Q-1 What, if any, changes do you suggest the Independent Health and Aged Care Pricing Authority (IHACPA) consider for the residential aged care pricing principles?

- No recommendation on the current pricing principles.

Q-2 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?

- The AN-ACC classes do group residents relevant to their care needs; however, resource utilisation can vary for residents who are classified in the same AN-ACC class leading to a higher cost of care delivery.
  Two specific examples include:
  1. Two residents who are both allocated Class 8 with lower cognitive ability, one may have challenging behaviours requiring more care intervention and time spent keeping the resident and others safe vs another resident who may be very quiet and withdrawn and require little staff time to support. Both these residents would receive the same amount of funding despite the significant difference in cost to deliver care.
  2. Two residents with complex care requirements who are allocated Class 5. One resident could require complex wound management that takes extra staff time and requires the provider to purchase expensive wound dressings/products vs another resident that may require daily injections and possibly some pressure area care. Both these residents would receive the same amount of funding despite the significant difference in cost to deliver care.

Q-3 What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?

- The revised care minutes requirements effective from 1st October 2023 substantially increased the care minute requirements for higher acuity residents, thereby increasing the cost of providing care to these residents. As the AN-ACC funding model stands now, there is no incentive for residential aged care providers to focus on higher acuity residents. In fact, serving higher acuity residents carries higher ancillary costs for providers, such as infrastructure costs (e.g. larger rooms to accommodate lifters) and administrative costs (e.g. higher marketing and onboarding costs due to the shorter tenancy of higher acuity residents). This presents particular challenges for older homes, smaller homes and homes located in MMM3 and MMM4 areas. Given the straitened finances of most residential aged care providers and the workforce challenges rampant in the industry, providers have a much greater incentive to serve lower acuity residents than higher acuity ones.

Q-4 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.

- The current arrangement of fixed, variable and adjustment components is addressing the entry of residents into services.
- The current palliative care arrangements for residents who deteriorate while in care do not always cover the increasing cost of care, particularly where residents deteriorate quickly. While the reclassification reassessment scheduling from Assessment Management Organisations (AMOs) for residents who require palliative care has improved with the introduction of the escalation process through email to the Department of Health, there are still many instances where residents deteriorate and pass away on lower AN-ACC classifications as the AMOs were not able to complete reassessment prior to the resident passing away. The resource utilisation to provide the necessary palliative care increases significantly and can be long lasting – the Department of Health should implement a streamlined palliative care reassessment declaration process to address this issue in a more timely way.

Q-5 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?

- Unlike permanent residents, there is no one-off payment for respite residents to help with one-off cost associated with the new admission. The department believes that the respite funding is sufficient to cover all the cost. However, often respite stays are shorter than two weeks, which means that the cost associated with

the new respite admission is not fully recovered. The one-off payment for admissions should be extended to respite residents.

- The fractured nature of the programs and mechanisms that fund residential aged care providers, along with the uncoordinated regulatory compliance and reporting requirements, imposes significant administrative costs on aged care providers. A unified funding mechanism with unified reporting requirements would reduce the administrative burden on residential aged care providers and leave more resources for resident care.

Q-6 What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?

- IHACPA should more carefully consider the QFR submission data semi regional homes in MMM3 and MMM4. The cost of providing care in these areas are noticeably higher than in metropolitan areas.
- IHACPA should provide greater clarity and commentary on the calculations used to arrive at a given year's indexation amount. In particular, indexation appears to include an implicit efficiency target, in addition to compensation for price increases. It would help to understand what that target is and IHACPA's view on how it might be achieved. The continuing erosion in residential aged care margins across the industry suggests that these targets may not be achievable.
- IHACPA should base indexation on price changes to the goods and services specific to the operation of residential aged care services, rather than on general inflation figures which may not reflect underlying financial realities faced by residential aged care providers.

Q-7 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?

- Similar to supplements available for the costs associated with oxygen and enteral feeding, the below specialised services should be considered when assessing funding classification variances:
    - Delivery of specific Allied Health Services (physiotherapy, dietetic services, podiatry etc)
    - Dementia Support Services requiring multidisciplinary input into care due to the complex issues involved
    - Complex wound management
    - Complex pain management interventions and services
    - Nutritional supplement management
    - Falls prevention management

Q-8 What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariffs (BCT) weighting?

- The main cost which is not currently addressed in the BCT weighting is the additional staffing cost associated with providing care in MMM3 and MMM4 locations. Workforce in these homes is a significant challenge and providers are often forced to fill shifts by sourcing agency staff from nearby metropolitan. In addition to higher compensation costs, providers must also pay for agency staff travel, accommodation, and meal cost. Two of our homes, on in Coffs Harbour and one in Wentworth Falls, spent over $10,000 per month on agency staff and accommodation. Agency staff costs, particularly in the case when penalty rates apply, are not covered by the BCT.
- Additionally, some homes in MMM4 areas are unable to find General Practitioners to look after residents. This negatively impacts occupancy as providers can't accommodate new admission without a GP. For some locations, providers are currently paying GPs to attend their residents. There is no funding provision or grant currently available to address these issues. Our home in Forbes spent $201,331 in FY23 for locum doctors.
- Medication packaging is an area of increasing costs for providers, and one for which no additional funding is provided.

Q-9 What, if any, evidence or considerations will support IHACPA's longer term development path for safety and quality of AN-ACC and its associated adjustments?

- We believe IHACPA should consider the challenges aged care providers are currently facing in the MMM3 and MMM4 locations. In the past 18 months, we have closed two residential aged care homes and have reduced operational capacity (taken beds offline) in two others. In terms of long-term sustainability in regional areas, IHACPA should consider how many aged care providers have made similar decisions to close homes or take beds offline in order to remain viable.