LASA response to implementation of Increasing Choice in Home Care

Issues Paper

September 2017

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EXECUTIVE SUMMARY

Implementation of the *Increasing Choice in Home Care* (ICHC) reforms is focused on improving the way home care services are delivered to older Australians. It aims to strengthen the aged care system, providing consumers more choice in accessing quality care and service innovation through increased competition. It also lays the foundations for future aged care service delivery, to be guided by the Aged Care Sector Committee Roadmap for Reform and jointly developed with industry.

With ICHC still in a relatively early stage of implementation, Leading Age Services Australia (LASA) is calling upon government to act in response to issues that have since emerged for both home care providers and consumers.

This 'issues paper' details seventeen outstanding implementation issues identified through consultation with home care providers throughout Australia. These issues have been mapped against a risk framework to draw out the most salient issues for government response. Recommended actions for Government and other stakeholders have also been provided.

It is important to note that the compounding effect of these issues has resulted in ongoing unsatisfactory experiences for many home care providers and consumers. There has also been additional unfunded administrative burden for both home care providers and government departments with risks for stakeholder disillusionment, disengagement and possible market failure in the event these issues are not promptly addressed.

Low consumer activation rates of home care packages

The most pressing concern is the low number of home care package (HCP) activations for consumers relative to the number of HCPs released to consumers from the national queue, with perceived insufficient infrastructure to support consumer HCP activation. LASA previously brought these concerns to the attention of the Department of Health (DoH) in early June 2017, with issues and recommendations tabled in LASA's *Home Care Provider Survey Report*[1].

Some HCP providers have since reported significant down turns in active HCPs. Current estimates are in the range of 15 to 34 per cent with LASA planning to re-survey HCP providers to gain a clearer picture of the extent of reductions in HCP activations.

HCP providers have further reported increasing staff turnover, being unable to provide staff sufficient work hours previously afforded to them.

Continued sector-wide reduction in HCP activity is at the detriment of HCP provider business viability and potential market failure.

As such, the release of performance data on the national HCP queue, twice delayed, should be released as a priority to increase transparency of ICHC implementation, assisting HCP provider to respond to the current market dynamics. Additionally, improved provisions and infrastructure are recommended to support consumers in researching HCP providers, to actively follow them up and to incentivise their HCP activation.

Barriers to consumer access to home care package activation

Other concerning issues that appear to hinder consumer access to HCPs include:

- Extensive delays in consumer access to assessments for HCP approval completed by Aged Care Assessment Teams (ACAT),

[1] https://lasa.asn.au/news/lasa-home-care-provider-survey-report/

- Unavailability of home care package levels relative to consumer demand,
- Redirection of consumers with a HCP approval to receive interim support using Commonwealth Home Support Programme (CHSP) resources, and
- Perverse incentives for consumers receiving interim CHSP support to activate a HCP once assigned.

In Victoria, home care providers have recently reported ACAT assessment wait times as ranging between 12-16 weeks, while in QLD they are reported in some regions as ranging between 6-8 weeks and in others 24 weeks. Other ACATs are reported as being more responsive. Importantly, extensive and variable delays to assessments across regions impact on consumer equity and prioritisation for access to care and support, particularly where consumer vulnerability is identified.

HCP providers have also reported their perception that the existing HCP prioritisation system is counterproductive in promoting wellness, independence and reablement. Consumers are assigned a HCP level from the national queue based on the availability of a HCP level irrespective of the consumers actual inherent care needs. Where high level support is required a low level HCP may be assigned because it is the only HCP available. Such an approach to managing consumer demand for HCPs can lead to speedier decline in condition, reduced client wellness and independence and ultimately may bring forward potential admission to residential care. One large scale provider has reported consumers on level two HCPs have entered residential care due to the unavailability of access to higher level HCPs.

In conjunction to this, CHSP providers have reported that their staffing and program outputs are now exceeding their block funded grant agreements with referrals for interim CHSP support being implemented in response to unmet HCP demand and limited HCP supply. The levels of interim CHSP support being issued to consumers are often as high as what is provided through a HCP. Consequently, CHSP providers may not have sufficient funds to respond to service demand in the second half of the 2017-18 financial year, creating additional risks for CHSP not yet realised.

Additionally, there are reports that CHSP consumers are rejecting their HCP assignment. One consumer has refused to pay any fees and has instead retained their current CHSP services, accessing additional financial support via means such as an oxygen supplement, a continence aids payment, transport assistance, Centrelink assistance, and through access to multiple government funded health services.

Clearly, there are some emerging implementation issues that are indicative of a vulnerable market environment. This signals a risk of stakeholder disengagement from the HCP program and market failure. It also exacerbates the significant financial pressures being placed on HCP providers who are dealing with decreasing HCP activity levels. Government must step in.

Accumulation of unpaid subsidies for home care package providers

There are also critical issues that have emerged for consumers and home care providers once a HCP has been activated. This includes:

- Unpaid subsidies relative to home care package activity,
- Incorrect home care package withdrawals (resulting in unpaid subsidies), and
- The inadequacy of My Aged Care (MAC) capability to respond to consumer and provider concerns for unpaid subsidies.

HCP providers continue to report on Aged Care Payment (ACP) system and process failures that appear to be a by-product of other issues referenced throughout this paper. Unpaid subsidies are referenced where:

1. Subsidies are partially adjusted with unpaid amounts still outstanding,
2. Subsidy payments have stopped part way through a month,
3. Incomplete adjustments to subsidy payments occur for HCPs which commenced prior to 27 February 2017,
4. MAC have assigned HCPs that have been activated by HCP providers and for which no subsidies have been paid or have been paid at the incorrect HCP subsidy level,
5. Subsidy payments are not consistent with commencement and leave dates submitted in ACP claims/Aged Care Entry Records (ACER), and
6. Subsidy calculation errors.

One HCP provider has reported the accumulation of unpaid subsides equating to near $125K since ICHC commencement. Additionally, HCP provider administration to manage subsidy payment reconciliation and error management has increased relative to the size of a providers HCP program. When both HCP providers and consumers contact MAC or Department of Human Service (DHS) staff for issue resolution they are often unable to respond with any clear direction. Combined, these issues run contrary to the intent of ICHC in reducing red tape and as such these ongoing system and process failures exacerbate frustrations and financial pressures for implementation of HCPs.

In summarising, this issues paper draws government attention to the prevailing ICHC implementation risks. LASA demands a considered approach to the review, resourcing and rectification of specified issues, acknowledging that there is potential to improve upon current systems and processes for ongoing implementation of ICHC. Action is required and industry is looking to government to respond urgently to safeguard and strengthen the Home Care program in Australia's aged care system.

INTRODUCTION

On the 27 February 2017, implementation of the ICHC reforms commenced, intended to improve the way home care services are delivered to older Australians.

Important elements of ICHC include:

- Supporting consumers so they can choose who provides their care, with the ability for consumers to change their provider at any time;
- Providing a consistent national process for prioritising access to home care; and
- Reducing red tape and regulation for providers.

Implementation of these reforms continues to occur as a collaborative co-design process, involving government, the aged care sector, carers, consumers and industry peak bodies, who collectively are taking significant steps to improve the way home care services are delivered to older Australians.

The ICHC reforms build upon a substantial body of work already completed. This includes:

- Announcement of the *Living Longer Living Better* reforms, including the introduction of new HCP levels;
- Commencement of consumer directed care for all HCPs, including individualised budgets, and income testing arrangements;
- Commencement of MAC and Regional Assessment Services (RAS); and
- The integration of all entry level in-home support programs into the CHSP except for Home and Community Care (HACC) Services in Western Australia which will be included from 1 July 2018.

Many issues have emerged in ICHC implementation since its commencement. Some of these issues have been resolved, accounted for within accelerated design sprints that commenced in late 2016. There are, however, many issues that remain unresolved.

The current set of implementation issues have been identified through consultation with home care providers from across Australia. They have been mapped into seventeen key themes with examples and recommendations listed for each.

Each issue has also had a risk ranking applied to it using a risk ranking matrix (see Table 1) with associated methodology listed in Appendices 1-2 accounting for the likelihood that an issue has occurred and the consequence of its occurrence. Risk rankings for each of the seventeen issues was completed independently by three expert home care advisors with the average score of these rankings applied to each issue as listed in Table 2.

