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Joanne Fitzgerald
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Dear Ms Fitzgerald

Thank you for the opportunity to comment on the Independent Health and Aged Care Pricing Authority's (IHACPA) consultation paper: *Towards an Aged Care Pricing Framework* (Consultation Paper). Victoria looks forward to working with IHACPA on the development of the pricing framework and the overall reform of the sector. Please refer to the enclosure for Victoria's response to the Consultation Paper.

Victoria has 178 public sector residential aged care facilities, which is approximately 12 per cent of all residential aged care places in Victoria. These facilities are an important component of the overall public health and wellbeing system in Victoria, providing care to many aged care residents and contributing to efficient flow of patients within hospitals.

If you have any queries about Victoria's response, please contact Ms Lucy Solier, Director, Funding Policy and Accountability at the Department of Health on 03 9821 6006 or at lucy.solier@health.vic.gov.au.

Yours sincerely

Andrew Haywood
Executive Director
Funding Policy, Accountability and Data Insights
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VICTORIA State Government

Enclosure: Response to Consultation Questions

Question	Response
What, if any, may be the challenges in using the AN-ACC to support activity-based funding (ABF) in residential aged care?	Victoria considers there are three core areas which may present challenges in using the AN-ACC to support ABF in residential aged: resident complexity; data limitations and in considering the needs of residents beyond clinical care. These are further highlighted below. **Resident complexity** The cohort of people using residential aged care is becoming more complex over time, as people remain in their own homes for longer and enter residential aged care services at a higher level of acuity. The AN-ACC classification system and activity-based funding model will need to remain agile enough to respond to these shifts in complexity. The binary split of classes into 'with and without compounding factors' may not appropriately capture variations in resident needs, now and into the future. Victoria therefore considers there is likely to be a requirement to continue to review the classification system and the assessment tools in order to capture variations in cost. **Data limitations** As identified in the consultation paper, nationally consistent cost data at a resident level is a key building block of a successful activity-based funding system. The data and information technology systems for a large proportion of public sector residential aged care service (PSRACS) providers in Victoria (about 12 per cent of all beds in the state) limits our capacity to provide the data as requested by IHACPA. Most of the PSRACS beds in Victoria are in small organisations that will face challenges in implementing new systems. The consultation paper outlines a series of costing studies to assist with the challenges of collecting resident-level data. Victoria's PSRACS have volunteered to be included in these studies and Victoria will continue to advocate for their inclusion, to ensure that the costing studies are inclusive and representative of the arguably unique cohorts and facility types offered by public sector facilities. PSRACs are often providers of care for residents with more complex care needs, and price weights will need to reflect the costs of providing care to these groups. The focus on more provision of care at home will mean that complexity and frailty of older people entering residential care will continue to increase, and the AN-ACC will need to be able to respond to this complexity. This will need to go beyond the current focus on homelessness and First Nations, for example giving due consideration to residents with a justice history, adults who have or were in out of home care, refugees, and/or veterans. **Beyond clinical care**

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	As highlighted in the Royal Commission as a fundamental tenet of care for people residing in residential aged care, it is important that costs include more than clinical care and provide for an individual's interests as well as an environment that is safe and stimulating - physically, culturally, intellectually and emotionally. A future challenge may be how to incorporate and recognise the provision of activities that support residents' wellbeing. Victoria recommends that consideration also be given to incentives in the model, or in allocated costs, to proactive care including secondary prevention, with a focus on keeping people well for as long as possible. This might include greater access to allied health and specialist oversight, consistent with other Royal Commission recommendations. While some aspects might be captured by the Medicare Benefits Schedule, there may be other costs which are not and will need to be covered, such as transport to attend appointments, administration and coordination of care. If not addressed, these costs may provide barriers to providing and improving the care model.
What, if any, concerns do you have about the ability of AN-ACC to support long term improvement in the delivery of residential aged care in Australia that is efficient, sustainable and safe?	It is difficult to comment on whether, or how much, AN-ACC will be able to support improvement in the delivery of residential aged care noting that AN-ACC is one of many reforms impacting the delivery of residential aged care. Key measures of its success will include its ability to deliver financial viability to the sector and drive increases in the quality of care. It will be important for IHACPA to continue to monitor and adjust the funding model in response to corresponding data to deliver these aims. Further work is underway in response to the recommendations arising from the Royal Commission, which will result in changes to the roles and responsibilities of aged care providers to provide additional care and supports for residents, with one example being greater provision of palliative care in place. It will be important that AN-ACC reflect these other reforms to ensure there are no barriers to care as intended.
What, if any, additional factors should be considered in determining the AN-ACC NWAU weightings for residents?	Victoria agrees with the assertion in the consultation paper that the approach to normative pricing of safety and quality and workforce will be important in the first few instances of AN-ACC weights. Victoria recommends additional factors to be considered should include the requirement to recognise needs beyond clinical care and respond to the individual's wellbeing. Further, there are likely to be cohorts that require additional funding recognition due to their complexity or particular needs. These may include those with mental illness, those who experienced out of home care, veterans, refugees or people with a justice history.
What should be considered in developing future refinements to the AN-ACC assessment and funding model?	Victoria recommends that future refinements should be made to the funding model as more data becomes available, noting that the currently available data is limited. As the integrated assessment model being proposed by the Commonwealth is still unclear in its design and commissioning, Victoria is not able to comment further at this time.
What, if any, changes do you suggest to the proposed principles to guide	Victoria considers the process principles of administrative ease, stability, evidence-based and transparency are sound. We note that it may take some time for PSRACS to update information technology systems to support an ABF framework.

