	WACHS Unit / Name			
	IHACPA consultation question	**Page**	**Related pages**	**Comments**
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?	10	11	The funding principles should consider and support the provision of care where economies of scale are not supported such as for smaller providers and thin markets/remote locations. For example, there is an empirical accounting understanding that to breakeven for aged care regional and remote providers need more than 60 residents to come within the nationally adjusted price. The number of aged care residences in rural and remote WACHS sites have lower bed numbers and therefore are at risk of not being sustainable.
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?	14	13 - 15	For rural and remote locations AN-ACC needs to consider cost of staff retention, additional employment positions, i.e., accommodation, FIFO models that are being used more often to attract staff and maintain legislated staffing levels. It also needs to consider technology used in the delivery of care.
3	What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?	14	13-14	Inclusion in resident assessments the predicted allied health service need. All tools currently focus on nursing and ADL support needs and risks. Tools utilised to not capture predicted allied health service needs for residents in terms of maintenance of function or address of function decline. Additionally, WACHS recommends a shadow price environment should be continued for a minimum of two years so that true cost of service can be understood, and a review of the AN-ACC conducted more thoroughly.
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.	16	13-16	Fixed cost at rural and remote sites are considerably higher than their metro counterparts. The price of care and the cost of delivery of aged care is complex and multidimensional in a rural and remote setting and activity data should take this into account. With the new AN-ACC price weight being identified as NWAU how will it differentiate between the existing WAUs given that it will be a mixed delivery of services such as in an MPS model.
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?	17	17	As above.
6	What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?	20	19 - 20	In rural and remote, the cost of labour has a premium attached that needs to be reflected in the indexation. Comparative systems pricing, most notably the NDIS (allied health, support workers etc). IHACPA will need to maintain contemporary pricing with other service systems. Refer to NDIS Price Guide.
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?	23	22-23	Adjustments for residents who have a need for higher intensity allied health services. This would require inclusion of allied health needs assessment in individual patient categories. Support is provided for categories identified including dementia/cognitive impairment, complex care, specialised equipment. Additional categories for consideration include residence with degenerative disorders (who requirement maintenance therapies), mental health conditions, and complex behavioural support needs. Additionally, high cognitive care needs do not necessarily corollate to high mobility needs. Currently AN-ACC model may not adequately reflect the clinical journey of residents with cognitive decline. Telehealth specialist appointments require onsite clinical staff to attend – cost associated with staff support-clinical notes as evidence of staff support. Family meetings – clinical notes as evidence.
8	What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariffs (BCT) weighting?	23	22 -23	MMM does not accurately reflect the complexities (and exceptions) of individual communities. The NDIS utilised the MMM to identify price loading and has made a number of exception/adjustments to the MMM for specific locations to better reflect the higher costs of service delivery (in WA the NDIS has adjusted the MMM ratings for Merredin, Kalgoorlie and Geraldton. Further, the MMM classification should not be the sole indicator to account for site location cost differences as sites within the same MMM classification can have very different locations, service requirements and costs. For example, Exmouth and Meekatharra are both classified as MMM7 and have very similar capacity and service profiles. However, Meekatharra demonstrates a unit cost almost three times that of Exmouth largely due to its

				isolated location and lack of community infrastructure, compared to Exmouth which is a more supporting infrastructure and is in a higher traffic location despite being classed as MMM7. BCT also needs to consider service models and method weight accordingly. For example – for residential facilities in remote locations, allied health services are not available in the local community, with the allied health professional needing to travel to the facility. The costs of travel can be significant in terms of the allied health professionals time and the cost of travel itself (e.g. petrol, flights etc). For example, allied health professionals flying from Perth to Port Hedland and return - would require 6+hours of travel time for the AHP + the cost of flights which would be upwards of $1,000 return. Additional costs would be incurred for multiday visits (accommodation). The Delivery of Aged Care Services in Remote and Regional WA does not fall in the "efficiency price model" parameters. The document identifies and notes on page 36 that "there are significant differences between the public hospital and residential aged care systems that require specific consideration". Some of the characteristics to note and consider are: • Hospital stay characteristics: Short term; and, Episodic. • Aged Care service characteristics: Length of stay cannot be determined; Residents' needs increase as length of stay increases; and, Residents' have varied needs: Cultural needs; Health needs, Mental health; etc. Additionally, high cognitive care needs do not necessarily corollate to high mobility needs and this needs to be reflected in the AN-ACC model.
