



LEADING AGE SERVICES AUSTRALIA

SECOND HOME CARE PROVIDER SURVEY REPORT

APPENDICES

**Home care package movement across the initial
six months of *Increasing Choice in Home Care***

NOVEMBER 2017

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APPENDIX ONE

Detailed analysis was undertaken concerning total home care package (HCP) activity, the direction and extent of HCP movements, as well as different types of consumer movements (exits, upgrades, transfers and queue activations) independent of each other. This Appendix lists the key findings of this analysis and supplements the findings reported in Leading Age Service Australia’s (LASA) Second Home Care Provider Survey Report.

Total home package activity

Total HCP activity (TPA) was extrapolated at two month intervals from 27 February 2017 across the first six months (30 April, 30 June, and 31 August) following commencement of *Increasing Choice in Home Care* (ICHC). Extrapolation accounted for TPA at commencement of each interval and movements that occurred during the interval period in determining the TPA at the end of each interval, noting respondents reported the total number of home care packages they had at 27 February 2017.

$$\text{TPA (end of interval)} = \text{TPA (start of interval)} - \text{Exits} + \text{Transfers} + \text{Queue Activations}.$$

Respondents with incomplete data were removed from this part of the analysis with a complete sample of 31 respondents. TPA at each of the consecutive interval periods commencing 27 February 2017 was 5,134; 5,161; 5,204 and 5,377 respectively (see Figure 11).

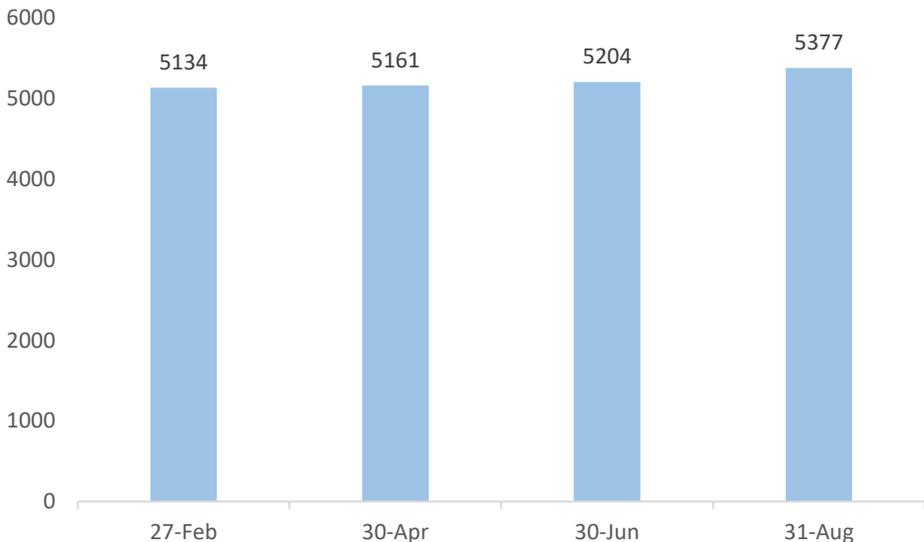


Figure 11: Change in TPA by two month intervals across the first six months of ICHC implementation.

Tests of equality of the mean (average) TPAs between intervals were conducted. The mean (average) level of TPA amongst respondents increased only very slightly in the six month period under review,

rising from an average of 165.6 HCPs at 27 February 2017 to 173.5 HCPs at 31 August 2017 - an increase of 4.7 per cent. The standard deviation (a measure of the dispersion) of TPA declined over the period under review, from 283.5 HCPs at 27 February 2017 to 255.5 packages at 31 August 2017 – a decline of 9.9 per cent (see Figure 12).

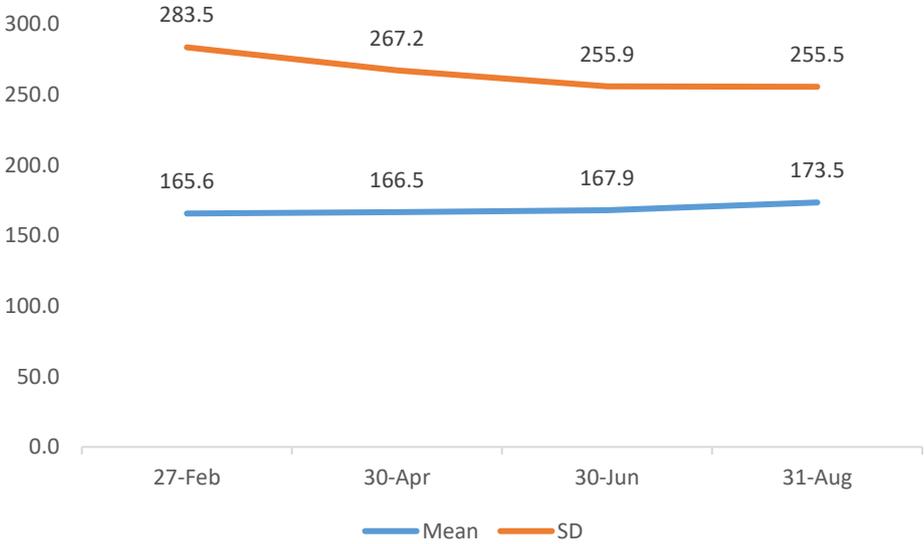


Figure12: Change in mean TPA (and standard deviation) across two month intervals.

While the average level of TPA rose (by $n = 8$; or 4.7 per cent) across the first six months of ICHC, this increase was not statistically significant ($t = -0.11$; $p = 0.91$). Similarly, while the standard deviation in the level of TPA dropped (by $n = 28$; or 9.9 per cent), this decline was not statistically significant ($t = 1.23$; $p = 0.57$). In summary, overall TPA over the six months under review essentially ‘flat-lined’ for this sample of respondents with little changes in the average level, or the variability, of total HCP activity.

Direction of total home care package movements

The proportion of respondents that experienced an increase in TPA at each subsequent interval relative to 27 February 2017 was 41.9 per cent at 30 April, 48.4 per cent at 30 June, and 61.3 per cent at 31 August 2017. The proportion of respondents that experienced a decrease in TPA relative to 27 February 2017 was 32.3 per cent at 30 April, 25.8 per cent at 30 June, and 19.4 per cent at 31 August 2017 (see Figure 13).