Table 1. Risk Ranking Matrix

Likelihood	**Consequences**				
	Insignificant	Minor	Moderate	Major	Catastrophic
Almost Certain	Low	Medium	High	High	Extreme
Likely	Low	Medium	High	High	High
Possible	Low	Low	Medium	Medium	High
Unlikely	Low	Low	Medium	Medium	Medium
Rare	Low	Low	Low	Low	Medium

Table 2. ICHC implementation issues

Operational Process	Issue	Risk Ranking
1. Entry level support assessments	1.1 RAS impartiality in CHSP referrals	Medium
	1.2 Incomplete support plans by RAS assessors	Medium
2. HCP assessments	2.1 Delays in consumer access to ACAT assessments	High
3. HCP national queue	3.1 Lack of transparency about home care package assignment wait times	High
	3.2 Unavailability of home care package levels relative to consumer demand	High
4. Interim CHSP Support	4.1 Excessive CHSP activity levels	High
	4.2 Perverse incentives for home care package activation	High
5. HCP assignment	5.1 Insufficient infrastructure for consumer activation of assigned home care packages	Extreme
	5.2 Consumer correspondence errors	Medium
	5.3 Presumptive provider home care package activations	Medium
6. HCP activation & subsidy payment	6.1 Low rates of home care package activations	Extreme
	6.2 Incorrect home care package withdrawals	High
	6.3 Inappropriate home care package regrades	Medium
	6.4 Incorrect home care package movements	Medium
	6.5 Inadequate MAC capability to respond to consumer and provider concerns	High
	6.6 Inconsistent subsidy payments relative to home care package activity	High
7. Other issues	7.1 Insufficient infrastructure to implement annual and life-time caps on consumer care fee contributions	Medium

The significance of theses unresolved issues for consumers, as well as for home care providers, cannot be understated. The non-resolution of these issues appears to have compounded over the last few months, with ongoing unsatisfactory experience noted for both consumers and providers. There has also been additional unfunded administrative burden for both HCP providers and government departments, and there is certainly a risk for stakeholder disillusionment, disengagement and market failure in the event these issues are not addressed as a priority.

LASA is committed to representing aged care providers and their consumers as part of co-design, providing an industry response to government for immediate and ongoing action to improve upon the current implementation status for the ICHC reforms.

RECOMMENDATIONS

There are 38 recommendations listed across the 17 operational areas for which issues have been identified and discussed within this issues paper.

RAS impartiality in CHSP referrals

medium risk

1.1.1 That current RAS contractual arrangements be reviewed by the DoH in the context of existing RAS to CHSP referral pattern data for the period 1 July 2015 to 30 June 2017. The examination of RAS referral patterns should occur promptly before contract renewal on 1 July 2018, accounting for any changes in referral patterns emerging following implementation of ICHC.

Referral patterns should be examined, separating out referrals by each RAS provider. Where referral patterns indicate a significant increase in referrals from a RAS provider to their affiliated CHSP service, by service type, comparative to RAS referrals to non-affiliated CHSP services for corresponding service types, contractual arrangements should be discontinued by the DoH with contract extension of RAS functions limited to the remaining RAS providers with new RAS contracts considered as required.

1.1.2 That DoH develops and communicates an escalation procedure for home care providers and MAC to support a consistent response to concerns identified about RAS impartiality in CHSP referrals that will strengthen accountability and sector confidence around monitoring home care provider adherence to procedures for separation of RAS and CHSP functions.

Incomplete support plans by RAS assessors

medium risk

1.2.1 The formal evaluation report for the RAS Programme, submitted to DoH in June 2017, be released by the DoH to the National Aged Care Alliance for industry consideration and response to inform program directions as part of the future care at home reforms.

1.2.2 The DoH establishes a cycle of random audits, assessing the completeness and quality of RAS assessments/support plans registered in MAC. This should include engaging with a sample of corresponding CHSP providers relative to audited support plans, identifying areas for workforce training and procedural improvement for implementation.

1.2.3 The DoH commissions the development of supervision and/or support structures for RAS assessors within future RAS contracts, to assist RAS to account for their response to clinical issues identified in entry level assessments, enhancing the responsiveness of support plans for entry level care.

1.2.4 The DoH in partnership with industry representatives, facilitates engagement between RAS assessors and CHSP providers at local levels to exchange critical information that will support continuous improvement for assessment and referral to CHSP services, with feedback to the DoH on issues as required.

Delays in consumer access to ACAT assessments

high risk

2.1.1 The DoH undertakes further investigation of 'referral to ACAT' wait list management models currently being utilised by MAC/ACATs to ensure risks to consumers are minimised until such time that assessment resource modelling can be applied and funded ongoing.

2.1.2 The DoH prioritises the review of ACAT assessment/reassessment wait time data for the period 2016-2017 and undertake assessment workforce resource modelling as part of the

future care at home reforms. Assessment workforce modelling should account for those mechanisms in the assessment process that are critical for completion of timely assessments.

2.1.3 Where there are significant delays identified in ACAT assessment/reassessment wait time data for the period 2016-2017 relative to ACAT resourcing and performance indicators, the DoH considers tendering out assessment functions of under-performing ACATs to alternate groups, like Primary Health Networks, to increase program performance and accountability commencing 1 July 2018.

Lack of transparency about home care package assignment wait times — high risk

3.1.1 The DoH promptly and regularly publish information on expected HCP wait times via MAC for access by consumers to assist them with preparation and planning as relates to researching HCP providers in the period prior to being assigned a HCP.

Unavailability of home care package levels relative to consumer demand — high risk

3.2.1 The DoH commences a review of the current allocation of HCPs across all four levels, accounting for the number of interim HCPs that have been allocated and facilitating a phased approach for the redistribution and topping up of HCP funds at each level consistent with consumer demand. Re-distribution of existing aged care funding should account for funds across CHSP and HCP programs currently being utilised by consumers with a HCP approval.

3.2.2 The DoH explores the feasibility for establishing protocols for escalation of immediate increases in care and services for vulnerable consumers.

3.2.3 That DoH explore the feasibility of implementing maximum wait times on the national queue.

Excessive CHSP activity levels — high risk

4.1.1 The DoH promptly develops a wait list interim support triage tool with support from industry representatives. The triage tool should account for consumer referrals to interim CHSP support that cannot be better accounted for by promoting consumer engagement in fee for service arrangements. The triage tool should also account for both consumers seeking a new HCP and those seeking a HCP regrade.

4.1.2 The DOH promptly develops a wait list interim support decision making protocol with the support of industry representatives. This protocol should provide direction for stakeholder communications, capping of interim supports relative to assessed need and processes for care plan transfer on HCP assignment.

4.1.3 The DoH, in partnership with CHSP providers, reviews and responds to the impacts of current interim CHSP support arrangements on overall CHSP activity and funding outputs, as well as risks to providers and consumers.

Perverse incentives for home care package activation — high risk

4.2.1 The DoH caps consumer access to interim CHSP support in terms of service activity levels and duration, incentivising consumer activation of their assigned HCP. This includes expiration of CHSP interim support at the HCP assignment end date or the HCP package

activation date with account for communication and implementation of a care transfer plan to respond to identified risks for consumer transfer from CHSP to HCP.

4.2.2 That DoH identify "grandfathered consumers" from prior HACC programs and explore the feasibility to register these consumers in MAC with reassessment of need relative to entry level and complex care provisions through reformed ICHC program structures.

4.2.3 The DoH, subject to advice received through the independent Legislative Review, promptly introduces a single fee policy that will align consumer co-contribution arrangements across CHSP and HCPs into the future.

Insufficient infrastructure for consumer activation of assigned home care packages

extreme risk

5.1.1 The DoH promptly considers the feasibility of adding functionality to MAC that will provide consumers the opportunity to register a preferred HCP provider prior to HCP assignment, with consent for MAC to notify registered HCP providers of pending HCP assignments to improve infrastructure for supporting timely consumer HCP activations.

5.1.2 The DoH builds confirmation of mailing addresses into HCP assessment processes and enhances MAC configuration as required, to support timely response to auto-generated HCP letters from consumers or appointed representatives.

5.1.3 The DoH addresses the inequity in the MAC Service Finder, accounting for multiple repeat HCP provider listings with generic content, hindering consumer experience and usage of the MAC Service Finder.

5.1.4 The DoH acknowledges the varied pricing models amongst HCP providers that have emerged pre-and post-1 July 2015 that do not support consumers in their comparison of service offerings by price, engaging with the sector to address this issue prior to directing HCP providers to populate this information into the MAC Service Finder.

Consumer correspondence errors

medium risk

5.2.1 The DoH promptly reviews and resources the rectification of system auto-letter generation errors and associated processes for HCP assignment and reminder letters that are issued to consumers, seeking ongoing sector feedback concerning the status of system and process improvements.

5.2.2 The DoH releases advice to the sector that supports HCP provider engagement with consumers around responding to error identification issues for auto-generated HCP letters distributed to consumers.

5.2.3 The DoH develops standardised practices for timely and supportive responses to rectification of HCP activation issues where errors are identified in official HCP letters. Such an approach should seek to minimise and/or alleviate adverse impacts to both consumers and HCP providers. KPIs should be introduced for MAC Contact Centre staff to enhance consumer and HCP provider experience, reducing the risk of program disengagement.

Presumptive provider home care package activations — medium risk

5.3.1 The DoH establishes and communicates mechanisms to both consumers and providers for response to suspected presumptive provider HCP activations with severe penalties for HCP providers where such behaviours are confirmed as having occurred.

