, lower pressure sore risk	0.80
Class 12	Not mobile, lower function, higher pressure sore risk, without CF	0.78
Class 13	Not mobile, lower function, higher pressure sore risk, with CF	0.96

CF = Compounding Factors (see Report 1)
MMM = Modified Monash Model. A measure of geographic remoteness where 7=most remote and 1=major metropolitan