With new entrants removed, similar trends in increases and decreases in TPA across the six month period were also noted. Additionally, new entrants delivering HCPs reported increasing TPAs relative to 27 February at a rate of 57.1 per cent of new entrants at 30 April which expanded to 71.4 per cent of new entrants at 30 August 2017.

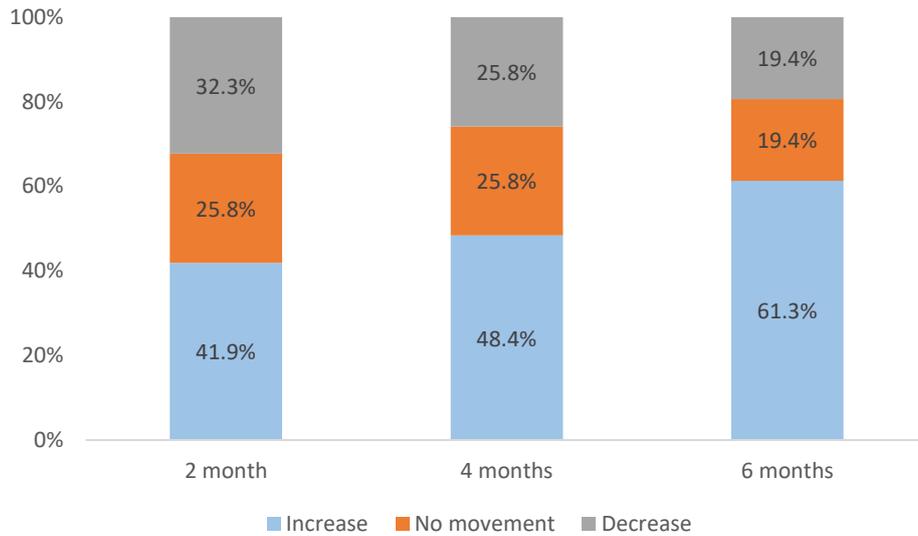


Figure 13: Proportion of directional change in TPA by two month intervals.

Extent of total home care package movements

Measuring the extent of change in TPA helps to understand how much HCP movement has occurred relative to the size of a HCP program. Changes have been reported as a percentage of HCP activity on 27 February 2017 to facilitate comparability of movements across providers holding different numbers of HCPs. For example, an increase of 10 consumers is proportionally a much larger change for a provider with TPA of 20 consumers (50 per cent) than for a provider with TPA of 200 consumers (5 per cent).

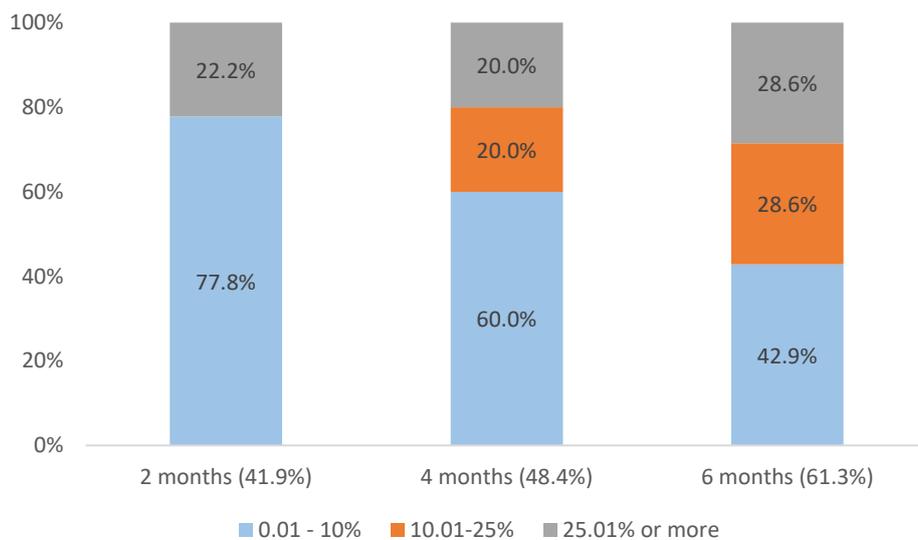


Figure 14: Extent of TPA increase at two, four and six month intervals from 27 February 2017.

Among respondents who experienced an increase in active HCPs from 27 February 2017 (new entrants excluded), the extent of increase in TPA was calculated as a proportion of TPA at two, four and six months from 27 February 2017 (see Figure 14). Over half of this group reported an increase in TPA of more than 10 per cent across the six month period. This more than doubled from 22.2 per cent of respondents at 30 April 2017.

Similarly, the extent of decrease in TPA was calculated as a proportion of TPA at two, four and six months from 27 February 2017 (see Figure 15). Among those respondents who reported a decrease in TPA over the first six months of ICHC (new entrants excluded), half of this group reported a decrease in TPA of more than 10 per cent. This increased five-fold from 10 per cent of respondents at 30 April 2017.

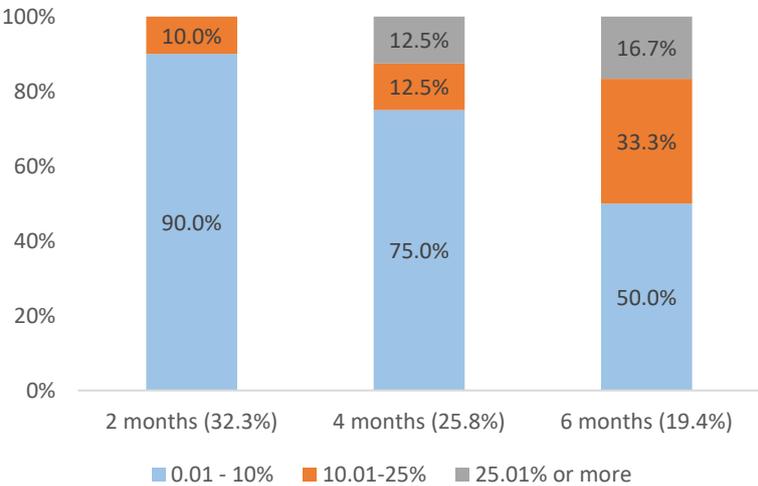


Figure 15: Extent of TPA decrease at two, four and six month intervals from 27 February 2017.