Low rates of home care package activations — extreme risk

6.1.1 The DoH implements the recommendations of LASA's Home Care Provider Survey Report as a priority. This includes:

6.1.1.1 Increasing the visibility of MAC performance data to better understand consumer behaviour in respect to package activations relative to package assignments;

6.1.1.2 Undertaking further investigation of consumer experience of home care package approval, assignment and activation to identify requirements to support improvement of consumer engagement in this process; and

6.1.1.3 Putting in place an interim strategy to facilitate active follow-up of consumers issued a package assignment.

6.1.2 LASA re-surveys home care package providers to provide an independent account of HCP activation changes relative to the commencement of ICHC implementation and gauge current provider experiences and challenges for thematic analysis in supporting a co-ordinated response to ICHC implementation.

Incorrect home care package withdrawals — high risk

6.2.1 The DoH promptly reviews and resources the rectification of system auto-letter generation errors and associated processes that:

- triggers incorrect HCP withdrawal letters being issued to consumers, and

- triggers consumer ACER registrations dropping off the Aged Care Payment (ACP) system,

seeking ongoing sector feedback concerning the status of system and process improvements.

Inappropriate home care package regrades — medium risk

6.3.1 The DoH promptly reviews and resources the HCP regrade system and associated processes with support from industry representatives, developing HCP regrade screening protocols for MAC staff with reassessment indicators. It should be noted that there is the need to consider requirements for additional re-assessment resourcing.

Incorrect home care package movements — medium risk

6.4.1 The DoH and DHS promptly reviews and resources the rectification of key system and associated process failures for management and communication of HCP movements across MAC/ACP, seeking ongoing sector feedback concerning the status of system and process improvements.

Inadequate MAC capability to respond to provider and consumer concerns

high risk

6.5.1 The DoH addresses the inconsistency of MAC Contact Centre staff responses to both consumer and HCP provider inquiries for resolution of ICHC implementation issues, seeking ongoing sector feedback concerning the status of process and communication improvements.

Inconsistent subsidy payments relative to home care package activity

high risk

6.6.1 The DoH and DHS promptly reviews and resources the rectification of key system and process failures across MAC and ACP systems for HCP consumer care subsidy claims and payments, seeking ongoing sector feedback concerning the status of system and process improvements.

6.6.2 The DoH and DHS promptly investigates and reinstates unpaid subsidies to HCP providers where issues are raised.

6.6.3 The DoH and DHS compensates HCP providers for administrative/financial loss as relates to additional reconciliation and reporting requirements in managing unpaid ACP subsidies for HCPs.

Insufficient infrastructure to implement annual and life-time caps on consumer care fee contributions

medium risk

7.1.1 The DoH and DHS promptly reviews and resources the rectification of key ACP system and process failures for management, monitoring and communication of accumulative consumer care fee contributions against which to track consumers having reached their annual and life time caps. Feedback should be sought from the sector ongoing concerning the status of system and process improvements.

7.1.2 The DoH and DHS addresses the need to track consumer care fee contributions across home and residential care settings. This is needed to track consumers having reached their annual and life time caps as a function of transferring between care settings. This should also respond to recent reports of HCP providers not charging ITFs to consumers and cover how consumer care fee contributions will be authenticated from HCP providers to DHS.

1. Entry level in-home support assessments, approvals, development of support plans and CHSP service referrals

Consumers who have undergone screening of their circumstances with the MAC Contact Centre and require entry level in-home support will be assessed by a RAS for referral to CHSP services.

The RAS is responsible for:

- Assessment of new consumers, with a holistic, goal-orientated, wellness and reablement focus;
- Matching and referral of assessed consumers to appropriate CHSP services and other appropriate support services;
- Review or reassessment of existing consumers where there may be a significant change in the consumer's circumstances or needs;
- Linking service supports to assist vulnerable consumers with complex care needs to access a range of aged care and other services e.g. health, housing, disability, financial and aged care services; and
- The provision of information regarding consumer co-contributions for CHSP services.

Assessments are conducted using the *National Screening and Assessment Form* (NSAF). The NSAF has been designed to support the collection of information for screening and assessment procedures conducted under MAC.

The NSAF has been designed to ensure RAS in-home support assessment questions are appropriate, minimise the need for consumers to retell their stories; and facilitate the completion of support plans to inform service referrals. The NSAF also includes a set of decision support rules that can assist RAS assessors to make recommendations for the type of support consumers require.

Importantly, the NSAF is not a decision-making tool nor is it designed to recommend service types that consumers should access. This is the role of the RAS assessor who, when developing support plans with consumers, should consider their needs holistically and recommend appropriate supports.

1.1 RAS impartiality in CHSP referrals

From 1 July 2015, thirteen organisations were selected to deliver RAS nationally. Ten of the thirteen organisations (77 per cent) are current providers of CHSP services or HACC in Western Australia.

Industry peaks have provided advice to the DoH about provider concerns over the conflict of interest that exists for RAS who also provide CHSP services. This advice was submitted for inclusion in the formal evaluation of the RAS programme undertaken by the DoH and was completed in June 2017.

Providers across multiple states have reported incidents in which RAS assessors have exclusively promoted their own CHSP services to consumers. This has included a RAS in Western Australia, alleged as doing product introductions during RAS assessments and a RAS in Queensland, alleged as referring consumers to receive services from an affiliated CHSP provider. Whether these allegations are substantiated remains to be seen and requires the DoH analyse RAS referral patterns.

It is noted that the DoH has advised industry peaks that RAS contractors are required to have strict procedures, protocols and other mechanisms in place to assure the separation of assessment from service delivery. There is, however, no mechanism to monitor the adherence of RAS to these

procedures within an emerging open market where financial pressures have become more apparent for home care providers.

Industry peaks have been advised by the DoH to report instances where they believe a breach of procedure has occurred, setting a tone for promoting provider informants to make allegations against their rivals for investigation.

The industry peaks suggest that data on RAS referral patterns to CHSP would provide an appropriate avenue through which the DoH could follow-up and respond to provider concerns.

Recommendations

1.1.1 That current RAS contractual arrangements be reviewed by the DoH in the context of existing RAS to CHSP referral pattern data for the period 1 July 2015 to 30 June 2017. The examination of RAS referral patterns should occur promptly before contract renewal on 1 July 2018, accounting for any changes in referral patterns emerging following implementation of ICHC.

Referral patterns should be examined, separating out referrals by each RAS provider. Where referral patterns indicate a significant increase in referrals from a RAS provider to their affiliated CHSP service, by service type, comparative to RAS referrals to non-affiliated CHSP services for corresponding service types, contractual arrangements should be discontinued by the DoH with contract extension of RAS functions limited to the remaining RAS providers with new RAS contracts considered as required.

1.1.2 That DoH develops and communicates an escalation procedure for home care providers and MAC to support a consistent response to concerns identified about RAS impartiality in CHSP referrals that will strengthen accountability and sector confidence around monitoring home care provider adherence to procedures for separation of RAS and CHSP functions.

1.2 Incomplete support plans by RAS assessors

There is considerable concern among home care providers regarding RAS assessors not being clinically trained. The RAS assessment workforce, having certificate-level competency, is suggested as lacking the sophisticated inquiry and decision-making skills required to pick up clinical issues in a time-pressured, single assessment contact with a consumer. It is further suggested that these types of assessment processes are often best completed by a tertiary level trained workforce.

The NSAF User Guide suggests that the NSAF provides sufficient structure to support RAS assessors to identify and action referrals in response to assessed clinical need, however this assertion is inconsistent with provider feedback.

Providers report that they cannot trust the accuracy of information provided by RAS assessors. They report considerable variability in the quality and completeness of in-home support assessments and support plans. They report that clinical issues are often not picked up or sufficiently detailed by RAS assessors.

One provider reported on a recent support plan completed by a RAS assessor that the consumer and her husband both had significant debilitating conditions requiring more support and case management than could be adequately accommodated through referral to CHSP services. The only contact listed on the consumer support plan sent to the provider was found to not be a contact at all. The provider could not make any phone contact with the consumer and no advice was provided

regarding an alternate method by which to contact the consumer. The provider queried why the consumer was not prioritised for an urgent ACAT assessment in which the assessor would have had sufficient experience to account for the importance of contact information with an assessed need for coordination of services and case management. Importantly, the incompleteness of the RAS support plan has had adverse impacts for the consumer seeking care. Many CHSP providers have reported similar experiences.

Incomplete and poor-quality support plans create additional work for CHSP providers who need to complete their own assessment after a CHSP service referral is made, with the aim of verifying the accuracy of the RAS assessment and updating support plans before commencement of service.

Where gaps are identified by CHSP providers in support plans, they will ring MAC who will ask why additional services are required and why the RAS assessment/support plan is missing clinical information. CHSP providers will then need to substantiate their claim for additional service requirements for inclusion in a consumer's support plan.

