Pricing Framework for Australian Residential Aged Care Services 2024-25

Consultation Report

July 2024

July 2024

IHACPA

Pricing Framework for Australian Residential Aged Care Services 2024–25 Consultation Report – July 2024

Table of Contents

1. Introduction

1.1 The Independent Health and Aged Care Pricing Authority

The Independent Health and Aged Care Pricing Authority (IHACPA) determines the annual national efficient price and national efficient cost for Australian public hospital services and provides evidence-based pricing advice for aged care services nationally.

IHACPA was established in 2011 under the *National Health Reform Act 2011* to promote improved efficiency in, and access to, public hospital services through the provision of independent advice to Australian governments.

In 2022, the scope of IHACPA's functions were expanded under legislative amendments to provide advice about aged care pricing and costing matters to the Australian Government (the Government) and to assess applications for higher maximum accommodation payment amounts and extra service fees for residential aged care.

1.2 About this Consultation Report

IHACPA conducted a public consultation on key issues to be included in the *Pricing Framework for Australian Residential Aged Care Services 2024–25* (the Pricing Framework) through the *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25* (the Consultation Paper).

The public consultation period ran from 17 July 2023 to 31 August 2023 and invited stakeholders to provide input into the development of the Pricing Framework.

Key themes arising from the consultation feedback are summarised in this report, with reference to the stakeholder groups that contributed to the perspectives and dimensions discussed under each theme. This stakeholder feedback has informed the development of the Pricing Framework.

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

This document should be read in conjunction with the:

- *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25*
- *Pricing Framework for Australian Residential Aged Care Services 2024–25*
- *Residential Aged Care Pricing Advice 2024–25.*

1.3 Summary of stakeholder submissions

IHACPA received 66 submissions to the Consultation Paper from a diverse range of stakeholders as outlined in Figure 1.

Government ministers and departments

One Australian government department and four state government health departments responded to the public consultation. Three state health ministers and one territory health minister also submitted responses. Together these submissions provided broad jurisdictional coverage.

Aged care residents, their representatives and family

Six peak organisations representing consumers and three individual residents, their representatives and family provided submissions. This included three peak organisations representing the interests of Aboriginal and Torres Strait Islander peoples.

Aged care providers and industry suppliers

One peak organisation representing aged care providers, 20 residential aged care providers and one home care provider responded to the public consultation. Of the residential aged care providers, 15 were not-for-profit and five were for-profit.

Three of the not-for-profit residential aged care providers were single site service providers, while the remaining 12 residential aged care providers provide services from multiple sites, ranging from three to 71 services. One for-profit residential aged care provider was a single site provider, with the remaining four residential aged care providers providing services from multiple sites, ranging from four to 58 services.

Four aged care industry suppliers provided submissions, including suppliers of telecommunications, technology and artificial intelligence, independent retirement living accommodation and dental services and products.

Aged care workforce

Eight peak organisations representing the aged care and related health workforce provided submissions, including organisations representing medical, nursing, allied health, and dental workforce groups. One of these peak organisations represented the aged care workforce, and one represented the rural workforce.

Aged care researchers

Four submissions were provided from aged care academic research institutions, including institutions involved in dementia, ageing, and aged care research.

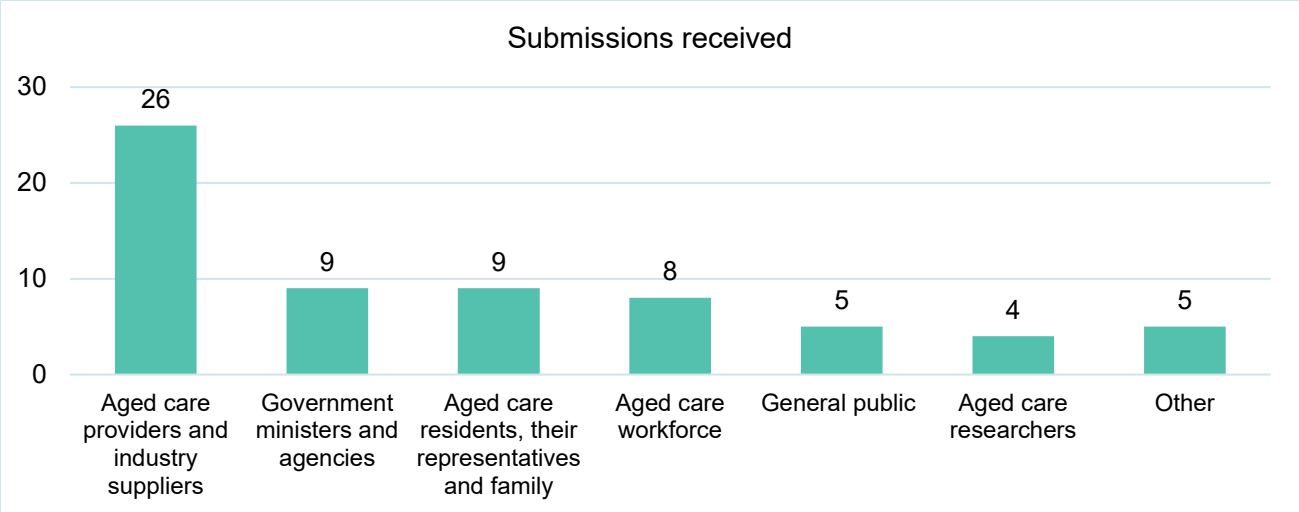
General public

Five individuals who were not residents, carers or family of people receiving aged care responded to the public consultation.

Other

Five other individuals provided submissions, including government and aged care employees and health professionals.

Figure 1: Number of submissions to Consultation Paper by type of stakeholder group (n=66)



2. IHACPA's role in aged care

To support the understanding and engagement of stakeholders, the *Consultation Paper on the Pricing Framework for Residential Aged Care Services 2024–25* included an overview of the Independent Health and Aged Care Pricing Authority's (IHACPA) role in providing pricing and costing advice to the Australian Government (the Government). While IHACPA did not ask questions relating to its role in the aged care system during the public consultation, stakeholders provided feedback in those areas, including:

- IHACPA's role and responsibilities within the aged care system
- the aged care landscape, funding, and regulatory reform.

2.1 IHACPA's role

Feedback received

Several stakeholders proposed an expansion to IHACPA's role and responsibilities. A peak organisation representing aged care providers called for clarification of IHACPA's role with respect to pricing and costing high-quality care, aligning with aged care reform processes.

Two responses supported IHACPA adopting a more comprehensive role in residential aged care pricing, considering pricing for daily living, accommodation, and care costs, as well as other aspects of pricing, to ensure fairness and transparency.

One response went further and called for the expansion of IHACPA's remit to conduct reviews, research, and analysis, making these findings public and inclusive of all funding sources and federally regulated aged care prices and subsidies.

IHACPA's response

IHACPA is committed to a transparent and consultative approach in the delivery of its aged care functions. IHACPA will continue to use evidence obtained through data analysis and stakeholder engagement to advise on pricing and costing for the delivery of residential aged care and respite aged care services, supporting better outcomes for those receiving care.

IHACPA's evidence-based pricing advice will also support and complement the various regulatory reforms occurring in the aged care system.

The costs in-scope for IHACPA's residential aged care pricing advice (pricing advice) are included in the Schedule of Specified Care and Services (the Schedule) of the *Quality of Care Principles 2014* under section 96-1 of the *Aged Care Act 1997* (Cth). This includes administrative costs directly related to care.

Costs excluded from IHACPA's pricing advice include:

- capital, depreciation and leasing costs, which are funded through refundable accommodation deposits and daily accommodation payments
- costs for extra services, which are funded through extra service fees and costs for additional services, which are funded through additional service fees.

The Department of Health and Aged Care (the Department) and the Aged Care Quality and Safety Commission (the Commission) remain responsible for a range of aged care functions that are outside the scope of IHACPA's remit.

IHACPA's functions relating to pricing advice for Support at Home and the former Aged Care Pricing Commissioner (ACPC) are not in scope for the *Pricing Framework for Australian Residential Aged Care Services 2024–25*.

Further information about IHACPA's role and responsibilities in providing aged care pricing advice is outlined in the Government's Expectations Setting Paper, and IHACPA's Statement of Intent.

2.2 Aged care landscape, funding and regulatory reform

Feedback received

A range of stakeholder groups provided feedback on topics that are currently outside IHACPA's remit for its pricing and costing functions. These included:

- the development of policies focused on addressing and regulating quality and resident wellbeing in residential aged care
- means testing, consumer co-contributions and related policies
- suggestions for other methods of aged care funding, workforce wage rates and capital costs
- the structure of the aged care sector, including the role of government and non-government providers and regional and local governments
- recommendations to support ongoing government-provided capital grant funding for building and upgrading services specialising in care for homeless elderly people
- a more sustainable model to support provider viability and a recommendation to extend the eligibility of the Australian National Aged Care Classification (AN-ACC) Transition Fund to residential aged care services in Modified Monash Model (MMM) categories 3 and 4.

IHACPA's response

IHACPA notes that many of these areas identified in stakeholder feedback are the policy responsibilities of the Department and the Commission and are outside of the scope and remit of IHACPA's pricing and costing functions.

The Department and the Commission have responsibilities for various aspects of the issues raised around the AN-ACC funding model, including care minutes, policy and regulation, data (collection, reporting and monitoring) and workforce matters, including wage rates.