In summary, the overall level of TPA for this survey sample was not associated with any significant change across the first six months of ICHC. However, there was some movement within the sample with some respondents reporting increases in TPA and other respondents reporting decreases in TPA that collectively levelled out across the entire sample.

Of particular interest, almost two thirds of respondents reported an increase in their number of HCPs over the first six months of ICHC, with over half of this group reporting an increase greater than 10 per cent of their HCPs. Concurrently, one fifth of respondents reported a decrease in the number of HCPs over the same period, with half of this group reporting a decrease greater than 10 per cent of their HCPs. This array of TPA movements is indicative of the increasing competition that has emerged among providers of HCPs since 27 February 2017 and is consistent with ICHC policy directions.

Consumer movements

Respondents were asked to report the number of differing consumer movements they had experienced across the first six months of ICHC. Types of consumer movements include:

- 1) Consumers who *exited* from their HCPs. Exits can occur because of, for example, the death of the consumer or the movement of the consumer into residential care or an alternate informal/formal care arrangement.
- 2) Consumers who *upgraded* from one HCP level to a different HCP level. Upgrades are only reported for HCP levels one through to three as consumers cannot be upgraded from a level four HCP.
- 3) Consumers who *transferred* to the respondent from another provider for administration of their HCP.
- 4) Consumer HCP referrals *activated* by the respondent through the national queue with intent to commence services.

In this stage of analysis, consumer movements differ from total HCP movements considered earlier. Total HCP movements investigated the combined effect of these consumer movements whereas in this section consumer movements will be investigated independently of each other.

Total consumer movements

The total number of each movement type (exits, upgrades, transfers, and queue activations) were reported by respondents and collated, with counts reported in Figures 16-19. Collation occurred by HCP level for each of the three consecutive intervals: March–April, May–June and July-August. Collectively, these three intervals spanned the first six months of ICHC.

Tests of equality of the mean (average) consumer movements for all respondents were conducted between intervals. Respondents with incomplete data were removed from this part of the analysis with a complete sample of 31 respondents.

Significant increases in the average number of consumer movements for respondents were noted for consumer upgrades across the period March-April to July-August from level two HCPs ($t = -2.23$; $p = 0.03$) and level three HCPs ($t = -2.11$; $p = 0.04$) that were upgraded to higher HCP levels. The average number of consumer upgrades from level two HCPs rose from an average 1.66 upgrades per respondent ($SD = 2.62$) during the period March-April to 4.22 upgrades per respondent ($SD = 5.94$) during the period July-August 2017 - an increase of 2.56 upgrades. The average number of consumer

upgrades from level three HCPs rose from an average 1.00 upgrade per respondent (SD = 2.74) during the period March-April to 2.91 upgrades per respondent (SD = 4.33) during the period July-August 2017 - an increase of 1.91 upgrades.

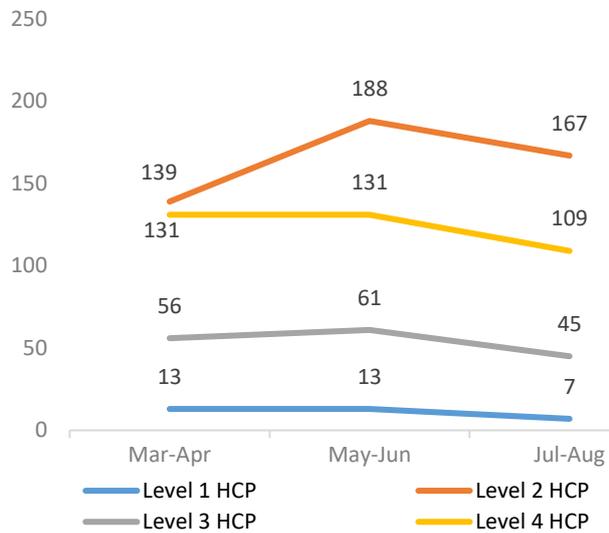


Figure 16: Movement in consumer exits.

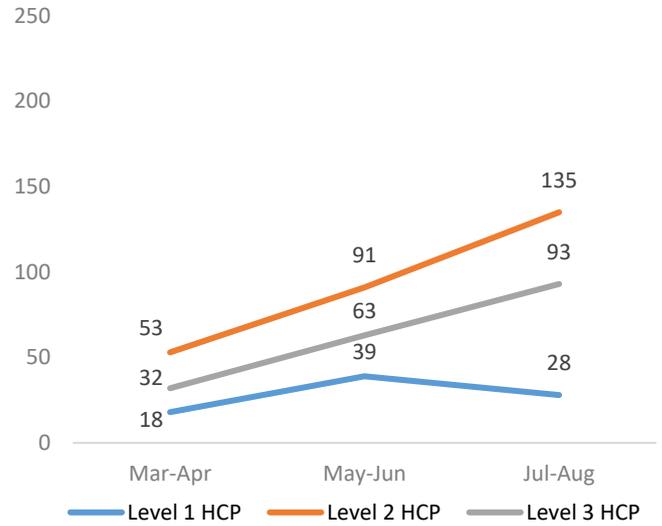


Figure 17: Movement in consumer upgrades.

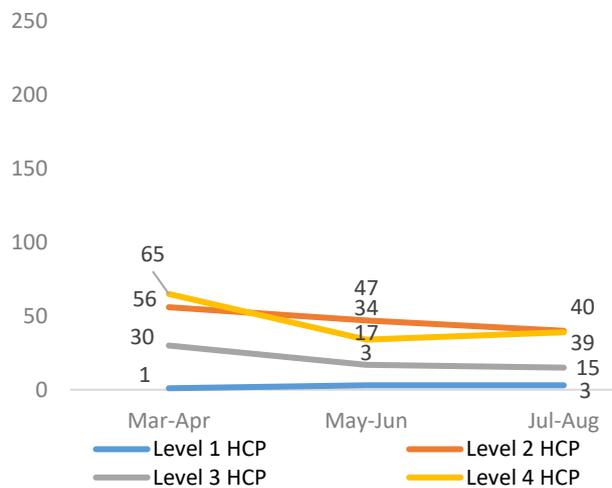


Figure 18: Movement in consumer transfers.