The impact for CHSP providers and the consumers they service equates to unfunded CHSP time, with the consumer retelling their story and duplicating assessment processes in set up for receipt of appropriately targeted entry level care.

Importantly, poor quality RAS assessments also translate to misrepresentation of consumer demand for entry level services in MAC and poor data quality for future care at home resource modelling.

Recommendations

1.2.1 The formal evaluation report for the RAS Programme, submitted to DoH in June 2017, be released by the DoH to the National Aged Care Alliance for industry consideration and response to inform program directions as part of the future care at home reforms.

1.2.2 The DoH establishes a cycle of random audits, assessing the completeness and quality of RAS assessments/support plans registered in MAC. This should include engaging with a sample of corresponding CHSP providers relative to audited support plans, identifying areas for workforce training and procedural improvement for implementation.

1.2.3 The DoH commissions the development of supervision and/or support structures for RAS assessors within future RAS contracts, to assist RAS to account for their response to clinical issues identified in entry level assessments, enhancing the responsiveness of support plans for entry level care.

1.2.4 The DoH in partnership with industry representatives, facilitates engagement between RAS assessors and CHSP providers at local levels to exchange critical information that will support continuous improvement for assessment and referral to CHSP services, with feedback to the DoH on issues as required.

2. Home care package assessments and approvals and development of support plans to receive packages at levels 1 through to 4

Nationally, there are over 80 ACATs, also termed Aged Care Assessment Services in Victoria, who deliver assessment services across all regions in each state or territory within Australia. ACATs are teams of medical and allied health professionals who assess the physical, psychological, medical, restorative, cultural and social needs of consumers, with intent to make a needs-based care approval decision for consumer access to in-home support.

Consumers will receive an ACAT assessment when seeking subsidised in-home support and will be considered for a HCP approval if they have complex care needs. ACAT assessors will consider the immediate needs of consumers, and will not recommend services that aren't supported by an assessment. ACAT approvals for in-home support will generally be for a HCP, level one through to four, although other types of support may be considered including residential care and flexible care.

After the assessment, consumers will receive an official approval letter from MAC with information about the outcome of the assessment. The letter will specify the HCP level that has been approved.

2.1 Delays in consumer access to ACAT assessments

Providers have advised that, generally, ACAT assessments for HCPs are of more substantive quality and credibility when compared to RAS in-home support assessments.

Unfortunately, they have also advised that there are considerable delays for consumers to gain access to an ACAT assessment after preliminary screening by the MAC Contact Centre.

It is noted that the DoH reported for the period 1 July 2016 to 31 December 2016 that 80 per cent of comprehensive assessments were completed by ACATs within 34 calendar days of referral from MAC. This occurs on the background of the overall number of ACAT assessments, including reassessments, for all care types decreasing by 13 per cent from 219,955 in 2011-12 to 192,087 in 2015-2016.

During this period RAS was introduced as of 1 July 2015, acknowledging there has been a small re-distribution of assessment referrals away from ACATs to RAS in 2015-16.

At the end of 2016, the DoH reported that ACATs in most states were meeting their target for timely assessment of low and medium priority referrals but only two states, Western Australia and the ACT, were meeting their target for high priority referrals. Such data highlights the current concerns about delays in consumer access to timely assessments for HCP approval.

Recent anecdotal reports by HCP providers in Victoria suggest that wait times for an ACAT assessment can range between 12-16 weeks while in QLD wait times for ACAT assessments are suggested in some regions as ranging between 6-8 weeks and in other regions 24 weeks. Such variations have significant implications for equitable access for placement in the national queue to access a HCP. It also raises concerns about the ability of ACATs to provide an urgent response to vulnerable consumers.

Providers report that ACATs have developed their own assessment wait list management models in response to the demand for new assessments and reassessments with questions as to whether, in the context of extensive ACAT assessment delays, some consumers are being redirected for RAS assessments. A provider recently reported that a RAS assessor attended a consumer in hospital who had been referred by MAC for a priority assessment with care needs equivalent to what might be appropriate for approval of a high-level HCP. The RAS assessor offered the consumer multiple CHSP service referrals.

In considering the above anecdotal provider reports, concerns exist surrounding consumers having timely access to HCP assessments by ACATs with account needing to be given to wait list management strategies being implemented by MAC/ACATs, some that may include considerable risk to consumers and providers taking on the care of these consumers.

Recommendations

2.1.1 The DoH undertakes further investigation of 'referral to ACAT' wait list management models currently being utilised by MAC/ACATs to ensure risks to consumers are minimised until such time that assessment resource modelling can be applied and funded ongoing.

2.1.2 The DoH prioritises the review of ACAT assessment/reassessment wait time data for the period 2016-2017 and undertake assessment workforce resource modelling as part of the future care at home reforms. Assessment workforce modelling should account for those mechanisms in the assessment process that are critical for completion of timely assessments.

2.1.3 Where there are significant delays identified in ACAT assessment/reassessment wait time data for the period 2016-2017 relative to ACAT resourcing and performance indicators, the DoH considers tendering out assessment functions of under-performing ACATs to alternate groups, like Primary Health Networks, to increase program performance and accountability commencing 1 July 2018.

3. Home care package national queue

Once consumers receive a HCP approval, they will be placed in a national queue of HCP approvals managed by MAC. A consumer's position in this queue will be prioritised based on the date of the approval and information gathered from the assessment concerning the urgency with which a HCP needs to be assigned.

There will be a waiting period between the time consumers are approved for care and the time they are assigned a HCP once reaching the top of the national queue.

If a consumer has been assessed as eligible for a particular HCP level, but there are none available, the consumer may be offered a lower level HCP as an interim measure when this becomes available and until the approved HCP level is available.

3.1 Lack of transparency about home care package assignment wait times

Consumers placed on the national queue after receipt of a HCP approval are provided a booklet*: Your guide to home care packages*. Within this booklet, consumers are encouraged to start making enquiries about who they would like to provide their services and the cost of these services.

The intention of encouraging consumers to research HCP providers is to ensure they are well informed in choosing a HCP provider that will best meet their needs and preferences once a HCP is assigned to them from the national queue.

It is important to recognise, however, that the benefit of consumer research about HCP providers, their services and associated costs, is relative to the wait times they experience before being assigned a HCP. This is an important consideration in accounting for the advice issued to consumers, encouraging them to research HCP providers.

HCP providers report that when visiting consumers, the consumer will often report themselves as having to spend considerable time meeting with multiple HCP providers and that they find the process both tiring and exhaustive.

A consumer's understanding of their position in the national queue relative to other consumers will help them better manage their responsibilities for researching HCP providers and their preparation process relative to the anticipated assignment of a HCP, increasing consumer satisfaction and influencing purchase decisions[2].

At the moment, there is no published data indicating the length of time consumers need to wait on the national queue from HCP approval to HCP assignment. Such information should be made available to both HCP providers and consumers, increasing transparency of wait times to inform consumer decision and influence purchase decisions.

Recommendation

3.1.1 The DoH promptly and regularly publishes information on expected HCP wait times via MAC for access by consumers to assist them with preparation and planning as relates to researching HCP providers in the period prior to being assigned a HCP.

[2] Ulku, S., Hydock, C. & Cui, S. 2017. Making the wait worthwhile: Experiments on the effect of queueing on consumption. https://ssrn.com/abstract=3007786

3.2 Unavailability of home care package levels relative to consumer demand

The consumer demand for HCPs based on assessed need appears to be incongruent with the distribution of current HCP availability to consumers on the national queue, noting that in 2015-16 over 60 per cent of HCPs were funded as level two HCPs and only 21 per cent of HCPs were funded as level four HCPs.

The Aged Care Financing Authority, in their recently released Fifth Report, have reported that HCP occupancy levels can provide some indication of consumer access to home care and whether the supply of services is meeting demand. It is noted that from the period 2014-15 to 2015-16 that HCP occupancy increased for levels 1, 3 and 4 but decreased for level 2. This outcome raises the question about the appropriateness of the current allocation of packages across the four levels.

HCP providers have also reported their perception that the existing package prioritisation system is counterproductive in promoting wellness, independence and reablement. As part of the system, consumers are assigned a HCP level from the national queue based on the availability of a HCP level irrespective of the consumers actual inherent care needs. The allocation of interim HCPs is indicative of this system dynamic and a measure of the number of interim HCPs allocated would confirm this.

Individuals may therefore be provided with services below what they require. Failing to operate a system that can fundamentally deliver care based on individual need can lead to speedier decline in condition, reduced client wellness and independence and ultimately may bring forward potential admission to residential care.

Recommendations

3.2.1 The DoH commences a review of the current allocation of HCPs across all four levels, accounting for the number of interim HCPs that have been allocated and facilitating a phased approach for the redistribution and topping up of HCP funds consistent with consumer demand for HCPs. Re-distribution of existing aged care funding should account for funds across CHSP and HCP programs currently being utilised by consumers with a HCP approval.

3.2.2 The DoH explores the feasibility for establishing protocols for escalation of immediate increases in care and services for vulnerable consumers.

