Secretary

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Michael Pervan
Chief Executive Officer
Independent Health and Aged Care Pricing Authority
Via e-mail: submissions.ihacpa@ihacpa.gov.au

Dear Professor Pervan

Thank you for the invitation to comment on the Independent Health and Aged Care Pricing Authority's Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25.

Victoria looks forward to continuing to work with the Independent Health and Aged Care Pricing Authority on the development and refinement of the pricing framework and funding model for the aged care sector. Please refer to the enclosed submission for Victoria's response to the consultation paper.

Victoria has 172 public sector residential aged care facilities, approximately 12% of all residential aged care places in Victoria. They provide care to many aged care residents and contribute to the efficient flow of patients accessing hospital services. Victoria's submission references these facilities, which are a very important component of the overall public health and wellbeing system in Victoria.

If you have any queries about Victoria's response, please contact Andrew Haywood, Executive Director, Funding Policy, Accountability and Data Insights at the Department of Health on [redacted] or at [redacted].

Yours sincerely

Jacinda de Witts
Acting Secretary

15/08/2023

Encl.

Victoria's response to the Independent Health and Aged Care Pricing Authority's Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25.

Question	**Response - Victoria**
What, if any, changes do you suggest the Independent Health and Aged Care Pricing Authority (IHACPA) consider for the residential aged care pricing principles?	Victoria considers the principles described in the Consultation Paper are sound, however notes that trade-offs between principles are likely to be required and how these trade-offs will be handled requires further explanation by IHACPA.
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 resource to support their care delivery). What evidence is there to support your answer?	Victoria recommends IHACPA consider and use the data from the costing studies to assess if additional clinical and social factors should be included in the methodology to allocate residents to an AN-ACC class, or if additional AN-ACC classes are required. Victoria considers that residents with higher clinical complexity or particular psycho-social needs may not be appropriately captured in AN-ACC and that these residents could be disrupting the resource homogeneity profile of some AN-ACC classes. The basis of this assertion is the under-sampling of these cohorts in the original studies used to develop AN-ACC. Residents that Victoria considers are particularly at risk are those with mental health illness, those who experienced out of home care, veterans, refugees or people with a justice or disability history. While these residents are a very small percentage of the overall resident population, they comprise a significant proportion of residents in Victorian Public Sector Residential Aged Care Services (PSRACS), especially those that focus their services on people with mental health illness.
What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?	Victoria is supportive of a continued refinement of the funding model for respite care. As older people stay in their home longer, 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 for respite class allocation seems simplistic and could have implications for families requiring respite. As an example, a resident with dementia, but who is fully mobile and safe at home, may not be attractive for a residential provider due to the low NWAU but the high resource costs to settle them into a new environment and ensure they are safe in an unfamiliar place. The pricing model for respite must continue to be financially attractive for providers so they accept a growing number of respite residents. In addition, in a similar manner as for permanent residents, it may be appropriate to include an adjustment for respite residents who are entering respite care for the first time.

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Question	**Response - Victoria**
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 cohort of residents in Victoria's PSRACS providers are different from the average resident cohort. The PSRACS cohort includes a higher proportion of people who have a history of significant mental illness, those who have a history of contact with the justice system and incarceration, refugees, veterans, disabled people or adults who experienced out of home care. While these groups are only a small proportion of the overall residential aged care population of residents, they comprise a significant proportion of the population of residents in PSRACS. The additional costs of these residents are experienced at all stages of these people's stay with aged care; at the time of entering aged care and also as part of daily care and support. The costs associated with introducing a resident to an aged care facility are recognised in AN-ACC with an adjustment. The current adjustment is a flat amount that is not further adjusted for the complexity of the resident. This seems to be an appropriate arrangement for a facility that will only infrequently accommodate a complex resident. The structure of a flat amount, based on the average resident complexity, is not appropriate for facilities that have a high proportion of their residents with above average complexity. IHACPA should consider assessing the data collected through its costing study for any differential costs of resident's entering aged care based on their complexity (as measured by AN-ACC).
What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?	Workforce costs comprise most 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. Over time it is may be possible to assess the accuracy of the current indexation policy as cost data is repeatedly collected, financial data is submitted and wages paid is known. Victoria would like to see IHACPA undertake to assess and publish the accuracy of its indexation methodology and models and to continue to refine and improve the approach.
What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariffs (BCT) weighting?	Victoria considers the review of the adjustments should include a statistical analysis of costs for specific elements of care that are associated with a facility's location, remoteness and the structure and size of any parent organisation. 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 the Base Care Tariff is considered may have an impact on MPS services and careful consideration needs to be given to the interaction of Base Care Tariff changes and the sustainability of MPS providers.

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Question	**Response - Victoria**
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?	Victorian recommends 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.
How could, or should the 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?	AN-ACC was developed as a funding tool for residential aged care. Multi-Purpose Services provide residential aged care as well as community care and acute care. The Aged Care Royal Commission noted the Multi-Purpose Services model was able to meet small community needs due to the flexibility in the funding model. Victoria notes that AN-ACC does not provide funding flexibility and was not designed as an alternative funding model for the community and acute care sectors. Victoria recommends that IHACPA await recommendations from the Commonwealth Multi-Purpose Services Working Group and Multi-Purpose Services Funding Sub Group.

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