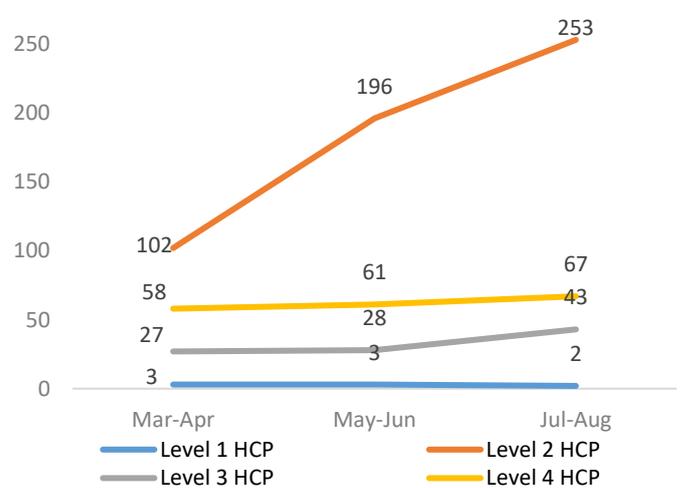


Figure 19: Movement in queue activations.

For all other consumer movements between intervals, changes in means were not statistically significant across the first six months of ICHC. This included an increase of 151 level two HCP queue activations reported across March-April and July-August intervals. This insignificant change was largely accounted for by consumer movements reported for three respondents (84.8 per cent of level two HCP queue activations) who identified as 'large' providers. There was also an increase of 49

consumer exits for level two HCPs across March-April and May-June intervals. Relative to the number of level two HCPs from which the exits are drawn, this count appears relatively small (estimated at 1.5 per cent of level two HCPs) and represents an average jump of 1.58 consumer exits per respondent over the March - April to May - June period.

Means (M), standard deviations (SD), as well as t-tests and p-values for tests of equality of means for consumer movements between intervals within the first six month of ICHC, are reported below.

Level 1 Consumer Exits				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	0.42	0.42	0.23	0.00	1.00	0.79	0.43	0.72	0.48
SD	1.29	1.13	0.71						

Level 2 Consumer Exits				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	4.48	6.06	5.39	-0.74	0.46	0.31	0.76	-0.49	0.63
SD	7.31	9.45	7.45						

Level 3 Consumer Exits				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	1.81	1.97	1.45	-0.16	0.87	0.60	0.55	0.38	0.71
SD	4.28	3.61	3.17						

Level 4 Consumer Exits				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	4.23	4.23	3.52	0.00	1.00	0.40	0.69	0.32	0.75
SD	10.47	7.69	6.35						

Level 1 Consumer Upgrades				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	0.56	1.22	0.88	-1.35	0.18	0.61	0.54	-0.74	0.47
SD	1.39	2.39	2.03						

Level 2 Consumer Upgrades				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	1.66	2.84	4.22	-1.37	0.18	-1.08	0.28	-2.23	0.03
SD	2.62	4.11	5.94						

Level 3 Consumer Upgrades				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	1.00	1.97	2.91	-1.21	0.23	-0.94	0.35	-2.11	0.04
SD	2.74	3.63	4.33						

Level 1 Consumer Transfers				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	0.03	0.10	0.10	-0.87	0.39	0.00	1.00	-1.10	0.28
SD	0.18	0.40	0.30						

Level 2 Consumer Transfers				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	1.87	1.57	1.33	0.29	0.78	0.26	0.80	0.52	0.61
SD	4.51	3.57	3.55						

Level 3 Consumer Transfers				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	1.00	0.57	0.50	0.81	0.42	0.24	0.81	0.95	0.35
SD	2.66	1.20	1.09						

Level 4 Consumer Transfers				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	2.17	1.13	1.30	0.80	0.43	-0.18	0.86	0.67	0.51
SD	6.09	3.62	3.74						

Level 1 Queue Activations				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	0.10	0.10	0.07	0.00	1.00	0.35	0.73	0.35	0.73
SD	0.40	0.40	0.25						

Level 2 Queue Activations				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	3.40	6.53	8.43	-1.29	0.20	-0.57	0.57	-1.61	0.11
SD	8.35	10.31	14.89						

Level 3 Queue Activations				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	0.90	0.93	1.43	-0.06	0.95	-0.88	0.38	-0.89	0.38
SD	1.94	1.67	2.64						

Level 4 Queue Activations				Mar-Apr to May-Jun		May-Jun to Jul-Aug		Mar-Apr to Jul-Aug	
	Mar-Apr	May-Jun	Jul-Aug	t-test	p-value	t-test	p-value	t-test	p-value
Mean	1.93	2.03	2.23	-0.12	0.90	-0.25	0.81	-0.35	0.73
SD	3.29	2.98	3.29						

Extent of consumer movements

Analysis of consumer movements was also conducted to reveal the extent of consumer movements across respondents for each movement type (exits, upgrades, transfers and queue activations).

Movements reported by each respondent were converted into a percentage of the respondents TPA at each two month interval to facilitate comparability of movements across providers holding different numbers of HCPs at each interval (see Figures 20-23). Respondents with incomplete data were removed from this part of the analysis with a complete sample of 31 respondents.