3.2.3 That DoH explore the feasibility of implementing maximum wait times on the national queue.

4. Interim CHSP Support

CHSP was implemented on 1 July 2015. At the time there were over 1,160 CHSP providers and 526 Victorian and Western Australian HACC providers who delivered basic support services to help older Australians to remain living independently in their own homes.

In 2015-16, CHSP services were allocated 61.5 per cent of all government funded spending for in-home support compared with HCPs, allocated 38.5 per cent.

With consumer demand for HCPs exceeding the current availability of HCPs, the aim of interim CHSP support is to reduce consumer wait times between receiving a HCP approval from an ACAT assessor and being assigned a HCP from the national queue. Leveraging off interim CHSP support has sought to provide a wait list management strategy for the national queue until such time that funds re-distribution occurs.

Anecdotal CHSP provider reports have indicated that HCP approved consumers that are redirected to receive interim CHSP support will typically be referred to CHSP providers with between three to five referral codes, indicating a complexity of need that is above what is intended to be serviced through CHSP.

CHSP providers have reported that interim CHSP support offers a level of service to consumers consistent with the support plan developed by ACATs. This could be as high as what is provided through a level four HCP.

4.1 Excessive CHSP activity levels

Some CHSP providers have reported that they have experienced a sharp increase in consumers who have multiple referral codes for CHSP services.

They report that CHSP service provision has been at capacity for a few months with the increase in interim CHSP support referrals occurring during the last few weeks.

Two such consumer referrals forwarded to a CHSP provider in early August have included:

Consumer A (referral for 6 CHSP service types)

- Transport (Direct (Driver is volunteer or worker))
- Allied Health and Therapy Services (Social Work)
- Allied Health and Therapy Services (Occupational Therapy)
- Domestic Assistance (General House Cleaning, Linen Services)
- Home modifications
- Social Support Individual (Visiting, Accompanied Activities e.g. Shopping)
- Refer the consumer to a GP for a mental health assessment (K10 Outcome)
- Consumer under a mental health plan and has a psychologist visit her at home

Consumer B (referral for 7 CHSP service types)

- Home modifications
- Allied Health and Therapy Services (Occupational Therapy)
- Social Support (Accompanied Activities e.g. Shopping)
- Home Maintenance (Minor Home Maintenance and Repairs, Major Home Maintenance and Repairs)
- Other Food Services (Food Preparation at Home)
- Transport (Direct (Driver is volunteer or worker))
- Domestic Assistance (Unaccompanied Shopping (delivered to home), General House Cleaning, Linen Services)

CHSP providers report that while they see the provision of interim CHSP support as an opportunity to take on extra service activity, this approach to managing consumer demand for HCPs and leveraging off CHSP is not sustainable.

Activity levels in CHSP are now exceeding grant agreements and what is intended in respect to staffing and program outputs. Consequently, CHSP providers will not have sufficient funds to respond to CHSP service demand in the second half of the financial year. This will create additional risks for the implementation of the CHSP for which the impacts are yet to be realised.

Additionally, HCP providers have reported that they have received advice through regional ACAT meetings that new consumers being ACAT assessed are no longer being approved for HCPs as there are not enough HCPs available to meet current demand. As such, CHSP providers are expected to absorb the demand for servicing consumers with high level care needs. CHSP providers have indicated that the demands being placed on them are outside the terms of their grant agreements.

In conjunction with this, it has been suggested that the current interim CHSP support arrangements favour providers of large scaled CHSP operations who are often accepting all consumer referrals, selecting those consumer referrals most suitable for service provision, and then pushing back other consumers to MAC if they are unable to supply the service.

Such an approach to referral management is clearly not in the interest of consumers but rather responsive to the financial and workforce rostering pressures these home care providers are experiencing, now perpetuated by low HCP activation rates relative to HCP assignment rates (see 6.1 Low rates of home care package activations).

Recommendations

4.1.1 The DoH promptly develops a wait list interim support triage tool with support from industry representatives. The triage tool should account for consumer referrals to interim CHSP support that cannot be better accounted for by promoting consumer engagement in fee for service arrangements. The triage tool should also account for triage of both consumers seeking a new HCP and those seeking a HCP regrade.

4.1.2 The DOH promptly develops a wait list interim support decision making protocol with the support of industry representatives. This protocol should provide direction for stakeholder communications, capping of interim supports relative to assessed need and processes for care plan transfer on HCP assignment.

4.1.3 The DoH, in partnership with CHSP providers, reviews and responds to the impacts of current interim CHSP support arrangements on overall CHSP activity and funding outputs, as well as risks to providers and consumers.

4.2 Perverse incentives for home care package activation

There is no mandated fee for consumers receiving interim CHSP support, making these arrangements very ‘comfortable’ for consumers and CHSP providers when compared to consumers receiving a HCP in a competitive open market environment where fees apply.

When consumers receiving interim CHSP support are assigned a HCP there is no incentive for the consumer to activate their HCP. The consumer is already receiving CHSP services at a level equivalent to what is accessible through the assigned HCP, having an established care routine in place with no mandated consumer fee.

A HCP provider has reported that they have a consumer who refuses to pay any fees and has rejected their HCP assignment, choosing to receive CHSP services as they can access a greater level of financial support via means such as an oxygen supplement, a continence aids payment, transport assistance, Centrelink assistance, and multiple other government funded health services.

Another provider has reported an incident in which MAC Contact Centre staff have advised a consumer to continue accessing CHSP services as it is more affordable than accessing a HCP.

Combined, home care provider feedback is indicative of a highly vulnerable market environment where consumer, MAC staff and assessor behaviours signal a high risk of stakeholder disengagement from the HCP program and market failure which further exacerbates the significant financial pressures being placed on HCP providers who are dealing with decreasing HCP activity levels.

It should also be noted that there is a group of "grandfathered consumers" from prior HACC programs that have not yet been followed up for registration in MAC.

Recommendations

4.2.1 The DoH caps consumer access to interim CHSP support in terms of service activity levels and duration, incentivising consumer activation of their assigned HCP. This includes expiration of CHSP interim support at the HCP assignment end date or the HCP package activation date with account for communication and implementation of a care transfer plan to respond to identified risks for consumer transfer from CHSP to HCP.

4.2.2 That DoH identify "grandfathered consumers" from prior HACC programs and explore the feasibility to register these consumers in MAC with reassessment of need relative to entry level and complex care provisions through reformed ICHC program structures.

4.2.3 The DoH, subject to advice received through the independent Legislative Review, promptly introduces a single fee policy that will align consumer co-contribution arrangements across CHSP and HCPs into the future.

5. Home care package assignment

When consumers with a HCP approval reach the top of the national queue they are sent an official HCP assignment letter. The consumer is advised to activate the HCP by an assignment end date and they may contact MAC to request a 28-day extension to this HCP assignment end date.

At 35-days after HCP assignment, an official HCP reminder letter is sent to consumers who have not yet activated their HCP, reminding them to activate their HCP before the assignment end date.

If consumers have not activated their HCP once the assignment end date has been reached, the HCP is returned to the national queue for re-assignment to another consumer. These consumers are then sent an official HCP withdrawal letter, advising them that the HCP has been withdrawn and that they will need to contact MAC to be returned to the national queue if they would still like to access a HCP.

A further wait period will then be required of the consumer before being reassigned a HCP from the national queue.

5.1 Insufficient infrastructure for consumer activation of assigned home care packages

HCP providers report that when consumers receive their official HCP assignment letter they struggle to understand it. Providers also report that in their engagement with consumers, they often express feeling overwhelmed with the process for activation of a HCP and have often delayed their engagement with the HCP provider in this respect. This creates a vulnerability for HCP withdrawal due to this delay (see 6.2 Incorrect home care package withdrawals).

These anecdotal reports are consistent with the findings of research conducted by the DoH, in which 48 per cent of consumers who had not activated their assigned HCP were reported as needing more than 56-days to activate the HCP and had consequently requested a 28-day extension. Of the remaining consumers, 45 per cent reported they did not understand what they needed to do next to activate the HCP, highlighting a range of reasons for not activating their package. This included:

- They had not received the government letter (20 per cent);
- They didn't understand the letter (20 per cent); or
- They hadn't read it (5 per cent).

To help understand these findings further, HCP providers have advised that some consumers do not have a letterbox address that can be entered into MAC and, in rural communities, may experience delays in their receipt of letters from the Post Office. Other HCP providers have reported that it is often the representative of consumers that are better positioned to receive and action HCP assignment letters, they're not getting any official letter or experiencing delays in being advised by consumers receiving official letters.

One HCP provider has also reported that on two separate occasions, consumers who could not speak or read English had received their HCP assignment letter written in English. Both consumers would have previously undertaken a MAC/ACAT assessment, at which time their language preferences should have been established and noted. Except for the good fortune of local community networks directing these consumers to the HCP provider, it is unlikely that these consumers would have activated their HCP by the assignment end date.