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the development and operation of the Pricing Framework for Australian Aged Care Services?	Victoria considers the system design principles are sound and support a recipient-based pricing model.
What, if any, additional principles should be included in the pricing principles for aged care services?	Victoria considers the principles set forward in the paper are sound. Trade-offs between principles are likely to be required and how these trade-offs will be handled is not clear. Victoria considers that changes to the AN-ACC model which add or remove financial signals to providers should only be included when the signal is linked to an outcome that is fully within the control of the provider. Victoria notes that it will be important to consider how to support a resident's wellbeing as well as their care, with pricing reflecting support for a resident's interests. A system design principle could be included to reflect this.
What, if any, concerns do you have about this definition of a residential care price?	Victoria is supportive of this definition of a residential care price. Victoria supports the inclusion of an element of normative pricing while the sector re-skills and moves towards a new higher level of safety and quality of care following the Royal Commission.
What, if any, concerns do you have about the proposed pricing approach and level of the residential aged care price?	Victoria considers the use of input pricing should have clear criteria for its cessation. While Victoria considers the approach set out in the Consultation Paper is sensible in the short term, it would be useful to define the criteria for when input pricing will cease, and an efficient price be set.
What should be considered in the development of an indexation methodology for the residential aged care price?	Workforce costs comprise the majority of operational costs for aged care facilities. A transparent methodology to bring forward current day costs for wages to the present-day prices and deal with the lag in these costs being captured, reported, and analysed using a cost data collection would reduce financial risk on providers.
What, if any, additional issues do you see in developing the recommended residential aged care price?	Nil.
What, if any, changes are required to the proposed approach to adjustments?	Victoria considers the framework set out in the Consultation Paper of adjustments being included if they are evidence based and transparent is sound. We note that the additional concept of legitimate and unavoidable variations in cost may be subjective and that it would be useful to define where legitimate and unavoidable variations in cost will be considered and not considered. For example, geographic drivers of wages to attract staff.

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	The current use of adjustments to provide a higher weight for facilities with specialist programs is not transparent as framed. The higher weight is explained as linked to the specialist program because this is a 'catch all' label or facility designation for a range of other characteristics. This is also linked to the residents at the facility. It would be preferable if this adjustment was not applied to the facility but incorporated in the price for the resident.
What, if any, additional adjustments may be needed to address higher costs of care related to resident characteristics?	As per the response to the question *What, if any, may be the challenges in using the AN-ACC to support activity-based funding (ABF) in residential aged care?* Victoria notes there are a number of cohorts that may require additional recognition in the AN-ACC. These include: people with a history of significant mental illness; those who have a history of contact with the justice system and incarceration; refugees; veterans, or adults who experienced out of home care. Victoria notes that as these are relatively small groups in the population, it may well be that they have been under-represented in the cost-studies to date and that other groups may also emerge in subsequent data and costing studies. Victoria considers that the AN-ACC should be agile enough to respond to increased needs and complexity of care for these groups.
What should be considered in reviewing the adjustments based on facility location and remoteness?	Victoria considers the review of the adjustments should include a statistical analysis of costs for specific elements of care that are associated with facility location and remoteness. For example, if a facility is in a remote area but is part of a larger network of facilities the cost structures may be different than for stand-alone facilities in a remote area or a small number of facilities that are all in remote areas.
How should any adjustments for quality and safety issues be considered in the long-term development path of AN-ACC and the associated adjustments?	In line with our comments on the proposed principles, adjustments should only be linked to resident outcomes that are wholly within the control of the organisation and the usual practice of its workforce. If adjustments are included in the model, they must be for events that are able to be prevented or outcomes that are achieved which are entirely predictable as a result of actions taken. Events that occur despite actions to prevent them should not be subject to penalties or bonuses for the facility.
What should be considered in future refinements to the residential respite classification and funding model?	Victoria is supportive of a continued refinement of the funding model for respite care. As older people stay at home longer in the community, carers and family members will continue to rely heavily on respite to support their own health and wellbeing. The focus on mobility alone as a cost driver seems simplistic. As an example, a carer looking after someone with dementia may not be attractive to the provider as they attract the lowest level of funding. The funding model for respite must continue to be attractive for providers and should include similar domains to those entering care permanently. In addition, as for those entering permanent residential aged care, it may be appropriate to recognise those entering respite care for the first time.
How might workforce challenges present in the implementation and	AN-ACC as an activity-based funding model is new to residential aged care providers, an area that has not traditionally had strong information technology support systems and management skills. It will be an additional data burden which will be exacerbated

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refinement of AN-ACC for the aged care system?	with additional costing studies. The introduction of AN-ACC should not lead to diversion of staff from care activities to meet data or information requirements. The drive for a better model and the data resources needs to be matched to what the sector can absorb as part of the many reforms. The current system favours facilities that can dedicate resources focussed on assessment and managing the associated paperwork. Facilities that can support the data requirements through economies of scale should not gain a funding bonus through their resident casemix being better represented in AN-ACC than those facilities that are unable to participate. This is an important aspect of equity.
What areas should be included in the proposed five-year vision for IHACPA's aged care pricing advice?	To assist with investment in data collection systems, Victoria notes it would be useful to have a multi-year pathway of minimum expectations for the collection and submission of cost data for AN-ACC. This would allow investment over an agreed time period and flag important changes such as an understanding of when the method of pricing will shift away from inclusion of normative elements to efficient care provision.
What would be considered markers of success in IHACPA's aged care costing and pricing work?	An even and equitable cost recovery of facilities after adjustment of quality of care, safety and resident casemix, and facility remoteness would be a marker of success for the AN-ACC model in technical terms and should see greater financial viability of many residential aged care providers. This may be a metric that ensures many of the proposed principles have been met.