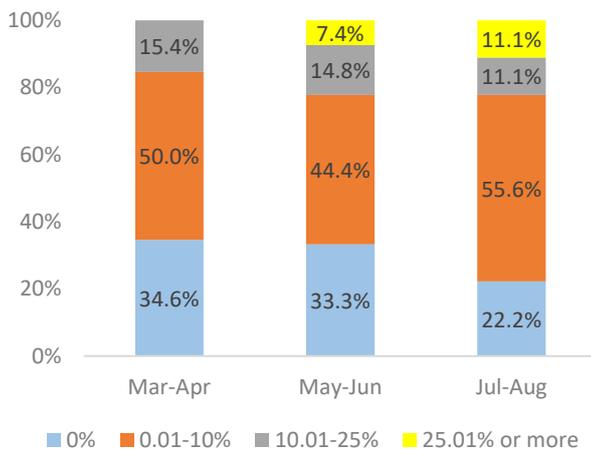


Figure 20: Extent of consumer exits

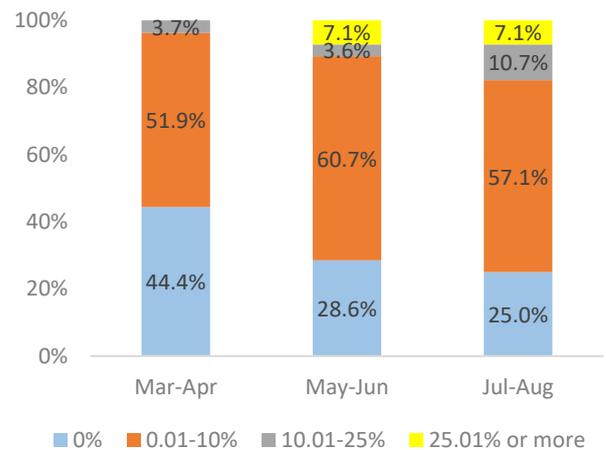


Figure 21: Extent of consumer upgrades

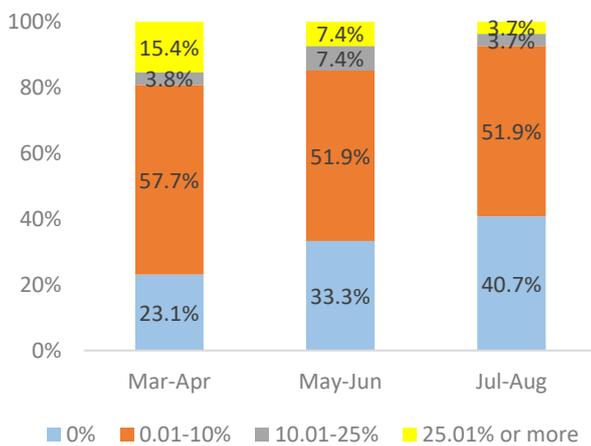


Figure 22: Extent of consumer transfers

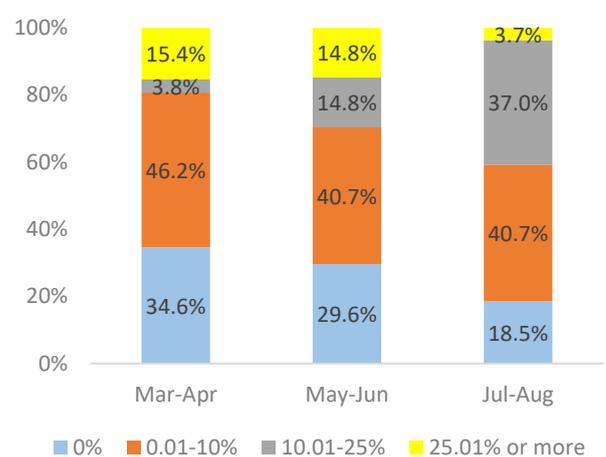


Figure 23: Extent of queue activations

There were 77.8 per cent of respondents that reported consumer exit movements from HCPs during the July-August period and this increased from 65.4 per cent of respondents who reported consumer exit movements in March-April, an increase of 12.4 per cent across the first six months of ICHC. Of those respondents reporting consumer exit movements, the majority reported consumer exit

movements at a rate equivalent to less than 10 per cent of TPA across each of the two month intervals (see Figure 20).

There were 75 per cent of respondents that reported consumer upgrade movements from HCPs during the July-August period and this increased from 55.6 per cent of respondents who reported consumer upgrade movements in March-April, an increase of 19.4 per cent across the first six months of ICHC. Of those respondents reporting consumer upgrade movements, the majority reported consumer upgrades at a rate equivalent to less than 10 per cent of their TPA across each of the two month intervals (see Figure 21).

There were 59.3 per cent of respondents that reported consumer transfer movements into their HCPs during the July-August period and this decreased from 76.9 per cent of respondents who reported consumer transfer movements in March-April, a decrease of 17.6 per cent across the first six months of ICHC. Of those respondents reporting consumer transfer movements, the majority reported receiving consumer transfers at a rate equivalent to less than 10 per cent of their TPA across each of the two month intervals (see Figure 22).

There were 81.5 per cent of respondents that reported queue activation movements into HCPs during the July-August period and this increased from 65.4 per cent of respondents who reported queue activation movements in March-April, an increase of 16.1 per cent across the first six months of ICHC. Of those respondents reporting queue activation movements, just under half reported receiving queue activations at a rate equivalent to less than 10 per cent of their TPA across each of the two month intervals while there also appeared to be increasing trend among respondents towards receiving queue activations at a rate equivalent to more than 10 per cent of their TPA as ICHC progressed (see Figure 23).

Importantly, some of this later group were represented by new entrants and small providers, where a few queue activations represent a significant proportion of TPA. There were also some medium and large providers who appear to have excelled in on-boarding consumers at a growth rate greater than 10 per cent of their TPA during the first six months of ICHC.

Combined, this analysis of the extent of differing consumer movements during the first six months of ICHC revealed that while the extent with which respondents received consumer transfers decreased over time, other movement types; comprising consumer exits, upgrades and queue activations, became more prevalent across respondents over the same period in respect to the extent of their occurrence. More than three quarters of respondents reported the occurrence of these later movement types in the July-August period.

Additionally, the majority of respondents reported the occurrence of consumer exits, upgrades and transfers at a rate equivalent to less than 10 per cent of TPA across the first six months of ICHC. In contrast, just under one half of respondents reported the occurrence of queue activations at a rate equivalent to less than 10 per cent while there also appeared to be another group who over time reported an increasing rate of queue activations. The pattern of consumer movements reported within this sample is somewhat consistent with expectations for ICHC implementation at this point in time.

APPENDIX TWO

Detailed analysis was undertaken concerning changes in incorrect HCP withdrawals across the first six months of ICHC and the extent to which incorrect HCP withdrawals occurred. This Appendix lists the key findings of this analysis and supplements the findings reported in the body of LASA’s Second Home Care Provider Survey Report.

Changes in incorrect home care package withdrawals

Means and standard deviations were calculated for the sample of HCP providers concerning the number of incorrect HCP withdrawals they reported across each two month interval (see Figure 24). Tests of equality of the mean (average) number of incorrect HCP withdrawals for all respondents were conducted between intervals. Respondents with incomplete data were removed from this part of the analysis with a complete sample of 31 respondents.