Providers and consumer peaks have also reported that the level of computer literacy among some consumers may be a contributing factor that delays their timely research of HCP providers using the MAC Service Finder. Consequently, this then delays their engagement with HCP providers to activate a HCP within the 56-day assignment-activation period.

In this respect, the absence of HCP provider information in MAC Service Finder listings has been reported by ACATs and the DoH as being an issue inhibiting consumer ability to make decisions in choosing a HCP provider. ACATs and DoH have encouraged HCP providers to complete their MAC Service Finder listings.

HCP providers, however, report that there are varied pricing models across old and new HCP providers listed in the MAC Service Finder. These varied pricing models have emerged from changed legislation commencing 1 July 2015 and don't support consumer comparison of HCP providers by fees charged for package administration/case management. On this basis, industry peaks have advised the DoH that further consideration be given to addressing the variability of pricing models prior to promoting HCP providers to complete their MAC Service Finder listings to support consumer decision making in researching HCP providers. No action has been taken on this matter yet.

In conjunction with this, there are multiple repeat entries of HCP provider listings in the MAC Service Finder that complicate a consumer's research experience in seeking out HCP providers. For example, in a search for level four HCP providers at a random postcode - 6063, 88 provider entries were generated of which 13 entries were repeat entries for a single provider. Other providers also had repeat entries. It is noted that there are some HCP providers with multiple listings in the MAC Service Finder because of historical configuration requirements. Additionally, there are new providers with a single listing in the MAC Service Finder, configured subsequent to September 2016, who may choose to create multiple listings to raise their profile in the MAC Service Finder relative to competitors. Additionally, there are some HCP providers who may have realised they can 'game the system', increasing their MAC Service Finder presence by generating multiple listings with repeat generic information to drive consumer traffic from the MAC Service Finder to their intake contact centres.

In accounting for the above issues, it is acknowledged that there are multiple factors contributing to consumer delays in activating assigned HCPs. Improved provisions and infrastructure are required to not only support consumers in researching HCP providers, but also to facilitate active follow-up to ensure consumers promptly activate their HCP in the 56-day assignment-activation period.

In seeking to improve the infrastructure within MAC to support consumer activation of assigned HCPs, the DoH has recently advised of a proposal for MAC Contact Centre staff to initiate routine outbound calls to consumers who have not responded to their HCP reminder letter that is sent out at day 35 after HCP assignment from the national queue.

Industry peaks caution the implementation of this approach to actively follow-up consumers without considering other factors that may be contributing to consumers not taking up HCPs on assignment. The proposed approach does not account for consumers on the national queue with a change of circumstance since ACAT assessment, this being particularly relevant in the context of lengthy wait times between HCP approval and HCP assignment. For example, consumers who have deceased or entered residential care prior to HCP assignment. Waiting 35 days after HCP assignment to identify a consumer's change of circumstance indicative of HCP withdrawal is unsatisfactory.

Prior to ICHC implementation, HCP providers had designated assessment staff who would actively follow-up consumers on their wait lists in the period prior to HCP assignment to identify and support consumer readiness for HCP activation. Such an approach to active follow-up of consumers accounted for the reality of managing an extensive wait list in which many consumers had a change of circumstance since joining the wait list. Consumers may have relocated, engaged in an alternate care arrangement or deceased, making them no longer suitable for HCP activation.

Anecdotal reports from HCP providers offering HCPs prior to ICHC implementation suggest that many consumers on their high-level HCP wait lists did not proceed to activate a HCP due to limited availability of these HCPs, lengthy wait times and the likelihood of change of circumstance while on the wait list. Such factors are just as relevant now in considering the assignment-activation process for HCPs from the national queue.

Given the lengthy period for consumers awaiting HCP assignment while on the national queue and the promotion of their early engagement in researching HCP providers, there is opportunity to improve current MAC infrastructure that can leverage off consumers researching HCP providers after ACAT assessment and HCP approval. Consumers could be encouraged to register a preferred HCP provider with MAC for notification of pending HCP assignment. Such an approach would facilitate registered HCP providers actively following-up consumers with pending HCP assignment. This approach would address the vulnerability of consumers not activating a HCP early in the 56-day assignment-activation period, reduce the number of inactive HCP days after package assignment, and allow for HCP provider early identification of those consumers with change of circumstance to prompt early HCP withdrawal. Such infrastructure enhancements would not compromise consumer choice, but rather support consumers to exercise the same choice, only earlier.

Recommendations

5.1.1 The DoH promptly considers the feasibility of adding functionality to MAC that will provide consumers the opportunity to register a preferred HCP provider prior to HCP assignment, with consent for MAC to notify registered HCP providers of pending HCP assignments to improve infrastructure for supporting timely consumer HCP activation.

5.1.2 The DoH builds confirmation of mailing addresses into HCP assessment processes and enhances MAC configuration as required, to support timely response to auto-generated HCP letters from consumers or appointed representatives.

5.1.3 The DoH addresses the inequity in the MAC Service Finder, accounting for multiple repeat HCP provider listings with generic content, hindering consumer experience and usage of the MAC Service Finder.

5.1.4 The DoH acknowledges the varied pricing models amongst HCP providers that have emerged pre and post 1 July 2015 that do not support consumers in their comparison of service offerings by price, engaging with the sector to address this issue prior to directing HCP providers to populate this information into the MAC Service Finder.

5.2 Consumer correspondence errors

HCP providers report that official letters received by consumers from MAC concerning HCPs have sometimes had errors in them, requiring follow-up with the MAC Contact Centre for clarification. HCP providers have also reported experiencing difficulties in getting a timely response to issues raised with MAC about these errors, with adverse impacts for both consumers and HCP providers.

For one consumer who was assigned a HCP, an official HCP reminder letter sent on the 28 April 2017 had an error indicating the assignment date was 28 April 2017 (the same date the reminder letter was sent). This error indicated HCP assignment was 38 days later than what was registered in MAC. In follow-up with MAC at 63 days after HCP assignment, the HCP provider received misinformed advice from MAC to activate the HCP and commence services.

MAC then contacted the provider at 105 days after HCP assignment indicating the HCP had been withdrawn and that the consumer needed to contact MAC to return to the national queue as they had not activated their HCP by the assignment end date. After the HCP provider requested that MAC review their decision, further advice was provided by MAC at 133 days after HCP assignment for the consumer to ring MAC and be placed in the national queue.

This consumer has since disengaged with MAC and the HCP provider, seeking restoration of her prior HACC services in Western Australia. The HCP provider has been left without reimbursement of time and expenses in providing support to the consumer.

At 149 days after HCP assignment, near 5 months after the original HCP assignment, the consumer and HCP provider have both been informed by MAC that a new HCP has been assigned to the consumer. Whether the consumer engages to take on the HCP remains to be seen.

Recommendations

5.2.1 The DoH promptly reviews and resources the rectification of system auto-letter generation errors and associated processes for HCP assignment and reminder letters that are issued to consumers, seeking ongoing sector feedback concerning the status of system and process improvements.

5.2.2 The DoH releases advice to the sector that supports HCP provider engagement with consumers around responding to error identification issues for auto-generated HCP letters distributed to consumers.

5.2.3 The DoH develops standardised practices for timely and supportive responses to rectification of HCP activation issues where errors are identified in official HCP letters. Such an approach should seek to minimise and/or alleviate adverse impacts to both consumers and HCP providers. KPIs should be introduced for MAC Contact Centre staff to enhance consumer and HCP provider experience, reducing the risk of program disengagement.

5.3 Presumptive provider home care package activations

While consumers are researching HCP providers, they will provide their referral code to each HCP provider they engage with when it is available. The HCP provider will then use this code to retrieve consumer assessment information and engage the consumer in providing an offer of support for their consideration.

Some providers have reported they have been locked out of the consumer's MAC record when trying to access a consumer's assessment information via the Mac Provider Portal. This has been due to another HCP provider, who has already discussed their service offering with the consumer, presumptively accepting/activating the consumer's assigned HCP without a Home Care Agreement. The impacts for consumers, HCP providers and MAC include process dissatisfaction, wasted time and additional administrative demands.

Presumptive provider HCP activations are an anti-competitive behaviour that limits consumer choice in a financially pressured HCP environment. These HCP activations may be deliberate attempt by one HCP provider to thwart the efforts of consumers for securing their HCP activation through an alternate HCP provider. The intent of offending HCP providers may be to leverage off the difficulty that a consumer will experience in unlocking their HCP activation through engaging with MAC, they're then surrendering to proceed with the HCP activation with the offending HCP provider for the sake of simplicity and prompt access to service commencement.

Presumptive provider HCP activations appear contrary to ICHC policy objectives, are harmful to industry reputation, and should be treated as such by the DoH.

Recommendation

5.3.1 The DoH establishes and communicates mechanisms to both consumers and providers for response to suspected presumptive provider HCP activations with severe penalties for HCP providers where such behaviours are confirmed as having occurred.

