LEADING AGE SERVICES
AUSTRALIA

The voice of aged care

ALTERNATIVE AGED CARE ASSESSMENT, CLASSIFICATION SYSTEM AND FUNDING MODELS

Member Briefing Paper

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Leading Age Services Australia (LASA)

Leading Age Services Australia (LASA) is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. Our vision is to enable a high performing, respected and sustainable age services industry delivering affordable, accessible, quality care and services for older Australians. We represent our Members by advocating their views on issues of importance and we support our Members by providing information, services, training and events that enhance performance and sustainability.

LASA would be pleased if you provided comment to this Member Briefing Paper on the *Alternative Aged Care Assessment, Classification System and Funding Models Final Report*. This Report can be found on the Department of Health's website. To learn more about the proposed changes to assessment and funding you can also access a webinar by the Department of Health via following link: http://livestream.education.gov.au/health/17may2017/ LASA is keen to learn your feedback to inform our advocacy regarding this funding reform to the Department of Health. You can provide your view on the proposed new funding models to Marlene Eggert, Senior Policy Officer on marlenee@lasa.asn.au

Introduction

Leading Age Services Australia (LASA) is pleased to provide a Member Briefing Paper on the *Alternative Aged Care Assessment, Classification System and Funding Models Final Report*. This Report heralds the Government's intention to seriously consider a major overhaul of current residential aged care funding arrangements. LASA is taking a pro-active approach in representing Members' interests to the Federal Government with regards to any consideration of changes to residential aged care funding systems and processes. Fundamental to this approach is hearing our Members' views on the *Alternative Aged Care Assessment, Classification System and Funding Models Final Report*. A such we are seeking your feedback on challenges and/or opportunities that the Report presents for providers of residential aged care services to Marlene Eggert, Senior Policy Officer on marlenee@lasa.asn.au.

Background

The Department of Health (the Department) commissioned the Australian Health Services Research Institute (AHSRI) at University of Wollongong to develop options and recommendations for future assessment and funding models in residential aged care. The study was commissioned following occasions of government expenditure for aged care outgrowing projections. These cost 'blow-outs' were followed by funding cuts to residential aged care and resulted in tensions between the Department and providers.

The Department's brief set out three design considerations for AHSRI:

- The model should be able to be integrated with existing client pathways in aged care and system structures such as the Gateway.
- How can incentives for maintenance or re-ablement of health status and function of recipients be built into future arrangements?
- Interface of the model with the broader health system.

The review of the current system and consideration of options for the future addresses five key issues:

- classification and assessment tools;
- pricing;
- funding models (including analysis of the resource and infrastructure implications);
- implementation considerations; and
- audit mechanisms.

As part of its study, AHSRI undertook stakeholder consultation and some quantitative data analysis. Stakeholder consultation revealed that a more sustainable and certain funding system for residential aged care was the number one priority for all stakeholders. AHSRI's analysis of eight years of ACFI data showed that the main drivers of cost increases to the government is almost entirely driven by four items in ACFI Question 12 (Complex Health)[1]

[1] Pain management (49.3% of all assessments), Management of oedema (40.2%of all assessments), Complex skin integrity management (39.6% of all assessments) Complex pain management II (33.3% of all assessments), Complex pain management I (30.3% of all assessments).

Option One: Refinement of the current ACFI model

Option One retains the overall ACFI structure and design and retains a comprehensive assessment across several domains. Evidence supports each rating. Retains additive model in which ACFI scores are added together across multiple domains.
Several refinements are envisaged:

- Rationalization of ACFI items and removal of redundant items.
- Develop evidence base to justify each ACFI rating to establish clear link to care plan.
- Consider whether the behaviour domain should remain in ACFI.
- May involve a resetting of prices paid by DoH based on a costing study.

Classification system and assessment tools: overall structure and design of the current ACFI would be retained. ACFI is unsuitable for use by an external assessor.