The average number of incorrect HCP withdrawals rose from 2.2 HCPs per respondent in the March - April period, to 4.6 HCPs in the May - June period; this movement was not statistically significant ($t = -1.54$; $p = 0.13$). By comparison, the average number of incorrect HCP withdrawals eased slightly from 4.6 HCPs per respondent in the May – June period, to 4.3 HCPs in the July - August period; this movement was not statistically significant ($t = 0.13$; $p = 0.90$). Furthermore, across the six months of ICHC implementation the average number of incorrect HCP withdrawals rose from 2.2 HCPs per respondent in March - April to 4.3 HCPs per respondent in July - August; a step-up of 2.1 HCPs, which was also not statistically significant ($t = -1.18$; $p = 0.24$).

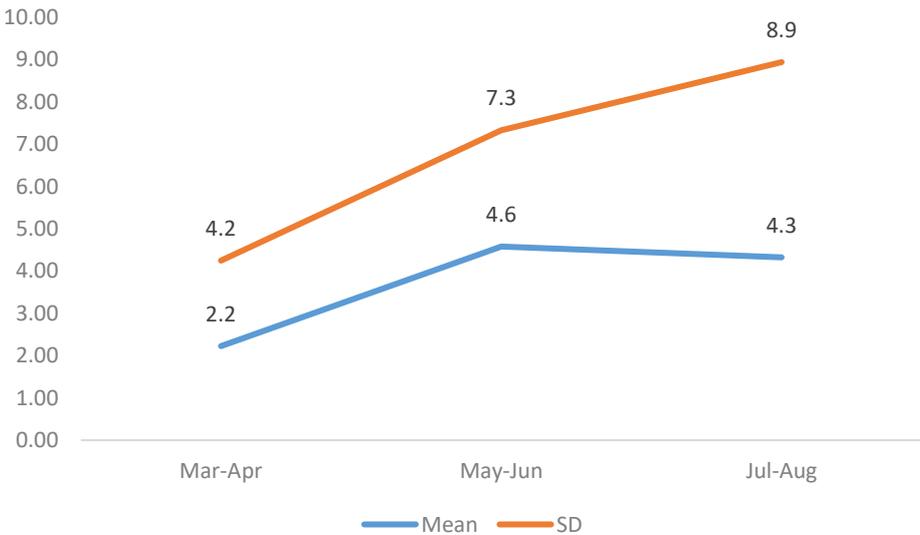


Figure 24: Changes in means and standard deviations for HCP withdrawals by interval.

In contrast, there were noticeable and statistically significant differences in testing the equality of the standard deviations (a measure of the variability) between intervals as were associated with the mean number of incorrect HCP withdrawals reported by respondents. For the period, March – April to May - June: $t = 0.34$; $p = 0.00$; for the period, May - June to July – August: $t = 0.67$; $p = 0.28$; and, for the period, March - April to July - August: $t = 0.23$; $p = 0.00$.

Taken as a whole, the movements in the mean (average) numbers of incorrect HCP withdrawals between intervals examined were not statistically significant – that is, could have been due to chance alone. By comparison, movements in the standard deviations as were associated with the mean number of incorrect HCP withdrawals between two of the pairs of data points (March - April to May – June and March - April to July - August) were statistically significant – that is, highly unlikely to be due to chance alone.

In effect, the extent of variability reported by respondents in the number of incorrect HCP withdrawals is significant across the initial six months of ICHC. This reflects the diversity of respondent experiences whereby some respondents have reported a more substantial number of incorrect HCP withdrawals relative to other respondents in the sample.

Extent of incorrect home care package withdrawals

Noting the diversity of respondent reports concerning the occurrence of incorrect HCP withdrawals, data was examined concerning the extent with which incorrect HCP withdrawals were reported by respondents. The extent of withdrawals was measured as a proportion of consumer movements comprising consumer upgrades, consumer transfers and queue activations as were reported by respondents for equivalent periods. Withdrawals reported by each respondent were converted into a percentage of consumer movements at each two month interval to facilitate the comparability of movements across providers holding different numbers of HCPs at each interval (see Figure 25). Respondents with incomplete data were removed from this part of the analysis with a complete sample of 31 respondents.

Nearly one quarter of the respondents that reported consumer movements in the March – April interval (23.1 per cent) also reported having incorrect HCP withdrawals that was at a rate of 25.01 per cent or more of TPA during this same period. During subsequent intervals this increased to 52 per cent of respondents for the May – June interval, and then decreased to 31 per cent of respondents for the July – August interval. In comparison, over half of the respondents that reported consumer movements in the March – April interval (57.7 per cent) also reported not having any incorrect HCP withdrawals during this same period. During subsequent intervals this decreased to 28 per cent of

respondents for the May-June interval, and then increased to 44.8 per cent of respondents for the July – August interval.

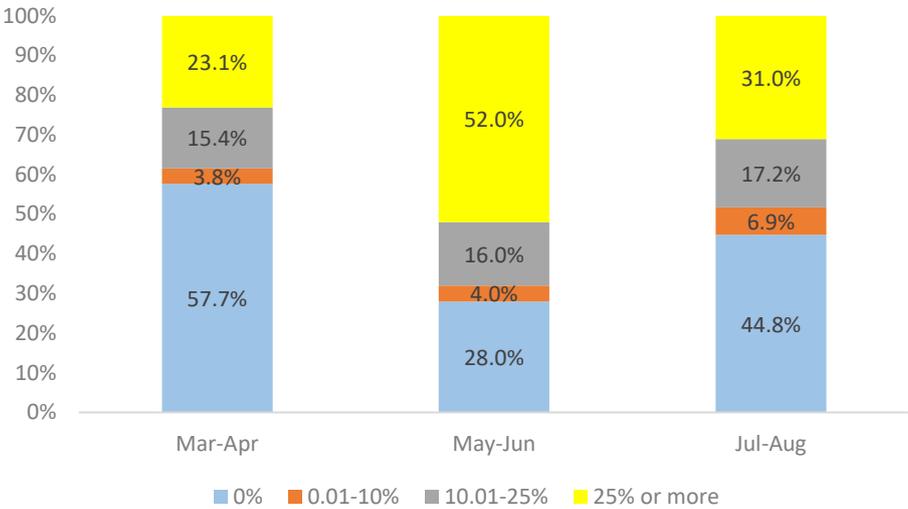


Figure 25: HCP withdrawals as a percentage of respondent's consumer movements at each interval.