While IHACPA will not provide advice on appropriate wage rates, IHACPA will consider the impact of wages, including increases on costs where these have been determined by the Fair Work Commission.

The Department remains responsible for the level and eligibility thresholds for means-tested care fees, and the policies related to resident contributions and co-contributions. IHACPA will work with the Government to understand the principles and recommendations of the Aged Care Taskforce, including any impact on IHACPA's pricing and costing advice.

IHACPA notes stakeholder feedback regarding grants and will continue to work with the Department to understand how revenue from sources, such as grants and their associated costs, are reflected in IHACPA's pricing and costing advice.

3. Principles for activity based funding in residential aged care

Consultation questions

What, if any, changes do you suggest the Independent Health and Aged Care Pricing Authority (IHACPA) consider for the residential aged care pricing principles?

3.1 General feedback on the residential aged care pricing principles

Feedback received

Of those providing feedback on the residential aged care pricing principles, many stakeholders supported the principles. However, some stakeholders asked for clarity or emphasised specific aspects of these principles for further consideration.

Three submissions were concerned with potential conflicts between the principles, particularly between efficiency and quality, and sought clarity on how conflicting priorities would be balanced. One submission suggested IHACPA align its principles with those of the Aged Care Taskforce for consistency across the sector.

Two submissions suggested that the principles should consider the provision of care in 'thin markets' or remote locations, where economies of scale are not possible.

One submission recommended the principles include a clearer focus on the aged care workforce, emphasising that wages for direct care constitute a significant portion of funding.

IHACPA's response

IHACPA notes stakeholder concerns, and the challenges of balancing multiple principles in developing pricing and costing advice.

IHACPA uses evidence and is transparent in the development of pricing advice for residential aged care and respite care, drawing on a range of data and information.

The residential aged care principles do not have a hierarchy and are used to inform decision making where IHACPA is required to exercise policy judgement in undertaking its functions relating to residential aged care pricing and costing advice.

IHACPA recognises that any response to the issues raised will require a coordinated cross-agency policy approach that spans areas beyond IHACPA's remit and responsibility.

Residential aged care provider viability remains the responsibility of the Department of Health and Aged Care (the Department) in partnership with the Aged Care Quality and Safety Commission (the Commission).The objective of broader sustainability in the aged care sector with respect to the Australian National Aged Care Classification (AN-ACC) funding model is considered and covered by a number of the existing principles, including the overarching principle of 'efficiency', and the system design principles of 'fostering care innovation' and 'promoting value'.

IHACPA notes the potential impacts of workforce challenges but does not recommend any changes to the principles based on this. Stakeholders provided specific suggestions and recommendations to individual principles for IHACPA to consider. This feedback and IHACPA's responses are outlined in sections 3.2 to 3.5.

3.2 Overarching principles

Feedback received	IHACPA's response
Access to care: Funding should support timely and equitable access to appropriate aged care services, for all those who require them.	
Two submissions suggested this principle consider equity of access regardless of geographic factors and location, equitable access to services within or near a person's local community, and the complexity of care needs. One submission added that there should be consideration of access to care for Aboriginal and Torres Strait Islander peoples. Three stakeholders provided a range of suggested changes to the wording of this principle noting that the aged care system offers a wide range of care and support services. One submission noted the principle should be updated to reflect that older people are assessed for the services they require within the aged care system.	IHACPA notes that this principle was updated from feedback received to the *Towards an Aged Care Pricing Framework Consultation Paper 2022* to better reflect the broader equity objectives. IHACPA considers that amendments to this principle are not required at this time.

Quality care: Care should meet the Aged Care Quality Standards, reflect continuous improvement, support resident wellbeing and deliver outcomes that align with community expectations.	
A range of submissions supported this principle. It was recommended in one submission, and raised among other stakeholder groups, that this principle should encompass the clinical, cognitive, and functional needs of residents, recognising their right to choose. A range of submissions stated this principle should ensure cultural safety and recognise Aboriginal and Torres Strait Islander peoples' status and rights. Additionally, it was proposed in one submission that the concept of high-quality care be considered in line with the proposed new Aged Care Act. Aligning the definition of 'quality of care' across the various aged care reforms was suggested. Stakeholders provided a range of suggested changes to the wording of this principle.	The reference to the Aged Care Quality Standards within this principle supports the need for residents to have good quality care that contributes to their safety, health and wellbeing. IHACPA considers that amendments to this principle are not required at this time.
Fairness: Activity based funding (ABF) payments should be fair and equitable, based on resident needs, promote the provision of appropriate care to residents with differing needs, and recognise legitimate and unavoidable cost variations associated with this care. Equivalent services should otherwise attract the same price across different provider types.	
While stakeholders supported this principle, it was emphasised across a range of submissions that the unavoidable and higher costs associated with regional, rural, and remote locations should be considered. Two submissions indicated that the higher costs associated with residents with complex needs and respite care should be considered. Stakeholders raised suggestions related to extra and additional service fees, along with proposed changes to the wording of this principle.	IHACPA acknowledges these stakeholder concerns. It is IHACPA's view that the fairness principle adequately considers the breadth and differences between residential aged care services nationally in respect of resident requirements and the recognition of legitimate and unavoidable costs. IHACPA will leave this principle unchanged.

Efficiency: ABF should ensure the sustainability of the aged care system over time and optimise the value of the public investment in aged care.	
This principle received widespread stakeholder support. One submission highlighted that understanding its implications is crucial, especially in the context of services provided to Aboriginal and Torres Strait Islander peoples who may be located in rural and remote areas and in areas of relative socio-economic disadvantage. Additionally, one submission suggested incorporating 'effectiveness' within this principle. The submission noted the limitations of pricing advice in ensuring sustainability and suggested IHACPA change this principle to reflect its role in 'facilitating' rather than 'ensuring' sustainability.	IHACPA notes the feedback around efficiency, including those related to Aboriginal and Torres Strait Islander peoples in rural and remote areas, and will continue to engage with Aboriginal Torres Strait Islander peoples and organisations representing their views. IHACPA will reword this principle to: "ABF should facilitate the sustainability of the aged care system over time and optimise the value of the public investment in aged care."

Maintaining agreed roles and responsibilities: ABF design should recognise the complementary responsibilities of each government agency and department in the funding and management of aged care services, as well as providers in delivering aged care services.	
Stakeholders supported this principle. One submission suggested that the resident should be included in this principle as an active participant within the system. The stakeholder acknowledged that the growing complexity of care and the interface between systems requires improved coordination. Additionally, they recommended roles could be better defined, and responsibilities reflected within the Pricing Framework for Australian Residential Aged Care Services to avoid negative impacts resulting from the interoperability of public hospitals and the aged care system.	IHACPA will reword this principle to: "ABF design should recognise the complementary responsibilities of each government agency and department in the funding and management of aged care services, as well as recognise the role of providers in delivering aged care services and residents as contributors to their care."

3.3 Process principles

Feedback received	IHACPA's response
Administrative efficiency: Funding arrangements should promote effective and efficient processes and should not unduly increase the administrative burden on aged care providers.	
Many stakeholders provided feedback on this principle. Submissions highlighted that the process of understanding and adapting to a new funding model has increased their administrative burden. It was further noted that the complexity of administration and reporting, meeting regulatory requirements, compliance with mandated care minutes, and associated Quarterly Financial Report reporting compounded this burden.	IHACPA acknowledges this stakeholder feedback and concerns. Issues related to reporting requirements, including those for the AN-ACC funding model, the AN-ACC assessors and the assessment process remain the responsibility of the Department, IHACPA will remain alert to these requirements and not unnecessarily add administrative burden. IHACPA will leave this principle unchanged.
Stability: The payment relativities for ABF should be consistent over time.	
There was overall support for this principle and there were no suggestions for change.	IHACPA acknowledges the responses and will leave this principle unchanged.
Evidence based: Funding should be based on the best available information.	
This principle was supported by stakeholders. It was suggested in one submission that IHACPA ensure pricing advice is informed by appropriate evidence. For example, evidence relevant to and tested against the needs and context of Aboriginal and Torres Strait Islander residents. One submission recommended that funding should be based on the best available information and data. It was also suggested that quality care is unlikely to be achieved if funding only addresses historical costs. It was suggested that IHACPA consider a blended funding approach (historical costs and pricing for quality outcomes) sooner rather than in a transition over time.	IHACPA notes the feedback received and considers this principle integral in providing advice on pricing and costing matters. This process principle illustrates that the best available information is required to adequately reflect the cost of delivering care for all residents within residential aged care services. IHACPA will leave this principle unchanged.

Transparency: All steps in the development of advice for ABF and fixed funding should be clear and transparent.	
This principle was supported by stakeholders. A number of submissions identified the need for increased transparency in several areas including the process for developing the funding model, allocation of residents to classes within AN-ACC, the breakdown of resources required for each class, and the reporting of how aged care providers utilise funding. A few submissions suggested this information be accessible to all stakeholders, including consumers and families, so that stakeholders can understand the rationale for the financial contributions they are asked to make.	IHACPA is committed to the development of ongoing, open and transparent pricing advice, including consultation with a broad range of stakeholders in the aged care system. Further clarification on IHACPA's methodology for developing the Residential Aged Care Pricing Advice (the pricing advice) is provided in the form of the Residential Aged Care Pricing Advice Technical Specifications (the Technical Specifications). The Technical Specifications accompany IHACPA's pricing advice to the Australian Government (the Government) and are published on IHACPA's website. The Department will retain responsibility for policies related to management and regulation of the aged care system and funding models, including the AN-ACC assessment, transparency of aged care provider revenue and expenditure and consumer contributions. IHACPA will leave this principle unchanged.