Pricing model: The pricing model would remain unchanged.

Implementation, workforce and transition: current infrastructure would be retained, no changes to assessment workforce and information systems.

Audit & validation: Existing audit processes and workforce need to be retained.

Overall assessment by AHSRI: Simple additive model like ACFI will never result in equitable funding distribution; ACFI does not reflect the true cost drivers of care.

Question for Members: Can a refined ACFI model ensure appropriate funding of the RACF sector into the next decade?

Option Two: A simplified model with four funding levels

A simplified 'consumer directed care' model with four funding levels that map to the four funding levels currently existing for home care packages.

Classification system and assessment tools: Assessment does not require the detail currently necessary for ACFI. Assessor would be external, working to guidelines as for HCP. Initial assessment and possibly also ongoing assessments through ACAT.

Pricing model: Modelled from current ACFI with view to maintaining current expenditure. Funding differences between levels to be determined by either expert panel or costing study based on ACFI data.

Implementation, workforce and transition: Moves assessment from internal to external. Significant impacts in terms of staffing, training and funding. No complex infrastructure implications as no explicit linkage to care plan required.

Audit and validation: External assessment would make current audit and validation processes redundant.

Overall assessment by AHSRI: alignment of this model with home care and the broader policy agenda is an advantage. A major disadvantage is that this model may result in funding instability for

providers and funders as a shift between levels represents a quantum shift in care needs rather than incremental changes. Does not align with factors that drive of cost of care.

Questions for Members: Would external assessment offer providers with advantages, such as freeing up labour and thus reducing costs? If external assessment is introduced, which processes should be in place to resolve disputed assessments? Who should pay for external assessments?

Do you agree that the four levels of funding may constitute a financial risk for providers as a resident's shift in funding level has a greater financial impact?

Does this model's alignment with the four funding levels for home care packages constitute an advantage for RACF providers?

Option Three: Option Two plus supplements subject to external assessment

Option Three is a variant of Option Two but Option Three has only a few levels or bands. Special supplements are available if specified criteria are met and following external assessment, but not necessarily ACAT. For example, a time-limited payment for end-of-life care or ongoing payments for complex conditions (e.g. PEG, chronic wound management, dialysis). Supplements may require a documented care plan and reporting of outcomes on each resident.

Classification system and assessment tools: A list of supplementary payments needs to be agreed along with assessment requirements.

Pricing model: The core of this option is the same as Option Two. Supplements are ongoing and time-limited.

Implementation, workforce and transition: Determined by modelling from current ACFI data with view to maintaining current level of expenditure.

Audit and validation: Audit of assessments would be largely unnecessary. Eligibility for supplements would require a documented care plan and reporting of outcomes on each resident.

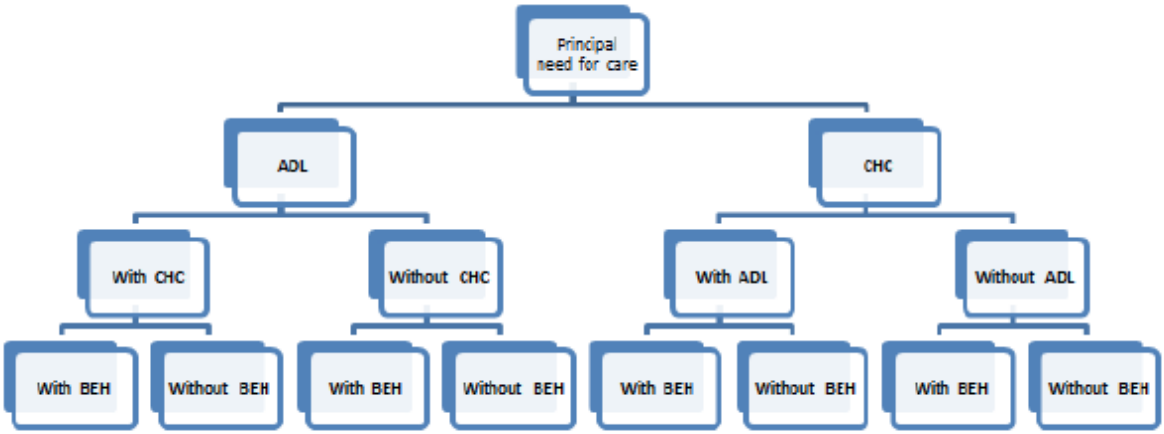
Overall assessment by AHSRI: Aligns with the current approach to home care packages and broader policy agenda. Access to supplements reduces financial risk to providers in short term. However, supplementary arrangements can be changed at short notice by Government. Supplements tend to shift attention from how best to utilize core payment to meet residents' needs to a focus on issues generating a supplement.