In conjunction with this, consistency of incorrect HCP withdrawals for respondents that reported consumer movements was examined across the three intervals; March – April, May – June, and July August. There were 31 per cent of respondents that reported recurring incorrect HCP withdrawals across all intervals where consumer movements occurred. There were 24.1 per cent of respondents that reported no occurrence of incorrect HCP withdrawals across all intervals where consumer movements occurred. There were 44.8 per cent of respondents that reported variability in the occurrence of incorrect HCP withdrawals, whereby there were some withdrawals at some intervals and no withdrawals at other intervals when examining withdrawals across all intervals where consumer movements occurred.

Such variability of incidence (as was confirmed statistically) does not assist to identify any clear pattern of occurrence for incorrect HCP withdrawals. In interpreting this level of analysis concerning incorrect HCP withdrawals, the variability of withdrawal occurrence suggests a respondent's operational procedures for facilitating consumer movements (when applied consistently across the first six months of ICHC) is unlikely to be a contributing factor to the occurrence of incorrect HCP withdrawals.

The DoH has recently advised of situations within which incorrect HCP withdrawals occur. This includes when consumers commence a new HCP, when HCPs are upgraded, and when service IDs are combined and/or consumers are transferred across service IDs.

Noting the analysis undertaken, incorrect HCP withdrawals were analysed as a proportion of consumer movements (identified in this sample as being 20.5 per cent across six months) and this does not account for whether some of these HCP withdrawals may have occurred in the process of respondents combining multiple service IDs. Data concerning incorrect HCP withdrawals as a function of combining service IDs was outside the scope of the survey design. As such, the actual extent with which incorrect HCP withdrawals have occurred may be lower than what has been reported for this sample and interpretation of this part of the analysis concerning the proportion of incorrect HCP withdrawals relative to consumer movements should be interpreted with caution.

APPENDIX THREE

Respondents were asked to comment on issues they were experiencing with ICHC and areas for improvement. Responses to this question are listed below.

Further work required to improve ICHC implementation as reported by respondents

- Better correspondence between MAC and Medicare to prevent package withdrawals. Fairer income testing across all home care including CHSP to ensure consumers transfer between programs. Limit to the amount of CHSP services consumers can receive.
- Ironing out of the MAC system. This has caused considerable stress for clients that have been accepted on to home care packages and then receiving withdrawal letters. Moving of clients to higher levels that may not need that level of care. We have a number of clients that prior to 27th February had been made eligible for home care packages at Level 4, yet did not require that level of service or care and were moved back to Level 2. Since the changes, these clients are now being moved back to Level 4 packages with unspent funds in excess of \$20,000 carried forward that cannot be spent. The banding of the levels. We have Level 2 clients that cannot access day centre once they become a Level 4. Perhaps Level 2/3 can be banded together instead of 3/4.
- Resourcing to ACAT teams to see customers more quickly. Seamless referral for RAS to ACAT if the MAC call centre have incorrectly referred people to RAS when clearly an ACAT was required. Time taken to get Medicare funding from ACAT approval - some of our customers have been waiting for 300+ days. Information about which regions HCP are being issued. More Home Care Packages at level 3 & 4. Integrate CHSP or remove Level 1 HCP. Open the CHSP contract to be CDC rather than a limited contract e.g.: Domestic Assistance only for the approved provider - at present the system requires customers to use multiple service providers and is hiding if a customer requires a HCP as they may be receiving up to 8 hours of CSHP a week across multiple service providers. Requirement for RAS assessors to have some clinical knowledge or training.
- Avoiding the devaluation of care/case management. Resolving pressure on CHSP (given the delay in moving to the CDC model). Resolve imbalance between the resourcing that goes into home care compared with residential care, by fast tracking the Tune review's notion of a level 5 HCP
- Better communication between MAC and DHS is required to avoid the current issues being experienced with packages incorrectly withdrawn, which also result in no subsidy payment for consumers. National queue and allocation of higher level packages requires further review to avoid premature entry into residential care by clients who are waiting for their assigned HCP level. Risk of hospitalisation would also be reduced. Parameters required for use of funds to purchase equipment.
- Improve communication and information exchange between Dept of Health/MAC and Dept of Human Services (Medicare). Improve communication to consumers when packages are assigned. Reduce wait times for assessment. Reduce wait times for assignment of HCPs. Cease provision of interim packages. Increase number of packages available. Better reporting on overall MAC

performance. Enhance access for special needs groups. Reduce 56 (+28) day HCP assignment acceptance timeframe. Introduce requirement for wait listed clients to identify and select preferred provider in advance of assignment of package.

- Fix the problem between MAC and Medicare causing client HCP's to be either cancelled or just disappearing. This is causing extreme anxiety for clients who receive letters from the Commonwealth advising their package is to be withdrawn when everything has been done correctly. MAC always advise that it is a 'known problem' with the system between them and Medicare and that they will escalate it to Canberra, nothing then seems to happen and you have to go back to MAC repeatedly. From a provider point of view there is also the situation whereby Medicare stops paying subsidies for no reason or advice and you then follow it through to discover it is aligned to the same issue as above. The communications from the Department needs to be clearer to clients about eligibility and assignment of packages as there is a lot of confusion. Increase scrutiny of new providers to the industry to ensure they meet regulatory compliance. There should be far stronger scrutiny on the application of additional CHSP services to existing HCP clients to 'top up ' their packages - this practice is being used in a way that is sitting outside the rules in the CHSP Program Manual which is very clear. A fairer distribution of HCP referrals thru MAC portal as there is anecdotal evidence that some larger providers have what could be seen as an unfair proportion of referrals coming their way.
- To make MAC simpler to navigate. To have MAC act as a database for all available home care programs, including their interaction with each other and any conflicts. To discriminate between approval codes and assignment codes which currently look the same. To have ACAT trigger fee assessment for those who agree to accept referral for a home care package. For ACATs to assess with eligibility for and current access to programs outside of HCPs and any conflicts. People are currently assessed for L3 or L4 but have been precluded from accepting high level packages because this will mean that they are precluded from more advantageous benefits on another program, e.g. DVA Community Nursing and Allied Health, which is a liberal benefit, must be transferred to a high level package which is budget limited and may ultimately disadvantage the client. There is need for information for transparency on lack of access to ENABLE equipment program, CAPS continence program, attendance at day care centres, if on a high level HCP. Explanation needed of transition from existing CHSP program services to HCP services which may mean a change of Provider. Explanation needed in MAC of the circumstances under which a person can access additional CHSP services and explanation that the fee for the CHSP services are on top of any HCP fees. Explanation of whether you can return to CHSP services by terminating the HCP in the instance where face to face services are inadequate on the HCP and Case Management has determined that the a high level of face to face services are needed to prevent premature entry into an Aged Care Facility. Explanation is needed in MAC of the ITF relationship to funding. That is for every \$ of ITF the subsidy to Providers is reduced by that amount. Currently the Govt advises that ITF assessments will be done within 2 weeks. In practice it is much longer than that. The Govt will claw back any funding retrospectively, and well after the Provider has commenced services. There is a high risk of 'bill shock for clients and financial risk for Service Providers in not having an ITF assessment at the time of acceptance of the HCP with a Provider. The ITF estimator tool is onerous and very complex for Veteran Gold Card beneficiaries. In our experience the