3.4 System design principles

Feedback received	IHACPA's response
Fostering care innovation: Pricing of aged care services should respond in a timely way to the introduction of evidence-based, effective new technology and innovations in the models of care that improve resident outcomes and service efficiency.	
This principle was supported by a broad range of stakeholders. Four submissions suggested further consideration of how the funding model could foster and incentivise innovation, including actively encouraging the adoption of technology.	IHACPA acknowledges the importance of innovation and stakeholder feedback on this principle. IHACPA will leave this principle unchanged at this time.

Promoting value: Pricing should support innovative practices and systems that deliver efficient, person-centred care.	
Stakeholders, in general, supported this principle. Some stakeholders suggested that an outcome or value-based approach to funding be adopted to better incentivise improved resident outcomes.	IHACPA acknowledges the concerns raised and will continue to seek stakeholder feedback on this issue. IHACPA notes that continued refinements to the AN-ACC funding model over time will ensure funding reflects the cost for delivering care.
One submission proposed modification to the wording of this principle.	IHACPA will leave this principle unchanged at this time.
Promoting harmonisation: Pricing should facilitate best practice, person-centred provision of care in the appropriate setting.	
This principle was in general supported by stakeholders.	IHACPA acknowledges the responses and will leave this principle unchanged.
Minimising undesirable and inadvertent consequences: Pricing should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.	
Stakeholders agreed with this principle. One submission recommended that there should be consideration of measures to ensure that the AN-ACC assessment remains independent.	IHACPA notes that management of workforce engaged to undertake AN-ACC assessments remains the responsibility of the Department. IHACPA will remain alert to indications of susceptibility of the model. IHACPA will leave this principle unchanged.
Using ABF where practicable and appropriate: ABF should be used for funding aged care services wherever practicable and compatible with delivering value in both outcomes and cost.	
Several stakeholders queried whether ABF would provide the funding required to ensure a holistic approach to care environments. One submission requested elaboration on how ABF will work towards supporting the key policy intent behind its development. Another submission sought to understand what the alternatives to ABF are in funding aged care. For example, who can decide that it is not practicable or appropriate?	IHACPA acknowledges stakeholder feedback and concerns. The use of ABF within IHACPA's pricing advice will assist in determining the cost of delivering care. However, IHACPA notes that if it is not practicable or appropriate to use ABF in providing its advice, then other alternatives that are best suited will be included in advice for adjusting the AN-ACC funding model. IHACPA will leave this principle unchanged.

Person-centred: Pricing adjustments should be, as far as is practicable, based on characteristics related to people receiving care, rather than those of providers.	
Some areas for consideration were identified by stakeholders under this principle. One submission suggested that for Aboriginal and Torres Strait Islander aged care services, this principle should include the characteristics of both the people receiving care and the aged care provider. Another submission supported this principle being moved to the 'overarching principles' as the foundation to safe and high-quality care. Furthermore, some stakeholders sought consideration for a more flexible and holistic approach to care that supports the diverse and individual requirements of all people in all locations.	IHACPA notes stakeholder feedback. This principle reflects the considerations raised, specifically the "Fairness principle", which relates to the policy intent of the AN-ACC funding model to generate payments based on the resident's assessed needs. This promotes the provision of appropriate care to residents with differing requirements and recognises legitimate and unavoidable cost variations associated with this care. IHACPA will leave this principle unchanged.

3.5 Suggested additional principles

Feedback received	IHACPA's response
Sustainability	
Whilst the Efficiency principle includes sustainability, a submission proposed that sustainability should be classed as a distinct principle. Another submission noted that with increasing demand on residential aged care services, this distinction may assist in providing a safeguard to the viability of services against potential threats posed by inadequate pricing adjustments.	IHACPA notes stakeholder concerns and that residential aged care provider viability remains the responsibility of the Department in partnership with the Commission. The objective of broader sustainability in the aged care sector with respect to the AN-ACC funding model is considered and covered by a number of the existing principles, including the overarching principle, 'efficiency' and the system design principles 'fostering care innovation' and 'promoting value'. The Department provides numerous financial viability and capability support resources for residential aged care providers on their website. IHACPA will maintain the consideration of efficiency within the current principles as outlined.
Flexibility	
A submission suggested IHACPA consider an additional 'flexibility' principle. It noted this would support the diverse needs of all people in all locations, and the seamless movement of people across types of care and between remote and urban locations.	IHACPA notes this suggestion and considers this is covered by a number of existing principles, including the overarching principles, 'access to care', 'quality care' and 'fairness' and the system design principles, 'promoting harmonisation' and 'person-centred'.

4. Residential aged care funding and the Australian National Aged Care Classification

Consultation questions

- Do the current Australian National Aged Care Classification (AN-ACC) classes group residents in a manner that is relevant to both care and resource utilisation? (That is, require the same degree of resources to support their care delivery). What evidence is there to support your answer?
- What, if any, factors should the Independent Health and Aged Care Pricing Authority (IHACPA) consider in future reviews of the AN-ACC classes?
- Are there any other legitimate or unavoidable costs associated with a permanent resident's stage of care? For example, entry into or departure from a service.
- Are there any other legitimate or unavoidable costs associated with a respite resident's stage of care? What evidence is there to support your answer?

4.1 The Australian National Aged Care Classification residential aged care funding model

Feedback received

One submission emphasised the unique nature of aged care compared with hospitals, where the former provides a home-like environment for residents. The submission suggested that pricing residential aged care services using the AN-ACC funding model encompass a broader understanding of care, rather than mimic a medical or hospital model.

Another submission proposed pricing residential aged care services using the AN-ACC funding model and aligning it with the care minute requirements (and the associated labour costs) for direct care staff.

One submission noted the limitations of a static funding model and care minute requirements against the dynamic care requirements of residents and their changing acuity. This stakeholder noted the challenges in rostering to meet care minute requirements and maintain staffing against fluctuations in funding. The stakeholder proposed a higher level of funding be incorporated into the base care tariff (BCT) to account for this.

Common suggestions were raised by stakeholders regarding allied health and their contribution to residential aged care. Some submissions proposed allied health care minute benchmarks and funding to enable comprehensive assessment, prescribing and delivery.

A range of submissions recommended separate classes or considerations within the AN-ACC funding model for permanent residents transitioning to palliative care. In addition, these stakeholders highlighted the importance of timely reassessments for reclassification of a resident, referencing the higher costs of end-of-life care where a resident dies before a reassessment, resulting in the service being financially disadvantaged.

One submission noted the need for more funding transparency and a clearer definition of compounding factors, particularly regarding how compounding factors are weighted and integrated into assessments and the classification.

IHACPA's response

IHACPA recognises that there are distinct differences between providing care in a hospital setting and the care required within a residential aged care service. IHACPA's aged care pricing and costing advice takes into consideration the home-like nature of residential aged care and is developed specifically for the residential aged care system.

IHACPA notes stakeholder feedback on the AN-ACC funding model and assessment process, and while IHACPA remains alert to the impact of AN-ACC assessment data and care minute requirements, as outlined in Chapter 2, the policy and system management for the AN-ACC assessment process remains the responsibility of the Department of Health and Aged Care. This includes decisions related to the following:

- system management of the AN-ACC funding model, including transparency of compounding factors
- timeliness of AN-ACC assessments and reassessments
- additional requirements for reassessment or movement to specific AN-ACC classes
- calculation, monitoring and reporting of care minute targets along with requests to include care minute requirements for allied health professionals.

4.2 The AN-ACC classes

Feedback received

Many stakeholder groups outlined instances where residents placed in the same AN-ACC class exhibited varying care requirements, necessitating different levels of staff time, equipment, supplies, or technology.

A number of submissions identified conditions and care requirements that they believe systematically lead to cost differences within classes, including dementia and cognitive impairment, palliative/end-of-life care, and other specific complex conditions or care requirements. These are described separately below.

Various stakeholders recommended future reviews and refinement of the AN-ACC classes to:

- incorporate more comprehensive clinical and non-clinical indicators of need
- introduce a new AN-ACC class for residents with higher level care requirements
- reflect new evidence and data as it becomes available
- recognise that clinical practice and service delivery change over time
- recognise that non-clinical care requirements were not included in the development of the AN-ACC classes, but have resource implications and these should be factored in.

To enhance monitoring, a submission suggested improved data collection, building on existing Aged Care Financial Report and Quarterly Financial Report reporting processes to enable analyses of activity and cost data and identify cost variations within AN-ACC classes and across different residential aged care provider types.

Independent mobility with medium or low cognitive ability

Of particular concern for a number of stakeholders was that the current AN-ACC classes do not account for the diverse and complex care requirements of individuals with dementia or a cognitive impairment who are mobile and exhibit challenging behaviours.

Some submissions recommended a separate class for residents diagnosed with a cognitive impairment or a diagnosis of dementia to sufficiently reflect the higher resource use in providing care to these residents.