Question for Members: How much would reporting on outcomes achieved for residents attracting a supplement increase providers' overall burden of accountability to the Department?

Option Four: An Activity Based Funding model with a branching classification

Option Four makes explicit the relationship between cost and price. It applies those elements of Activity Based Funding relevant to aged care. Option Four includes the development of an aged care Weighted Activity Unit (WAU) and determination of a National Efficient Price (NEP) for aged care. The NEP paid for each WAU is determined in appropriate intervals and can be adjusted by additional weightings for example for indigenous status. Payments may be per diem or monthly plus incentive payments. Each resident attracts a per diem or monthly subsidy based on the **average cost** of providing care. Option Four utilises a branching classification which would align the funding model with the drivers of care costs.

An illustration of a branching classification structure



Classification system and assessment tools: A casemix classification is based on those resident attributes that best explain and predict the cost of care (cost drivers). In residential aged care a casemix classification would be a branching classification with classes defined by resident attributes that drive care needs (and thus cost). Under this Option ACFI domains are likely to be included in the residents' assessment. The assessment is unlikely to require the same level of detail as under the current model. Assessments may be made internally or by externally.

Pricing model: A casemix classification and WAU is in place for each classification. The subsidy paid is the total WAU for the facility multiplied by the NEP. Policy on the relationship between cost and price is explicit with price being set by reference to the cost of an efficient provider (plus a reasonable return on investment).

Implementation, workforce and transition: Significant considerations for the development and implementation of this funding system. If internal assessment is retained, the implications for the workforce are minimal. External assessment will largely result in additional costs to the system. This option requires regular costing studies to be undertaken within the aged care sector across a range of provider types and sizes and participating services need to generate financial data and

client level activity data to support the studies. Costs from one year inform prices in a subsequent year.

Audit and validation: A system using branch classification and regular costing studies is less exposed to gaming.

Overall assessment by AHSRI: Model Four is both efficient and transparent. The major disadvantage is that Model Four represents significant change. This model assumes all care costs to be variable when aged care facilities have both, fixed and variable care costs. This needs to be acknowledged to ensure the sustainability of smaller facilities.

Questions for Members: Activity based funding is used to fund acute hospitals. Do you think this model constitutes 'overkill' for the more stable and less costly environment of RACFs?

Would a branching model be successful in identifying the cost drivers of care and thus be more likely to result in adequate funding or residents' care needs?

Would funding based on formal cost studies offer more transparency to providers as to how the government determined the funding provided? Would such transparency be a disadvantage or advantage?

Option Five: A blended payment model

This Option recognizes that a significant proportion of the cost of care is fixed and is determined by the number of residents in care. Variable costs are based on the care complexity of each resident. Option Five has a standard 'per diem' (fixed) payment to cover the cost of care all residents receive equally. The variable payment covers the cost of individualized care. It may also include costs of social activities and outings. The variable payment is based on Option Four with a classification system with WAUs reflecting the differences in care needs and a NEP.

Classification system and assessment tools: ACFI domains are likely to be included to the residents' assessment under this model. Assessments are unlikely to require the same level of detail as under the current model. They may be made internally or externally.