6. Home care package activations and subsidy payments

After a consumer has been assigned a HCP and they have selected their preferred HCP provider that best meets their needs, they will work with the HCP provider in developing a care plan and HCP budget. This will then form the basis of the consumers Home Care Agreement with the HCP provider, which sets out how services will be provided, who will provide them, and how much they will cost.

The HCP provider will accept the HCP referral in MAC after the consumer signs the Agreement, this being completed before the HCP assignment end date. The HCP provider will also submit an Aged Care Entry Record (ACER) to the Department of Human Services (DHS) for registration and entry of consumer details in the Aged Care Payment (ACP) system to commence payment of government subsidies to the HCP provider for administration of the consumer's HCP budget and communication between DHS to MAC.

6.1 Low rates of home care package activations

HCP providers have reported a significant down turn in active HCPs since 27 February 2017. Concerns surround HCP provider reductions in active HCPs was communicated to the DoH in LASA's *Home Care Provider Survey Report* released in June 2017. In this report, it was also emphasised that any continued sector-wide reduction in HCP activity would be detrimental to HCP provider resource management and business viability.

Communication from DoH to LASA on 4 August 2017 advised that HCPs were being released to consumers on the national queue on a regular basis, usually weekly. Every HCP release includes level three and four HCPs to enable access to higher level care for those consumers next in line on the national queue. The number of HCPs at each level has continued to be determined by the Aged Care Provision Ratio.

In this context, providers in Western Australia have more recently reported continuing reductions in HCP activations ranging between 15 and 34 per cent relative to their HCP activity when ICHC commenced. Similar issues of continuing low HCP activations have been reported in other states, particularly for higher level HCPs. One large scale provider has reported consumers on level two HCPs have entered residential care due to the unavailability of access to higher level HCPs.

HCP providers have further reported that with the continuing reduction in HCP activations they have experienced increasing staff turnover, being unable to provide staff sufficient work hours previously afforded to them. In the context of an ageing home care workforce, the loss of direct care staff to other industries because of low rates of HCP activations relative to HCP releases runs counter to the principles of retaining a skilled aged care workforce for response to future aged care demand.

Interestingly, HCP providers have reported receiving advice through regional ACAT meetings that consumers are no longer being approved for HCPs as there are not enough HCPs available to meet current demand. Greater transparency is required. It is noted that DoH has twice delayed their release of MAC performance data for the period 27 February to 30 June 2017 and have only recently commenced a survey of home care package providers to further inform them of what is working and what they need to amend.

Recommendations

6.1.1 The DoH implements the recommendations of LASA's Home Care Provider Survey Report as a priority. This includes:

6.1.1.1 Increasing the visibility of MAC performance data to better understand consumer behaviour in respect to package activations relative to package assignments;

6.1.1.2 Undertaking further investigation of consumer experience of home care package approval, assignment and activation to identify requirements to support improvement of consumer engagement in this process; and

6.1.1.3 Putting in place an interim strategy to facilitate active follow-up of consumers issued a package assignment.

6.1.2 LASA re-surveys home care package providers to provide an independent account of HCP activation changes relative to the commencement of ICHC implementation and gauge current provider experiences and challenges for thematic analysis in supporting a co-ordinated response to ICHC implementation.

6.2 Incorrect home care package withdrawals

The issue of incorrect HCP withdrawals has been an ongoing issue for consumers, HCP providers and the DoH since ICHC implementation.

A HCP provider supporting a consumer who has terminal cancer reported that the consumer received an incorrect HCP withdrawal letter causing considerable distress to the consumer and aggravation to the provider. Other providers continue to consistently report the same experience.

Consumers for which a HCP has been activated in MAC and for whom services have commenced were later advised via a HCP withdrawal letter sent to the consumer that the HCP assignment had been withdrawn and that the consumer would need to contact MAC to be returned to the national queue. These incorrect HCP withdrawals appear to occur irrespective of the time of HCP activation in the 56-day period between HCP assignment and the end of assignment date.

A provider who called DoH on 23 August 2017 was advised that the causal factor contributing to incorrect HCP withdrawals was that ACERs were not being registered promptly by MAC/DHS in their MAC/ACP systems. The provider was also advised that if the ACER is not entered by MAC/DHS by the end of assignment date the HCP is automatically ceased by MAC, triggering the HCP withdrawal letter being sent to consumers.

With the inability for MAC and DHS staff to meet the demands for ACER data entry, the current approach for resolution of HCP withdrawals appears to be correction of errors after the fact. The consequences of HCP withdrawal letters being sent to consumers includes the undue distress caused to consumers, additional unfunded administrative demand for both HCP providers and MAC/DHS in rectifying the issue, and unpaid subsidies in the context of service commencement born at the expense of the HCP provider.

It is noted that a DoH broadcast was issued on the 26 May 2017 concerning home care package withdrawals. Advice from the DoH to providers at that time was to:

1. Accept a referral in MAC and then
2. Submit entry information to DHS (either as a paper based ACER or through ACP online claiming).

Where a consumer package has been withdrawn in error, the HCP provider is to contact the DoH who will investigate this as a priority and attempt to resolve these errors within two weeks of being escalated.

LASAs advice to its members on 31 July 2017, 2 months later, in response to continued issues with incorrect HCP withdrawals, was to.

1. Submit ACERs promptly after a consumer enters into a home care agreement within the 56-day assignment-activation period
2. Contact the MAC Contact Centre to request the consumer's 56-day assignment period be extended by 28 days to allow additional time for the ACER to be processed by DHS and registered in MAC.

Recommendation

6.2.1 The DoH promptly reviews and resources the rectification of system auto-letter generation errors and associated processes that:

- triggers incorrect HCP withdrawal letters being issued to consumers, and

- triggers consumer ACER registrations dropping off the ACP system,

seeking ongoing sector feedback concerning the status of system and process improvements.

6.3 Inappropriate home care package regrades

There are concerns in respect to the way consumers are managed in receiving a HCP regrade when they already have an active interim low level HCP and are receiving additional CHSP services to 'top up' their package. There is the assumption that a HCP regrade will be sufficiently responsive to the support needs of these consumers independent of the CHSP services that have been put in place. This is often not the case, with adverse impacts for the HCP provider and consumer when these 'top-up' CHSP services are suddenly removed without prior notice and without contingency planning upon an automatic HCP regrade being issued through MAC.

A HCP provider reported that they are administering a HCP for a consumer who was also receiving additional 'top up' CHSP services provided by other providers. This arrangement was working well for the consumer. On the consumers regrade to a high level HCP, CHSP providers were notified by MAC and they withdrew their services without consultation with the consumer. The consumer and HCP provider were faced with a reduction of services, with the HCP provider having to explain this to the consumer in the context of their inability to instantly access additional supports from other services, creating strain in the consumer-provider relationship.

In addition to this, another HCP provider reported that a consumer on an interim lower level HCP received a HCP regrade to a higher-level HCP even though they had a near $5000 budget surplus prior to the HCP regrade.

Activation of HCP regrades, triggered automatically by MAC, need to account for those circumstances immediately preceding the intended regrade. This may include accounting for CHSP services already in place, unspent HCP funds and other key factors identified by the sector as important in facilitating a care transfer plan on regrade between HCP levels.

Recommendation

6.3.1 The DoH promptly reviews and resources the HCP regrade system and associated processes with support from industry representatives, developing HCP regrade screening protocols for MAC staff with reassessment indicators. It should be noted that there is the need to consider requirements for additional re-assessment resourcing.

6.4 Incorrect home care package movements

There are concerns that HCP movements across MAC/ACP systems are not being registered and/or are being missed in the context of internal MAC/DHS HCP movement data management processes.

One provider has reported they received a notification from MAC on 21 August 2017 for a consumer's HCP regrade commencing 22 August 2017. This consumer had previously ceased utilising the HCP, entering residential care on 8 June 2017. Further investigation of these types of HCP movement errors is required.

The provider indicated that this type of incorrect HCP movement was not the first time this had happened, suggesting it to be a regular issue. This indicates there are key system and associated process failures in the management of HCP movements across MAC/ACP.

Recommendation

6.4.1 The DoH and DHS promptly reviews and resources the rectification of key system and associated process failures for management and communication of HCP movements across MAC/ACP, seeking ongoing sector feedback concerning the status of system and process improvements.

6.5 Inadequate MAC capability to respond to provider and consumer concerns

Home care providers have reported their concern with the capability of MAC Contact Centre staff to respond to the varied issues home care providers and consumers have sought support and advice on, referenced throughout this issues paper.

One HCP provider reported that when an issue arises with MAC, they will often take a screenshot of the MAC Provider Portal and email it to MAC to communicate the issue to avoid misunderstanding.

Other HCP Providers report hanging up on MAC Contact Centre staff and ringing again, indicating they have come to realise that the helpfulness of MAC Contact Centre staff for issue resolution depends on who you speak to when you call.