Some stakeholders proposed an approach that considers cognitive and behavioural factors, both in the classification process and in the allocation of funding.

Representation of other indicators of higher complex requirements

A number of submissions emphasised that the AN-ACC classes do not group residents in a way that adequately captures variations in resident complexity or allow accurate reporting variations in cost to inform the development of price weights, particularly in relation to:

- mental illness, particularly when residents experience episodes of psychosis
- multiple comorbidities and/or dependence on multiple staff for support
- residents with a history of contact with the justice system and incarceration
- refugees
- veterans, and those requiring trauma-informed care
- residents with a history of out-of-home care
- residents with a history of homelessness.

These stakeholders noted the necessity for a more nuanced and comprehensive classification system that captures the diverse and complex care requirements of aged care residents.

Some stakeholders recommended a range of further work to achieve this, including conducting additional cost data collections, subdividing existing classes, and introducing a new AN-ACC class ("Class 14") that is specifically tailored to individuals with very high or complex care requirements.

Palliative care costs

A range of stakeholders suggested the requirements of residents in palliative and end-of-life care present additional financial pressures on residential aged care providers, as they involve complex administrative tasks and emotional support for residents and their families. While there is an AN-ACC class for palliative care at intake, there is not one for permanent residents transitioning to palliative care.

IHACPA's response

IHACPA acknowledges stakeholder concerns that pricing residential aged care services using the AN-ACC funding model should reflect the variation in the cost of care across the different classes and that the classes group residents with similar levels of resourcing requirements.

IHACPA conducted the 2023 Residential Aged Care Costing Study (RACCS). The resident-level cost data collected in this study, along with other relevant data, is being used to inform the development of pricing advice. Over time, IHACPA will enhance and further develop additional cost data collections. This will support advice on updates to the AN-ACC national weighted activity unit (NWAU) values.

IHACPA notes the diverse range of care requirements of residents within residential aged care services.

IHACPA will continue to develop and refine data collections to enable assessment of the level and complexity of need and the associated groups of residents' resourcing requirements to ensure relative homogeneity in resident resource utilisation within each AN-ACC class.

Pricing adjustments may be considered where classification refinement cannot fully account for legitimate and unavoidable costs for certain cohorts.

4.3 AN-ACC entry adjustment payments and consideration of exit adjustment payment

Feedback received

Initial entry adjustment payment for entry into permanent residential aged care

A number of submissions made proposals for an adequate initial entry adjustment payment (entry payment) for residents entering permanent residential care. Some submissions contended that the existing entry payment, while welcome, does not cover the actual resourcing requirements.

Stakeholders noted an entry payment is relevant for both clinical and non-clinical activities required to transition residents to permanent care. Stakeholders identified that non-clinical activities are currently not adequately factored into the price. Examples provided by stakeholders included assessing the residents' spiritual and cultural requirements, documenting the residents' life stories, planning for dietary requirements, assessing risks, and liaising with families during the transition process.

A submission suggested that transfer of long-term hospital patients to residential care may be more complicated, and the costs of this should be investigated. The stakeholder recommended that the entry payment be adjusted for complexity of the resident, rather than be a fixed amount for all residents.

Consideration of exit adjustment payment for residential aged care

A range of submissions noted that exiting residential care incurs additional expenses and this should be integrated into the AN-ACC funding model.

A few submissions noted that certain tasks are currently underfunded, including preparing handover documentation, addressing room-related damages, and handling items left behind by departing residents. A stakeholder noted that these costs are increasing due to shorter stays and increased resident turnover.

One-off adjustments for transitions within a residential aged care service

While some stakeholders acknowledged the need to minimise the re-classification of

residents to reduce administrative burden, a few stakeholders contended that there are some transitions within an aged care service that need to be recognised. Examples provided by stakeholders included transfer to a memory support unit or transfer to and from a hospital.

IHACPA's response

IHACPA notes the diverse range and care requirements of residents within residential aged care, including those related to entry and exit.

When designing future cost data collections, IHACPA will continue to seek to better understand any costs associated with a permanent resident's stage of care, including the costs associated with entry and exit from a residential aged care service.

4.4 Residential respite care

Feedback received

Stakeholders supported the introduction of respite classes and encouraged continued refinement of the funding model in this respect.

While some stakeholders noted that a distinction between respite and permanent care should be retained, one stakeholder suggested that the classes could be amalgamated or better aligned to simplify the system and recognise consistent resourcing requirements.

There was support from some stakeholders for the introduction of an initial entry payment for respite care corresponding to that of permanent residents entering care.

Some stakeholders noted that respite onboarding costs may even be higher than permanent residents and attributed this to:

- respite residents often present with complex health requirements requiring greater resourcing on entry
- costs of bed vacancies and higher administration costs generated by higher resident turnover and gaps between respite bookings.

Stakeholders proposed incentives for residential respite aged care providers to make available opportunities for respite care, with one stakeholder characterising respite as a loss-leading activity for the residential respite aged care provider that enabled people to 'try before they buy'. Another stakeholder noted that current market pressures result in residential respite aged care providers giving preference to permanent resident places over respite care.

One submission proposed that the care costs for respite residents are, at the very least, equal to those of permanent residents, and therefore, price weights should be adjusted accordingly.

There was a view from some stakeholders that cost data collections should be undertaken to assess the adequacy of current funding for respite care, especially given the anticipated increases in the level of respite care required in the future.

IHACPA's response

IHACPA notes the feedback provided on AN-ACC respite classes, the views provided on the alignment of these classes with permanent residents, and the proposal for an entry payment for residential respite care.

Residents assigned to the respite AN-ACC classes were included in the 2023 Residential Aged Care Costing Study (RACCS). The RACCS included a sample of respite residents, and this cohort will continue to be a focus of future studies.

IHACPA will seek to expand the sample size through future cost data collections to increase the extent of data captured for respite residents. This is intended to enable refinement of the AN-ACC funding model for residential respite, to ensure it reflects the costs of residential respite care.

IHACPA will continue to monitor and review resource utilisation and costs for residents assigned to AN-ACC respite classes when providing advice on the refinement of the classification and providing future costing advice.

In undertaking pricing and cost data collections for residential respite care, IHACPA will consider the feedback provided by stakeholders and further engage with advisory committees and stakeholders to determine priorities for future consideration.

5. Developing residential aged care pricing advice

Consultation questions

- What, if any, considerations should the Independent Health and Aged Care Pricing Authority (IHACPA) seek to review in its indexation methodology for its residential aged care pricing advice?

5.1 What the residential aged care price covers

Feedback received

While IHACPA did not ask questions on what the residential aged care price covers or should cover, stakeholders provided feedback on the following issues.

Several stakeholders questioned the boundaries of the cost categories. There was a view from one stakeholder that some everyday living and accommodation costs should be considered as care costs, whereas some care costs related to personal lifestyle preferences could better be considered as hotel costs.

Some stakeholders highlighted concerns that the current price does not enable residential aged care providers to make a fair return on investment. Various submissions emphasised that pricing levels should encourage further capital investment, including emerging technologies, service innovations and infrastructure to meet growth in demand.

Several stakeholders recommended that the residential aged care price cover a range of health care costs associated with:

- medication, dental and related oral health
- telehealth supports
- medical supplies and nutritional supplements.

IHACPA's response

IHACPA notes the feedback provided in submissions. IHACPA's pricing advice is reviewed annually, is evidence-based and developed transparently to reflect the available cost and activity data and other relevant information.

IHACPA's aged care pricing and costing functions, including the in-scope costs for pricing advice, are outlined in the Australian Government's (the Government's) Expectations Setting Paper and IHACPA's Statement of Intent.

The recommended residential aged care price is intended to cover the cost of care. Elements of care in-scope for the recommended Australian National Aged Care Classification (AN-ACC) price are specified under Parts 2 and 3 of the Schedule of Specified Care and Services (the Schedule) of the *Quality of Care Principles 2014* under section 96-1 of the *Aged Care Act 1997* (Cth).

IHACPA notes that the following costs are excluded from IHACPA's AN-ACC pricing advice:

- capital, depreciation and leasing costs, which are funded through refundable accommodation deposits and daily accommodation payments
- costs for extra services, which are funded through extra service fees (paid by residents)
- costs for additional services, which are funded through additional service fees (paid by residents)
- hotel costs included in Part 1 of Schedule 1—Care and services for residential care services (the Schedule) of the *Quality of Care Principles 2014* under section 96-1 of the *Aged Care Act 1997* (Cth).

Further clarity on the scope of inclusions is provided in the form of the Residential Aged Care Pricing Advice Technical Specifications that accompany IHACPA's pricing advice to the Government.

IHACPA's role in providing pricing advice includes a requirement for advice on the gap between the costs of delivering required hotel services, and specific types of revenues received. The hotelling supplement rate is set by the Government and paid per resident per day.

IHACPA will remain cognisant of the feedback as data collections develop and mature.

5.2 The pricing approach and level

Feedback received

Some submissions were concerned that the current *Pricing Framework for Australian Residential Aged Care Services 2023–24* and costing methodology are not adequately aligned to the proposed new draft Aged Care Act, and the price is insufficient to provide a level of care that meets the Aged Care Quality Standards.