Pricing model: Both fixed and variable prices would best be determined by a costing study. Fixed payments may be standard across Australia however, specific geographical locations may attract different rates. In addition, the facility would receive a per diem variable care payment for each resident, based on the residents' assigned ABF class.

Implementation, workforce and transition: Option Five represents considerable change. Information systems may require modifications to capture the level of data required for classification and costing and accommodate new payment systems. Assessment may be external, requiring significant workforce changes.

Audit and validation: A system using branch classification and regular costing studies is less exposed to gaming.

Overall assessment by AHSRI: Incorporating a fixed component into the funding structure reduces financial risk for Government and providers. The model may be perceived as being too complex for the aged care sector.

Questions for Members: Would timely access to external assessors be likely to constitute a problem for new residents and for residents requiring re-assessment?

How would rural and remote facilities be affected by an external model of assessment?

Do you agree that the inclusion of a fixed component in the funding model reduces providers' financial risk?

LASA Member feedback so far

LASA conducted a preliminary consultation with its Members on the five funding and assessment options:

1. ACFI structure is retained with refinements, assessment remains internal;
2. four funding levels and external assessment;
3. four funding levels plus supplements, external assessment;
4. Activity Based Funding with a branching classification, external or internal assessment; and
5. standard payment per resident with a variable payment for individualized care, external assessment.

Overall, Members felt that the Report did not provide them with enough information to make an informed decision. Not surprisingly, overall Members expressed little appetite for a fundamental change to the funding instrument.

Assessment

- Many providers want to retain internal assessment of their residents' care needs while others do not see a problem with external assessors.
- If external validators are used, these must have a clinical background.
- Some providers consider the option of a joint determination of care needs with assessments being carried out jointly by an internal and external assessor.
- Members would welcome some additional funding for the assessment work they do.
- External assessment may constitute a problem in rural and remote areas.

Refining ACFI

- Many members do not think that ACFI is broken and thus prefer a refinement of the ACFI.
- ACFI will need to be made appropriate to Consumer Directed Care as it does not facilitate the meeting of individual requests well.
- Any refinement should remove the two category jumps currently required for a re-classification.
- Currently payment under ACFI's behaviour domain does not meet the real cost of care. This is because residents with behavioural issues tend to have low scores in the ADL and CHC domains but require a high level of care for the management of their behaviour.
- ACFI does not cover some frequently occurring need for clinical care such as joint mobilisation for residents with arthritis and bariatric care.
- ACFI does not include funding for lifestyle issues such as outings.
- ACFI validators have become inconsistent.
- Target outlying providers with validation.

Funding Models

- Some Members would prefer a funding model with just two bands (as the funding for respite care) and supplements. Branching may be used for supplement payments.
- Option Five, a blended payment model, reminds many Members of the Care Aggregate Model/ Standard Aggregate Model in use prior to the *Aged Care Act 1997.*
- Information provided in AHSRI's report is of insufficient depth for providers to work out how the different Options proposed will affect their funding.
- The development of Option Five requires some years of preparation. The aged care industry requires a timely response to its funding issues because currently ACFI does not include indexation, but EBAs still do.

Other

- The five options do not explicitly address incentives for maintenance or re-ablement of health status and function. There need to be rewards for re-ablement and wellness.
- Will 'Specified Care & Services' be revisited in view of Consumer Directed Care?
- Who is going to set funding levels?

Next steps

Please provide your feedback on the *Alternative Aged Care Assessment, Classification System and Funding Model Final Report* to Marlene Eggert, Senior Policy Officer on marlenee@lasa.asn.au. We will use your feedback to provide Government with a submission about LASA Members' views on the funding options presented. LASA's aim is to be proactive and use the information provided by Members to engage with Government to ensure a residential aged care funding model that puts providers on a sustainable financial footing and enables them to respond to their residents' care needs.