Estimator Tool is never used by the time the client approaches the provider. The Assessor for the Provider is put in an unenviable position of second guessing what the ITF is likely to be from casual conversation with the client. Therefore some of our HCP clients have experienced 'bill shock' and we as Provider have incurred losses because of the delay and complexity of the ITF assessments. It is necessary to protect both parties to have an interim ITF agreement estimating in what range the fee is likely to be, but there is little to rely on in making that estimate. In our experience, the Basic Fee has to be almost universally waived if there is a significant ITF, particularly for L1 and L2 clients - as clients quite fairly, cannot see the benefit in a package program given the fees required. In some cases it is probably economically viable for them to take private services, but that would mean that the essential case management of the HCP is neglected and not taken up as a private service because clients do not generally understand the benefits to them. It can be very difficult to explain those benefits to them.

- Faster take up times for Home Care Packages. Shorter waiting lists. Get rid of Level 1 Packages, Integration between MAC and Department of Human Services has to improve as it causes packages to 'drop off' or cease due to the slow turnaround in processing the ACER's for new clients and the lack of communication between the 2 departments.
- Greater training and education on the use of the My Aged Care Portal, and the DHS portal for claims. Greater feedback and some form of identification of withdrawn packages and outcomes timeframes. Communications with DHS and My Aged Care is appalling, and withdrawn packages are not being communicated, causing distress to clients, and organisations.
- Reliance on the national queue - it makes little sense to date. Issuance of more packages - we are mainly seeing upgrades. MAC Gateway with increased skills and ability to address issues quickly. Communication between the MAC and Medicare - they seem to be operating in complete silos.
- Use it or loose it policies. Injection of home care packages. Revision of aged care places vs HCP allocation ratios. Increased accountability between DHS and MAC systems.
- Faster assessment and referral from consumer to provider. Better communication of what a package allocation means and that it is time limited. Improve information exchange between Centrelink (ITF) Medicare (Payments) and My Aged Care (Approvals) - no substantive link is evident. Fork out some money on advertising and education for the general public. Remove all these extra steps which are suspiciously like blocks to funding, care and services - not a transparent approach to providing care and services to people to stay at home for example. How many of the packages released were actually accepted? and by who? Is the ultimate aim to privatise home care services to corporations where the end user pay? The USA got it wrong - why would we want a system like that?
- Dementia clients need to stay on CHSP to allow them to attend centre-based day centre 3 days per week so that the carer can function. This way it keeps them from entering a nursing home. The package does not give the carer privacy or long enough to stay home and sleep, rest etc.

- High care packages are in high demand as we struggle to provide appropriate care to high needs clients
- Need to have a higher level package with funding at approximately \$60k. This will allow the needs of people of very high care to stay at home longer.
- Suggest having a search function in MAC for client to put into search engine, by area, what they require. The results of the search should show what programs can provide these services, and how to access those programs. Explanation of return of unspent fees in case of clients who die interstate. Programs both Federal, State and Local should be included on MAC. The following aged care programs are just some that come to mind that would be beneficial and which are not currently mentioned in MAC - Palliative care is only cursorily dealt with in MAC, ENABLE, CAPS, CHSP (regarding services which can be provided by HCPs such as social support) and services which can't be met on HCP (social support in-centre, MOWs, community nursing, allied health, falls prevention programs), Overnight Cottage Respite, Taxi transport subsidy scheme, SABRE Program (smoke alarm and battery replacement), POOPS (pet care while client in hospital/respite), SMHOP (specialist mental health services for older people), CRCC (carer respite), Chronic Disease Management (allied health on Medicare), AIDER (bush fire prevention for seniors).

APPENDIX FOUR

Respondents were asked to provide examples of questionable consumer purchasing behaviours using HCP budget expenditure, noting the purpose of a HCP is to deliver care and services that support a consumer to remain living at home. Responses to this question are listed below.

Examples of questioned consumer purchasing behaviours from respondents

- TV, fridges, phone, lounge.
- We ensure there is a close link between expenditure and care need to meet a care plan goal.
- Questionable items would include: Concreting of paths, Repairs to roofs, Respite, Repairs to fences, Installation of blinds, and Purchase of bedding/linen.
- Chair lift for Level 2 home care package, Bed sheets and accessories, Repairs/painting of patio deck, New double front doors, Replacement and rollers on windows, Steam clean curtains/blinds, Roof repairs, clean and painting, Equipment for swimming pools, Concreting paths, Garage door services, Sensor lights, Sandals and other personal items.
- To the best of our capacity questionable expenditure is avoided/refused as a standard practice.
- Air conditioner unit for bedroom, Reimbursement for eye operation.
- Meals on wheels.
- We have a discussion with clients but the requests are: Air conditioning repairs, Dish washer, Washing machine, Air purifier. We always go back to the overall objective of the legislation and review the excluded list however if the client has a condition that would mean that the item would assist in their clinical health we definitely consider it as a green light.
- Ice cream maker to enable a diabetic client to make sugar free ice cream, Chinese medicine.
- Ride on lawn mower for a Level 4 home care package, new fridge.