Stakeholders referred to the need for an uplift in pricing levels to enable high-quality care to be delivered and to support best practice and service innovation.

A submission proposed that for nursing care, the current price does not reflect the necessary direct care time for best practice. Additionally, another submission noted a lack of guidance on appropriate levels of direct allied health to promote multidisciplinary models of care, indicating that service costing based on existing levels is insufficient.

In addition to clinical care, a stakeholder expressed the need for the price to support care focused on the lifestyle choices, social engagement requirements and pastoral care preferences of residents in promoting their wellbeing. Other stakeholders noted similar concerns.

A number of submissions noted that infection prevention and control measures introduced during the COVID-19 pandemic are now common practice and that related additional costs should be reflected in pricing decisions.

Training and ongoing workforce development and support was cited by many stakeholders as being important for promoting quality care, with some stakeholders concerned residential aged care providers will reduce investment unless this cost overhead is reflected in the pricing level.

A few stakeholders reported that administration costs for compliance with the new funding, regulatory and service delivery systems have not been reflected in pricing levels.

IHACPA's response

IHACPA recognises the need for residential aged care providers to deliver services that meet the Aged Care Quality Standards, and that the pricing advice will be informed by available and emerging evidence-based data sources. As the Government is developing a new Aged Care Act, IHACPA will continue to ensure that the pricing advice is reflective of these changes.

IHACPA will utilise resident-level cost data collections, updated data from the Aged Care Financial Report (ACFR), the Quarterly Financial Report (QFR) and other relevant information to develop pricing advice that will be informed by the costs of delivering care and how these may change over time. Annual public consultation and engagement with advisory groups and stakeholders will inform how IHACPA balances residential aged care pricing approaches and develops pricing and costing models over time.

Where allied health services are included in Schedule 1—Care and services for residential care services (the Schedule) of the *Quality of Care Principles 2014* under section 96-1 of the *Aged Care Act 1997* (Cth), their costs are in-scope for AN-ACC pricing and costing. Regular cost data collections will support the recognition of allied health costs in AN-ACC pricing, enabling AN-ACC funding to be responsive to changes in underlying models of care.

Administrative costs to meet regulatory and compliance requirements are included in Parts 2 and 3 of the Schedule of Specified Care and Services and are therefore in-scope for IHACPA's pricing advice.

IHACPA notes the feedback in response to the costs of infection prevention and control measures introduced during the COVID-19 pandemic. Infection prevention and control are covered under the Aged Care Quality Standards. Additional funding through the Department of Health and Aged Care (the Department) to address COVID-19 costs are currently covered under the Aged Care Outbreak Management Supplement. IHACPA considers that the ongoing costs of managing COVID-19 and other illness outbreaks will be reflected in the ACFR, the QFR and other cost data collected by IHACPA. This will inform the future development of pricing.

5.3 Indexation

Feedback received

Whilst stakeholders broadly supported the changes to the indexation methodology for IHACPA's *Residential Aged Care Pricing Advice 2023–24*, a few submissions indicated that ongoing transparency and consultation is required to identify and establish further refinement.

Many stakeholders noted that labour costs and weighting of wages should be considered in the development of the indexation methodology.

Many stakeholders raised concerns about the lag between changes in costs and indexation advice to the Government. While there was broad support for more timely recognition of costs, there were mixed views on how to achieve this, with some stakeholders advocating for:

- a more dynamic indexation methodology involving more frequent indexation, including out-of-cycle advice based on Fair Work Commission wage decisions and more frequent reference to input cost indices
- a retrospective adjustment to indexation that reflects any previous year under or over estimation of changes of costs
- a prospective approach to indexation that avoids underfunding by reflecting historical trends in costs and building in anticipated changes in costs (noting the impact of the COVID-19 pandemic).

A variety of stakeholders suggested that IHACPA review the rationale for differences in the approach to indexation for residential aged care and other sectors, including the public hospital sector and the National Disability Insurance Scheme and those recommended by the Royal Commission into Aged Care Quality and Safety. In relation to non-wage cost indexation, there was broad stakeholder support for an approach that looks beyond the existing Consumer Price Index based methodology, with stakeholders noting the aged care sector has experienced cost increases beyond general inflation.

A few stakeholders noted concerns that indexation in previous years under previous funding models has not been adequate and recommended a price correction to avoid

compounding the problem through future indexation.

IHACPA's response

IHACPA notes stakeholder feedback and has, within its current indexation methodology, accounted for areas stakeholders have identified as concerns. In addition, IHACPA will reflect the available Fair Work Commission decisions on wage rises and annual wage growth trends in its pricing advice. IHACPA will, if requested by the Minister for Health and Aged Care, update previously finalised advice to reflect new Fair Work Commission decisions outside of the IHACPA pricing advice cycle through supplementary advice. The Government's Expectations Setting Paper anticipates scenarios involving out of cycle updates and outlines the approach.

IHACPA's annual pricing advice indexation methodology will continue to be refined over time, to account for new data collection through IHACPA's longitudinal cost data collections and time series cost data collected through the ACFR and QFR, reflecting cost growth over time. In addition, this methodology will be informed by feedback from advisory committees and the public consultation.

6. Adjustments to the recommended price

Consultation questions

- What, if any, additional cost variations are associated with the provision of care to residents who require specialised services? What evidence is there to support this?
- What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariff (BCT) weighting?
- What, if any, evidence or considerations will support the Independent Health and Aged Care Pricing Authority's (IHACPA) longer-term development path for safety and quality of the Australian National Aged Care Classification (AN-ACC) and its associated adjustments?

6.1 Adjusting for resident characteristics

Feedback received

Stakeholders recommended the cost of care delivery for the following resident related characteristics be considered as basis for an adjustment to the recommended price:

- Aboriginal and/or Torres Strait Islander status
- cultural and linguistic diversity
- dementia/cognitive impairment
- mental illness
- specific complex conditions or care requirements (including wound management, tracheostomy or ventilation)
- other factors leading to higher costs, including the requirement for specialised care and equipment.

Adjustment for Aboriginal and Torres Strait Islander peoples

A range of submissions suggested the need for an adjustment for Aboriginal and Torres Strait Islander peoples to account for increased care costs.

In addition, a few stakeholders advised that cultural considerations for Aboriginal and Torres Strait Islander peoples include translators and cultural interpreters in the preparation of care plans, support for cultural activities, allowance for culturally appropriate design in resident environments within the service, and coverage of travel, transport, and medical costs for end-of-life care to be provided on Country or in the community.

One submission supported the inclusion of Aboriginal and Torres Strait Islander peoples in the specialised BCT. However, this stakeholder suggested that the BCT should be accessible to all Aboriginal and Torres Strait Islander peoples regardless of the Modified Monash Model (MMM) classification of the residential aged care service.

Adjustment for people from culturally and linguistically diverse backgrounds

A range of submissions recommended pricing adjustments to accommodate individuals from culturally and linguistically diverse backgrounds, noting additional costs associated with translation and interpreter services, specialised staff training and culturally-specific food and activities.

Adjustment for people with dementia, cognitive impairment or behavioural issues

Several stakeholders commented on the higher costs of residents with dementia, cognitive impairment and/or behavioural issues. Some of these stakeholders recommended a review of AN-ACC classes to better reflect the care requirements of these individuals. Additionally, one submission recommended a bed-based supplement for this group and another suggested an adjustment for services specialising in the care of this cohort.

Adjustment for people with mental illness

The need to consider adjustments for the additional costs related to residents presenting with complex mental health issues was highlighted by numerous stakeholders. The additional costs include specialist staff training and education to ensure staff safety and a safe environment for the residents.

Adjustments for other factors

A range of stakeholders recommended additional adjustments for residents requiring specialised care and equipment, such as:

- bariatric care
- nutritional supplement management
- complex wound management
- complex pain management
- falls prevention management
- tracheostomy or ventilation care
- assistive technologies
- specialised supplies and equipment.

One submission proposed lump-sum payments for specialist equipment provision and additional payments to cover the costs of delivering specialised care, including costs of higher staffing levels.

IHACPA's response

Adjustment for Aboriginal and Torres Strait Islander peoples

The differential BCTs for residential aged care providers specialising in care for Aboriginal and Torres Strait Islander peoples are a starting point designed to address the different care requirements for these residents.

IHACPA notes feedback that differential BCTs, or other pricing adjustments may be required for Aboriginal and Torres Strait Islander peoples residing in services not eligible for a specialist BCT to ensure equity in access to effective culturally appropriate care. IHACPA will continue to consult with Aboriginal and Torres Strait Islander peoples, and organisations representing them as well as residential aged care providers specialising in care to Aboriginal and Torres Strait Islander people, prior to recommending any refinements to the AN-ACC funding model and pricing. It will be important to ensure future cost data collections are representative of these specialist facilities and consideration is given to person-centred adjustments where possible.

Adjustment for people with dementia, cognitive impairment, or behavioural issues

IHACPA notes general support for better recognition of the requirements of residents with cognitive impairment and/or challenging behaviours.

To provide an evidence base for future advice on refinement of price adjustments, IHACPA will work with stakeholders and its advisory committees to ensure appropriate inclusion of relevant residents in future cost data collections.