Providers also report receiving inconsistent advice from MAC Contact Centre staff across multiple contacts.

Recommendation

6.5.1 The DoH addresses the inconsistency of MAC Contact Centre staff responses to both consumer and HCP provider inquiries for resolution of ICHC implementation issues, seeking ongoing sector feedback concerning the status of process and communication improvements.

6.6 Inconsistent subsidy payments relative to home care package activity

HCP providers continue to report that once a consumer's HCP has been activated and ACERs have been submitted to DHS for processing, unpaid subsidies have started accumulating. DHS have not paid subsidies equivalent to corresponding HCP activity, resulting in additional unfunded administrative burden for both HCP providers and DHS in working to resolve these issues for continued HCP subsidy payments.

One HCP provider with unpaid subsidies has been advised by DHS that non-payment of subsidies was due to HCP activity not being communicated by MAC to DHS for ACER registration in the ACP

system, directing the HCP provider to contact MAC for issue resolution. Consequently, this HCP provider has not been successful in obtaining any resolution with HCP subsidy claims since early August 2017. Unpaid subsidies have increased from near $78K to $125K for this one HCP provider.

The reconciliation process and dealing with the MAC issues has been reported by HCP providers as being very time consuming and frustrating. One HCP provider has reported administrative costs as equating to a 0.75 FTE staff member or the equivalent of $100k per annum. For this HCP provider, unpaid subsidy issues have been noted for 45 HCP consumers with the consumers reported as being considerably upset and anxious.

Another HCP provider has reported that some of their consumers are ringing DHS themselves in desperation to have subsidies paid for their HCP.

Unpaid subsidies have been grouped by one HCP provider into the following categories:

7. Subsidies partially adjusted with unpaid amounts still outstanding (5 consumers),
8. Subsidy payments have stopped part way through a month (4 consumers with no leave movements),
9. Adjustments to subsidy payments for HCPs which commenced prior to 27 February 2017 (6 consumers),
10. MAC assigned HCPs for which no subsidies have been paid or have been paid at the incorrect HCP subsidy level (13 consumers),
11. Subsidy payments not consistent with commencement and leave dates submitted in ACP claims/ACERs (4 consumers), and
12. Subsidy calculation errors (3 consumers).

It is evident that there are systematic MAC/ACP system and process failures for HCPs that are resulting in the accumulation of unpaid subsides and that are exacerbated by the issues referenced throughout this paper.

Recommendations

6.6.1 The DoH and DHS promptly reviews and resources the rectification of key system and processes failures across MAC and ACP systems for HCP consumer care subsidy claims and payments, seeking ongoing sector feedback concerning the status of system and process improvements.

6.6.2 The DoH and DHS promptly investigates and reinstates unpaid subsidies to HCP providers where issues are raised.

6.6.3 The DoH and DHS compensates HCP providers for administrative/financial loss as relates to additional reconciliation and reporting requirements in managing unpaid ACP subsidies for HCPs.

7. Other Issues

7.1 Insufficient infrastructure to implement annual and life time caps on consumer care fee contributions

There remains considerable inertia by the DHS and DoH to notify providers when consumers have reached their annual and life time caps for payment of means tested fees for contribution to care.

Residential care providers report that DHS are not monitoring the accumulation of consumer care fee contributions for response when consumers reach their annual and life time caps. It has been reported that they have no system in place to stop deducting the means tested care fee from residential care provider subsidies when it gets to the cap for any resident. The result effect is that ACP statements continue to reflect consumers paying their means tested care fees for residential care once they have reached their annual and/or life time cap.

Residential care providers have taken it upon themselves not to charge consumers means tested care fees once annual/life time caps have been reached. Instead they have chosen to manage their own data in accounting for consumer care fee contributions that accumulate to reach annual/life time caps. Residential care providers are then spending considerable time and difficulty in an unfunded capacity, trying to get a timely response from DHS for adjustment of subsidy payments to account for annual/life time caps to consumer care fee contributions being implemented.

This has resulted in a loss of revenue for residential care providers against those consumers for who subsidies should be paid but are not paid, with the amount of unpaid subsides accumulating quickly.

In conjunction with this, DHS have advised a HCP provider that they are not able to locate an area in the ACP system for HCP consumers where life time cap details are displayed and accounted for in tracking the accumulation of consumer care fee contributions.

Tracking consumer care fee contributions across home and residential care to identify when annual and life time caps apply will become increasingly important and this should be addressed now as part of a broader approach to system development for monitoring and managing annual and life time caps on consumer care fee contributions.

It is also noted that a recent report was released indicating that not all HCP providers are charging ITFs to consumers receiving a HCP and this will need to be accounted for in tracking consumer care fee contributions as relate to identifying when annual and life time caps have been reached. There is also the question of who will be responsible for authenticating consumer care fee contribution information submitted to DHS as part of data transfer from approved care providers to government.

Recommendations

7.1.1 The DoH and DHS promptly reviews and resources the rectification of key ACP system and processes failures for management, monitoring and communication of accumulative consumer care fee contributions against which to track consumers having reached their annual and life time caps. Feedback should be sought from the sector ongoing concerning the status of system and process improvements.

7.1.2 The DoH and DHS addresses the need to track consumer care fee contributions across home and residential care settings. This is needed to track consumers having reached their annual and life time caps as a function of transferring between care settings. This should also respond to recent reports of HCP providers not charging ITFs to consumers and cover how consumer care fee contributions will be authenticated from HCP providers to DHS.

Appendix 1 – Likelihood Rating: Evaluation Criteria

LASA has applied the following evaluation criteria to determine how likely it is that providers and/or consumers will be exposed to issue-based risks after taking account of existing controls that have been developed in response to implementation of ICHC, considering factors such as:

1) Anticipated frequency of occurrence;
2) The external environment (e.g. regulatory, economic, competition, community expectations and market issues);
3) The procedures, tools and skills currently in place; and
4) History of previous events.

Likelihood rating

The number of times within a specified period in which a risk may occur either because of operational process or through failure of operating systems.

Rating	Description	Occurrence	Probability
Almost Certain	Expected to occur in most circumstances	Constantly / 3 months	> 80%
Likely	Will probably occur in most circumstances	Multiple / 3 months	61 – 80%
Possible	Might occur within the last 6 months	Occasional / 6 months	41 – 60%
Unlikely	Could occur during the last 6 months	Once / 3 months	21 – 40%
Rare	May only occur in exceptional circumstances	Once / 6 months	< 20%

Appendix 2 – Consequence Rating: Evaluation Criteria

Issue-based risks are assessed in terms of the consequence of their impact on providers and/or consumers in the implementation of the ICHC reforms. Indirect financial consequences such as reputation and management effort are key considerations. Direct financial impacts are also considered. The following table is used to guide the assessment of impact of each identified risk.

Factor of Consequences / categories of risk	Consequence Category				
	Insignificant	Minor	Moderate	Major	Catastrophic
Quality Care	Resolution of care crisis with additional attention, service and care management.	Resolution of care crisis with increasing level of attention, service and care management over short period.	Resolution of care crises with increasing level of attention, service and care management over extended period.	Severe care crisis due to care failure (significant impairment/incapacity without intervention for duration of 3 months).	Consumer death, significant disability or multiple unresolved care crises due to care failure.
Damage to industry reputation	Minimal adverse publicity in local press. Letters received and printed but no further action taken.	Adverse publicity in local/state press. Letters to the Editors, with follow up comments from the readership or interested parties.	Extended negative local/state, plus national media coverage. Requirement to manage key stakeholders.	Longer-term national coverage. Need to increase focus on management of a broader group of stakeholders.	Extended negative national and international wide coverage. Requirement to implement communication for all stakeholders.
Disruption to established routines and operations	No interruption to service. Inconvenience to localised operations.	Some disruption within broader provider operations, manageable by altered operational routine. Minor reduction in operational efficiency.	Disruption to multiple provider operations. Managed by altered operational routines with broader sector inefficiencies.	Several key operational areas disrupted. Continued frustration of key business activities ongoing.	Disruption to services causing sector disengagement or key business failure.
Industry wide financials	Less than $1M.	$1K to $5M.	$5M to $20M.	$20M to $50M.	Greater than $50M.
Consumer/Provider Satisfaction	Minor inconvenience. No lasting dissatisfaction for consumer and/or provider.	Short-term dissatisfaction with resolvable strain in consumer provider relationship and with other stakeholders.	Ongoing low levels of dissatisfaction with continued strain in consumer provider relationship and with other stakeholders.	Ongoing moderate levels of dissatisfaction with gradual relationship damage in consumer provider relationship and with other stakeholders.	Extensive dissatisfaction with relationship breakdown among consumers, providers and other key stakeholders.
Management Time and Effort	Event absorbed by normal activity.	Management effort required to minimise the impact.	A significant event managed through attentive practices.	A critical event, which with proper management can be endured.	Executive Management focus away from day to day key functions for extended periods.