Adjustment for people from culturally and linguistically diverse backgrounds, people with mental illness, and other factors

IHACPA notes the diverse range and care requirements of residents within residential aged care services. IHACPA will work to understand the range of evidence and data that may support recommendations to further refinements to the AN-ACC funding model for certain cohorts. It will be important to group residents with similar resource requirements so pricing advice can be better formulated to reflect the costs of care. Pricing adjustments may be considered in the future where it is evident that classification refinement cannot fully account for legitimate and unavoidable cost variations for certain cohorts.

6.2 Adjusting for unavoidable service factors

Feedback received

Adjustment relating to non-metropolitan locations

A stakeholder supported adjustments in the residential aged care price to account for the higher costs associated with providing aged care services in small rural towns and remote communities (MMM categories 5 to 7).

Many stakeholder groups noted the following higher costs associated with care provided in rural and remote areas:

- salaries paid to staff to attract and retain them, including securing appropriate accommodation
- training and onboarding resulting from greater staff turnover
- contractor and/or locum staff to fill roster gaps
- greater reliance on visiting services for some categories of staff (for example, allied health)
- implementing technologies, such as telehealth and remote monitoring, to compensate for lack of local specialists
- utility costs (which may be prone to fluctuation) and limitations in areas without access to energy grids
- medical supplies, equipment and services
- maintaining infrastructure, such as call bells and IT systems
- maintenance of specialised equipment
- building, maintaining or leasing suitable services.

Several stakeholders suggested the current adjustments for location incorrectly assume uniform service delivery across MMM 1 to 4 categories, stating:

- MMM 2 to 4 categories encounter similar cost challenges to those in MMM 5 to 7 (as listed above)
- a public hospital nearby increases rather than decreases costs for residential aged care services, due to the competition with the government sector for staff.

Some stakeholders recommended the introduction of progressively higher rates in the BCT for MMM 2 to 7, with the highest rates applying to the most remote areas. It was proposed this measure be put in place as an interim measure while a comprehensive costing study is undertaken.

A range of stakeholders noted that the MMM classification is not suitable to differentiate the operating and capital costs across geographic areas. Some stakeholders reported that the MMM is used inconsistently across government, while others recommended IHACPA explore the suitability of the Australian Statistical Geography Standard and the National Disability Insurance Scheme Isolated Towns Adjustment as alternatives to the MMM classification.

Adjustment relating to other geographic factors

A stakeholder proposed differential pricing and costing adjustments by state and territory, to reflect the differential costs associated with operating services in different jurisdictions.

Characteristics of jurisdictions identified by stakeholders that potentially contribute to higher costs of delivery included differences in population dispersion, uniqueness of the population and differences in legislation or regulation.

It was recommended that IHACPA undertake cost data collections to determine the materiality of differences in the costs of delivering aged care services between jurisdictions.

Adjustment relating to service size

A submission suggested that in recent years, although the total number of residential aged care providers has remained relatively stable, the number of smaller residential aged care providers (those with fewer than 61 places) has decreased, while the number of larger residential aged care providers (those with more than 100 places) has increased.

Various stakeholders recommended funding adjustments for smaller residential aged care providers. They noted that smaller residential aged care providers may have difficulty remaining financially viable under existing conditions. They argued that it is important to address the challenges faced by smaller residential aged care providers to prevent a 'one-size-fits-all' model, which may compromise the person-centred principle of aged care.

Stakeholders also noted that if smaller residential aged care providers exit the market, this could result in certain regions lacking any access to residential aged care services, placing additional pressure on local public hospital services.

Adjustments relating to service financial structure

Several submissions identified that the exemption from payroll taxes afforded to not-for-profit residential aged care providers has created a financial imbalance in the aged care sector. They noted that if this is not rectified, it may undermine competitive neutrality, potentially reducing sector efficiency and increasing costs to taxpayers.

These submissions proposed arrangements that would renumerate residential aged care providers subject to payroll tax in the short-term, thereby reducing the current financial burden on for-profit residential aged care providers. In the longer-term, the goal would be to exempt all aged care providers from payroll tax through collaborative arrangements with the states and territories. In the interim, it was recommended that IHACPA incorporate the costs related to payroll taxes by for-profit residential aged care providers into its cost data analyses.

Adjustments relating to specialised role of the residential aged care provider

Stakeholders recommended funding adjustments for services specialising in providing aged care to:

- Aboriginal and Torres Strait Islander peoples
- people at risk of or experiencing homelessness
- people with higher complexity, including those living with dementia/cognitive impairment and/or challenging behaviours.

In relation to services specialising in the care of older Aboriginal and Torres Strait Islander peoples, some stakeholders proposed an adjustment for services operating in MMM 1 to 5 regions, in addition to the existing adjustments for MMM 6 and 7 communities.

These stakeholders suggested it would help to accommodate the specific care needs and costs associated with delivering culturally appropriate aged care to Aboriginal and Torres Strait Islander peoples across various regions, including urban areas, and to improve aged care accessibility for Aboriginal and Torres Strait Islander communities. Stakeholders noted this would provide a focus on fairness, cultural sensitivity, and addressing the complex care requirements for some Aboriginal and Torres Strait Islander peoples.

One submission identified that the withdrawal of Homeless and Viability Supplements may pose financial viability concerns for residential aged care providers specialising in the care of people at risk of or experiencing

homelessness. This stakeholder recommended specific Government-funded capital grants for building aged care homes for the residents experiencing or at risk of homelessness.

A stakeholder recommended funding be based on ‘operational places’ rather than ‘occupied places’, allowing residential aged care providers to offer essential services without being restricted by the number of residents in their care. This stakeholder also recommended the inclusion of recreation and diversional therapists as eligible roles for these services when calculating mandatory care minute requirements.

A submission identified instances where state governments are providing services for populations where private market solutions fall short, namely residents with complex physical, cognitive and/or challenging behaviours. These models come with higher operating costs due to their unique service structures.

To address the additional costs of these services, stakeholders argued for an adjustment for services with a high proportion of their residents with above average complexity. The adjustment would be contingent on evidence regarding the proportion of residents with high complexity. It would be aimed at achieving increased staff ratios, employing appropriately skilled staff, ensuring purposely designed environments, providing proactive and specialised support for advanced dementia care, and managing challenging behaviours for the safety of residents and staff while reducing the use of psychotropic medications.

IHACPA’s response

Adjustments relating to non-metropolitan location

The 2023 Residential Aged Care Costing Study captured data across the MMM classifications and was utilised in IHACPA's development of the *Residential Aged Care Pricing Advice 2024–25* (the Pricing Advice).

IHACPA reviewed the existing BCTs covering non-specialised services in the MMM 1-5. IHACPA’s analysis showed variability in costs across MMMs and that the existing BCTs do not adequately address these differences in terms of funding.

IHACPA’s advice includes replacing the current BCT categories (Standard MMM 1-4 and Standard MMM 5) with three BCT categories, those being Standard MMM 1, Standard MMM 2-3 and Standard MMM 4-5. IHACPA has not proposed changes to the BCTs for Standard MMM 6-7 or specialised services (Specialised homeless and Specialised Aboriginal or Torres Strait Islander MMMs 6 and 7).

IHACPA’s annual data collection will increase in sample size over time, improving data availability for facilities across the MMM classifications. This will provide IHACPA with an expanded evidence base for pricing and costing advice and recommendations on refinements to the BCT categories, including those for remote, rural and regional services.

Adjustments relating to service size

IHACPA will consider evidence relating to adjustments which support stable funding of services. Consideration will be given to factors that may have a significant impact on the cost of delivering care while also ensuring consideration for the AN-ACC funding model to ensure it does not unduly incentivise certain business structures or sizes.

Adjustment relating to other geographic factors

The AN-ACC funding model is a national model and uses a single AN-ACC price that is multiplied by the AN-ACC national weighted activity units (NWAU). IHACPA will consider available information on cost growth but is not considering the development of multiple indexation rates or AN-ACC prices based on different jurisdictions.

Adjustments relating to service financial structure

IHACPA notes this stakeholder feedback, however IHACPA’s pricing advice will remain in line with the principle of ‘Fairness‘, where pricing advice should be fair and equitable, based on

resident requirements, promote the provision of appropriate care to residents with differing requirements, and recognise legitimate and unavoidable cost variations associated with this care. Equivalent services should otherwise attract the same price across different residential aged care provider types.

The state and territory governments remain responsible for the policies regarding payroll tax, and thus remains out of scope for IHACPA's pricing advice.

Adjustments relating to specialised role of the residential aged care provider

Service-related adjustments should account for unavoidable factors that have a significant impact on the cost of delivering care. Currently, remote services receive a BCT based on approved beds, rather than per occupied bed day, due to their low and variable occupancy. Future cost data collections will seek to identify legitimate and unavoidable costs associated with particular types of services and, if needed, recommend potential options and additional adjustments to address these.

6.3 One-off adjustments

Feedback received

One-off adjustments for unforeseen events

A stakeholder identified unforeseen events such as natural disasters (for example, floods) challenge the existing funding model as they may result in higher costs and resource requirements to residential aged care providers. Stakeholders noted insurance premiums had increased significantly over the past 12 months, and stakeholders were unsure about how this would be accounted for within IHACPA's pricing advice.

IHACPA's response

IHACPA recognises that there may be unforeseen circumstances that may influence a provider's costs. The Department of Health and Aged Care (the Department) remains responsible for additional supplements in such situations and retains joint responsibility for sector viability with the Aged Care Quality and Safety Commission (the Commission).

6.4 Adjusting for safety and quality

Feedback received

Stakeholders supported the development of safety and quality adjustments within the AN-ACC funding model. A stakeholder emphasised that these adjustments should not be punitive, instead should provide support for residential aged care providers to achieve high levels of quality care.

One submission proposed tying any adjustments to resident outcomes to outcomes that are under the control of services and their workforce.

Another stakeholder was keen to ensure that any unintended negative consequences of risk-adjusted funding are avoided, while still encouraging the delivery of high-quality care.

This stakeholder contended that the pricing methodologies employed in the hospital sector might not be directly transferrable to aged care and noted the inherent challenge of distinguishing adverse events from the natural progression of age-related conditions. It was also noted that in the context of aged care, supporting residents' self-determination remains an important priority, even if the activities they choose may introduce inherent risks.

Another submission suggested that to select appropriate areas of focus for safety and quality adjustments, IHACPA should:

- evaluate complaints data and quality indicators

- consider international evidence on classification approaches that link funding to quality outcomes
- consult with consumers, aged care providers, workforce representatives and other stakeholders in a transparent fashion.

A few stakeholders identified the necessity for incentives that promote innovation in care and service delivery. Some stakeholders noted concerns that funding based on the AN-ACC model may hinder the introduction of innovative care and services and argued that it might not allow for investment beyond the essential costs of current care delivery.

Accountability and transparency were highlighted by several stakeholders. They advocated for strong reporting and accountability measures, specifically in relation to safety and quality adjustments.

There was collective recognition for the need to continually monitor and evaluate the AN-ACC system to ensure that safe, high-quality care is consistently delivered.

IHACPA's response

IHACPA will work with the Department and the Commission to ensure IHACPA's approach to advice on pricing safety and quality adjustments is complementary to other reforms and compliance activities.

IHACPA acknowledges that adjusting for quality and safety will take time and will continue to engage with stakeholders through its advisory committees, working groups and through public consultation to inform priorities and develop a plan for implementing safety and quality pricing adjustments.

7. Pricing and costing for other aged care programs

7.1 Multi-Purpose Services

Consultation questions

- How could, or should the Australian National Aged Care Classification (AN-ACC) model be modified to be used for Multi-Purpose Services (MPS) and are there any factors that aren't accounted for under the AN-ACC model?
- How could, or should the AN-ACC model be modified to be used for National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and are there any factors that aren't accounted for under the AN-ACC model?

Feedback received

Numerous stakeholders had reservations on modifying the AN-ACC funding model to fund MPS. Whilst stakeholders supported initial in-principle analysis, other stakeholders were not supportive of modifying the AN-ACC, acknowledging the differences between stand-alone residential aged care services and MPS.

Funding flexibility

Numerous stakeholders expressed concerns to ensure that the existing flexibility in the MPS funding model is maintained, noting that MPS receive funding through a flexible care subsidy from the Australian Government for aged care services and state and territory government funding for health services, capital and infrastructure costs. This flexible funding enables MPS to provide a mix of acute care, residential aged care, respite care and community care and support.

A variety of stakeholders referred to circumstances where staff and services are flexibly utilised across service functions, underlining the importance of being able to pool resources to meet fluctuating service demands in the community. One stakeholder noted support for a more holistic view to funding where pricing would reflect each component of MPS service delivery.

A submission recommended the Independent Health and Aged Care Pricing Authority (IHACPA) include MPS in hospital activity reporting and the dataset for the National Hospital Cost Data Collection to allow a better understanding of the cost profile of MPS care recipients before introducing any changes to existing funding model arrangements.

Adequate funding

Stakeholders recommended funding levels meet the full costs of delivering aged care through MPS. A few stakeholders noted that existing AN-ACC prices would result in a deficit for aged care services provided by small regional and remote MPS sites.

These stakeholders supported building upon existing costing studies, such as the *Aged Care In MPS: Response to the Australian*

Government Terms of Reference (2019)[1], to better understand the range of costs to MPS and establish prices that reflect the true costs of MPS.

A range of stakeholders noted concerns to the financial viability of smaller sites or those within 'thin markets' or remote locations. These stakeholders suggested that block funding may better support MPS and provide funding assurance that fixed costs would be adequately covered regardless of occupancy.

A few submissions identified appropriate indexation as being important. Another submission recommended IHACPA await recommendations from the Multi-Purpose Services Working Group and its Services Funding Subgroup in considering its pricing advice.

Impact of infrastructure

A number of stakeholders identified the variation in infrastructure utilised by MPS, including stand-alone services and those co-located and integrated into hospital facilities. These stakeholders indicated that this impacts the care costs faced by services. Another stakeholder recommended that further modelling should be undertaken with a wide sample of MPS to understand variations across jurisdictions, regions and sites prior to modification of the funding model.

Stakeholders also recommended that if funding for MPS is transitioned to an AN-ACC like funding model, it should be based on the number of approved places rather than actual occupancy.

Impact of workforce

A variety of submissions identified workforce concerns within MPS, including increased wages to attract and retain staff, difficulty in recruiting permanent staff leading to high use of agency and locum staff, as well as a lack of skill mix or appropriately trained aged care staff.

Stakeholders suggested that although direct care minutes established through AN-ACC had the potential to ensure the correct skill mix for MPS, additional staffing resources would be required. A stakeholder recommended minimum staffing requirements to deliver safe care be explicit within each AN-ACC class for MPS.

Changes to classes

Stakeholders proposed changes to the AN-ACC classes to better suit the nature of MPS. One stakeholder proposed that additional AN-ACC classes could be introduced that reflect the wider range of residents typical to MPS, including residents with complex behaviours, and non-clinical and psychosocial requirements that influence care requirements and resource utilisation. The stakeholder also suggested that price loadings could be applied to existing AN-ACC classes to better align with the different cost structures of MPS.

IHACPA's response

IHACPA notes the feedback related to fixed costs, fluctuating occupancy, and requests for continued flexibility to meet the requirements of their community for MPS, and those in residential aged care or receiving in-home aged care services.

IHACPA acknowledges the impact of workforce shortages within the aged care sector, particularly in rural and remote locations. While IHACPA will not assess appropriateness of wages within the aged care system, it will seek to understand reported wage costs and cost growth along with any location specific issues.

IHACPA will continue its commitment to ongoing collaboration with stakeholders, including jurisdictions, to understand requirements of any funding model advice for MPS residential aged care in the medium to long-term and what adjustments or

[1] Review of the Multi-Purpose Services Program | Australian Government Department of Health and Aged Care

refinements may be required to ensure the model is fit for purpose. This will consider the interaction of the aged care, health, and disability systems and funding models, particularly referencing how this may differ in regional, rural, and remote areas.

7.2 National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Feedback received

Feedback received from stakeholders on the appropriateness of an AN-ACC like funding model for NATSIFACP services was mixed.

Whilst some stakeholders supported a move to an AN-ACC based funding model, many stakeholders were cautious, communicating concerns and considerations for how the funding model could be configured to provide funding certainty to aged care providers within the NATSIFACP.

Some stakeholders did not support a move away from existing grant funding. One stakeholder noted concerns with adapting the AN-ACC funding model to meet the requirements of NATSIFACP funded services.

Consultation and partnership

Several stakeholders identified the importance of consulting with Aboriginal and Torres Strait Islander stakeholders when considering any change to the funding model to ensure their requirements are best met through the provision of high quality, culturally appropriate, and trauma informed services.

One submission recommended any future funding model should be codesigned in partnership with the Aboriginal and Torres Strait Islander Aged Care Commissioner, the Aboriginal Community Controlled sector and services delivering aged care to Aboriginal and Torres Strait Islander peoples.

Cultural safety

A high priority for stakeholders was to ensure, irrespective of the model, funding supports culturally-safe care and allows services to meet the cultural, social, emotional, and health requirements of Aboriginal and Torres Strait Islander peoples. Stakeholders identified that this includes consideration of any additional costs and resources that may be associated in providing culturally-safe care.

Funding flexibility and certainty

Several stakeholders identified concerns with a move from block funding, due to the risk of reduced funding flexibility and certainty that an AN-ACC transition may impact NATSIFACP services, particularly those in small remote communities.

One submission highlighted the importance of funding flexibility for service viability given the diversity of service models, changing requirements of residents and fluctuating levels of demand in transient populations.

It was identified by a variety of stakeholders that the Royal Commission into Aged Care Quality and Safety recognised the importance of block funding and flexibility to the security and sustainability of the Aboriginal and Torres Strait Islander aged care pathway.

A stakeholder identified that for services funded under AN-ACC as Specialised Aboriginal and Torres Strait Islander services, funding is less flexible given it only covers direct care, whereas NATSIFACP integrates basic daily living and other service funding with capital funding provided through grants.

There was a view from one stakeholder that block funding provides reduced administrative burden as well as cost savings for Aboriginal Community Controlled Health Organisations (ACCHO), with the ability to pool funds across a range of services, including aged care.

Review of funding implications

A number of stakeholders were cautious about the impact of a transition to an AN-ACC-like funding model on existing NATSIFACP services, recommending IHACPA consider various cost implications, including:

- a review of the real costs that existing NATSIFACP services face in delivering care in rural and remote areas. Stakeholders noted that increased funding levels were provided to services under the AN-ACC model that were not passed onto NATSIFACP services, and an uplift may be justified in any transition to a funding model based on AN-ACC
- comparison of each component of the current NATSIFACP funding model with the respective component of the AN-ACC model to establish where funding challenges may occur. Stakeholders identified that while NATSIFACP funded services may operate under similar arrangements to AN-ACC Specialised Aboriginal and Torres Strait Islander services in remote areas, there may be significant funding implications for services in other geographical locations
- undertaking a costing study of the variety of care arrangements currently being provided by NATSIFACP services. A stakeholder identified that each service is likely to be providing different care arrangements and programs for their care recipients and the funding model will need to reflect impacts on costs.

Other considerations

The following considerations were recommended by several stakeholders for the potential transition of NATSIFACP to an alternative AN-ACC-like funding model, including:

- use of culturally appropriate, evidence-based methods when proposing any modification to the AN-ACC model in relation to Aboriginal and Torres Strait Islander peoples
- maintenance of block funding during the transition to an alternative funding model
- supplementation of funding for Specialised Aboriginal and Torres Strait Islander services to account for delays in resident assessment in remote areas
- expansion of Specialised Aboriginal and Torres Strait Islander services to include services located in Modified Monash Model (MMM) categories 1 to 5 with an appropriate funding uplift
- funding of services based on allocated resident places rather than actual residents or occupancy
- establishing a dedicated capital grants program for regions categorised as MMM 6 and 7. Stakeholders proposing this program would provide financial support to remote services for infrastructure development
- funding arrangements that encourage the entry of ACCHOs into residential aged care service provision.

IHACPA's response

IHACPA notes the range of recommendations and concerns, including those related to high costs, fluctuating occupancy, and a need for flexibility within the NATSIFACP.

In providing advice to the Government, IHACPA will seek to understand through scoping projects and studies the appropriateness of an AN-ACC type funding model and any relevant adjustments and refinements.

IHACPA will continue to consult with Aboriginal and Torres Strait Islander peoples and their representative organisations to assess suitability.

7.3 Costing studies

Feedback received

Stakeholders emphasised the importance of developing a more efficient and streamlined data collection and reporting infrastructure to track costing variation within and between AN-ACC classes. Noted by stakeholders was the importance of cost data collections to better inform future advice on developments and adjustments to AN-ACC.

Stakeholders further identified the need for costing of residential aged care services so that future pricing better reflects the costs of providing high-quality care. In addition to the

need for ongoing costing, stakeholders recommended cost data collections and cost analysis focused on the areas outlined below.

Specific resident cohorts: A submission noted that some residents require special attention and proposed cost data collections that focus on residents who:

- are mobile and cognitively impaired
- have a history of drug or alcohol use
- are at risk of homelessness
- display responsive behaviours
- require complex wound management.

Stakeholders proposed these studies would help establish a nuanced understanding of the resource utilisation and associated costs for these distinct groups.

Psychosocial factors: One stakeholder identified concerns that the current AN-ACC classes may not adequately account for residents with specific psychosocial requirements and recommended that these requirements be better captured and costed in ongoing costing studies. This stakeholder noted that residents could potentially disrupt the overall resource allocation balance within certain AN-ACC classes. This concern stems from the limited representation of these cohorts in the initial studies that informed the development of the AN-ACC funding model.

High-quality care: A stakeholder recommended costing best practice in aged care unconstrained by current funding levels to incorporate what the aged care industry aspires to be in the future, and to bring alignment with the draft new Aged Care Act, the Aged Care Quality Standards, and other planned industry reforms. Another stakeholder requested clarification to gain an understanding of the factors that distinguish 4 or 5 star rated aged care services from the 3-star rated services. Stakeholders proposed studies that assess residential aged care provider quality, with a particular emphasis on staffing levels, as staffing has a key role in service quality.

Compliance costs: a submission identified that service compliance with regulations and the Aged Care Quality Standards is a significant component of aged care, and it is essential that these costs are analysed.

Comprehensive account of costs: A submission identified concerns that cost data collections have been too focused on direct care at the detriment of indirect care. Stakeholders recommended ensuring indirect care activities are included in these studies. Case conferences, incident management, reporting, family enquiries, resident and family consultation, reporting, analysis, reviews, and notifications were noted for consideration.

Differential costs associated with geography, size, financial structure, and specialised role: A variety of stakeholders recommended costing analysis to determine any cost differentials, including by metropolitan versus rural or remote location, jurisdiction, service size, residential aged care provider financial structure and specialised residential aged care provider role. One submission recommended representative samples of each of these groups are required in costing studies.

Allied health services: A stakeholder suggested that costing studies consider the care provided by allied health professionals, differentiate services by discipline, and assess whether the allied health professional is an employee or a contractor.

The stakeholders noted this will ensure that pricing accurately reflects the costs associated with the allied health requirements of residents. Stakeholders wanted to ensure that sites providing multidisciplinary models of care are adequately represented in costing studies.

Palliative care: It was suggested by a stakeholder that costing studies measure the costs associated with implementing best practice guidelines for palliative care to ensure an appropriate level of support for residents, reducing the individuals to be transferred to hospital.

Death of a resident: The activities required when a resident dies, including appropriate care for their remains, family communication, legal notifications, and property transfer were identified by a stakeholder.

IHACPA's response

IHACPA notes stakeholder recommendations regarding future priorities for costing studies. The 2023 Residential Aged Care Costing Study (RACCS) was the first of what will be many cost data collections for residential aged care and residential respite care.

IHACPA will build and refine this initial data set over time, including through supplementary cost data collections, to ensure IHACPA's pricing advice remains relevant, and is evidence-based.

In general:

- IHACPA aims to improve costing and data points, to better understand the costs of care for various resident cohorts
- the Aged Care Quality and Safety Commission (the Commission) remain responsible for the assessment and monitoring of quality of care and services provided against the Aged Care Quality Standards, as well as the Star Ratings. However, IHACPA will continue to work with the Commission to better align high-quality care in future cost data collections
- future cost data collections, including the Residential Aged Care Cost Collection 2024 will allow IHACPA to better understand the costs of care in residential respite
- the 2023 RACCS captured the costs of care provided by allied health. In addition, the Quarterly Financial Report now distinguishes between allied health professions, enabling IHACPA to better understand the costs of care provided by allied health professions when undertaking future cost data collections
- self-reported service characteristics were captured for specialisation in the 2023 RACCS, and other aspects will continue to be explored in expanded cost data collections in the future
- the journey of a resident and their variants in costs will be considered in future cost data collections. An increased sample size and breadth from cost data collections will assist in capturing the nuances of these changes
- whilst the 2023 RACCS has initially captured the cost of indirect care provided by staff, future studies will consider how to better understand the costs of indirect care at the resident level
- the Department of Health and Aged Care remain responsible for monitoring any impacts new regulatory changes have on the residential aged care and respite sector.

Appendix A: List of stakeholders

The stakeholders that made submissions in response to *the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25* have been outlined below, except where respondents have been kept confidential due to commercial or other reasons.

- Aboriginal Community Elders Services Inc
- Aged and Community Care Providers Association Ltd
- Aged Care Crisis Inc
- Aged Care Workforce Remote Accord
- Allied Health Professionals Australia
- Alpha Global
- Anglicare Australia
- Anglicare Sydney
- Australian Association of Gerontology
- Australian Dental Association
- Australian Institute of Health and Welfare
- Australian Medical Association
- Australian Nursing and Midwifery Federation
- Australian Unity
- Baptist Care Australia
- Bolton Clarke
- BUPA
- Carinya Home for the Aged
- Catholic Healthcare
- Dementia Australia
- Grandton Limited
- Hall & Prior
- HammondCare
- Homestyle Aged Care
- Hon Amber-Jade Sanderson MLA, Minister for Health, and Mental Health WA
- Hon Chris Picton MP, Minister for Health and Wellbeing SA
- Hon Ryan Park MP, Minister for Health, and Minister for Regional Health NSW
- Hon Selena Uibo, former Minister for Health NT
- Hon Shannon Fentiman MP, Minister for Health, Mental Health and Ambulance Services and Minister for Women QLD
- La Trobe Valley Village
- National Aboriginal and Torres Strait Islander Ageing and Aged Care Council
- National Aboriginal Community Controlled Health Organisation
- National Rural Health Alliance
- Queensland Dementia, Ageing and Frailty Clinical Network
- Ryman Healthcare
- SA Oral Health Plan Monitoring Group
- Seniors Dental Care Australia
- Speech Pathology Australia
- St Basil's Homes
- Tasmania Department of Health
- Telstra Health
- Uniting Care Australia
- Uniting Care Queensland
- University of Melbourne
- University of Tasmania
- University of Technology Sydney
- ValleyView Residence & Riverview Residence Collie Inc
- Victorian Department of Health
- Victorian Public Sector Residential Aged Care Leadership Committee
- WA Country Health Service
- Whiddon Aged Care
- Wintringham
- Fourteen confidential submissions.

IHACPA

Independent Health and Aged Care Pricing Authority

Eora Nation, Level 12, 1 Oxford Street
Sydney NSW 2000

Phone 02 8215 1100
Email enquiries.ihacpa@ihacpa.gov.au

www.ihacpa.gov.au