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?	24	22-24	Assurances that residential facilities are providing optimal allied health services to residence. There is currently minimal guidance (in terms of minutes). With quarterly reporting there is opportunity to provide future advice on benchmarks for allied health services.
10	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?	26	26	WACHS is not supportive of the current ANACC model being applied to MPS as the service delivery model requirements of MPS differ to stand alone RACFs. The MPS model includes acute, residential and community-based services as a flexible service delivery model with staff and resources shared across the site. A holistic approach should be considered for the site with consideration given to how funding of each component impacts the overall operation i.e. that the combination of funding streams provides enough financial viability for the site especially for smaller sites, thin markets and remote locations. Any IHACPA review of the MPS model must also consider synergies with the proposed review of the the new Support at Home Program. Significant work is required to determine the true cost of service delivery and better understanding of key cost drivers and inputs for MPS, building on the MPS Review from 2019 that reviewed the effectiveness of the MPS program funding model. Further, any proposed funding model must ensure that fixed costs are adequately covered to ensure financial viability of service delivery regardless of occupancy; emphasising the importance of a sustainable fixed component should a variable model be considered. The model should also consider mechanisms for the service to address unmet needs of the community e.g., ability to respond flexibly to accommodate changing local community needs including supporting additional residents, respite and community services, a key goal of the MPS program. WACHS is supportive of IHACPA's independent, annual review of costs and pricing, to ensure funding keeps pace with the cost of delivering care, noting MPS funding is currently not determined by the cost of care and lacks mechanisms to deliver funding increases (apart from annual indexation). This includes the need to improve understanding of the various jurisdictions' service delivery models, including better data on cost drivers e.g. number of beds, location, length of stay, morbidities, First Nations status, service needs dependent on community requirements, impact of other hospital services delivered by the site, resident needs/complexity/acuity including mobility and cognitive impairment, etc noting there are risks in relying on current, fragmented data to inform future policy.

				Recognition that the infrastructure of an MPS influences the operating costs and service design. For example, a MPS which has the residential component within the hospital area has different operational requirements (e.g. minimum staffing profiles to maintain acute services) to a facility where the RAC may be a co located or separate building to the hospital (e.g. where staffing could be flexed up or down to suit resident occupancy and needs). The initial modelling of ANACC to MPS undertaken by the AGDHAC as part of the MPS Funding Subgroup is welcomed and it is recommended that further modelling be undertaken with a wider sample of MPS to better understand jurisdictional, regional and site-based variations. WACHS' recommends that an adequate timeframe to implement a new funding model is considered, indicatively two to three years) to agree on data requirements, validate data, and undertake shadow pricing assessments, etc. In additional to the IHACPA principles, a new MPS funding model should consider supporting the delivery of quality care, equity, efficiency, value for money, quality outcomes, flexibility, and responsiveness to consumer needs and choices. WACHS is currently undertaking a desktop costing analysis into the cost of aged care service delivery. Initial findings demonstrate that the current MPS funding model unit price is substantially lower than the unit cost for all 38 WA MPS sites. What is emerging is the unit cost provided by the Australian Government per place does not equate to the cost of providing care to the older person in an MPS. MPS funding, historically, has been characterised by a pooled model of place to provide flexibility. MPS are located in areas that historically cannot support aged care facility and a hospital – so any reliance on an ABF type model would disadvantage rural and remote, smaller scale MPS. As noted in response to Question 8 the MMM classification should not be the sole indicator to account for site location cost differences as sites within the same MMM classification can have very different locations, service requirements and costs Factors to be accounted for: Higher cost of staffing MPS in order to attract and retain – housing/rental subsidies, agency and locum use high, difficulty recruiting permanent staff; lack of consistent staffing increases care needs of AN ACC; lack of appropriately trained staffed increases care needs of AN ACC – eg dementia trained staff not available – agency/short-term staff trained then leave, means have to go through training again thus increasing cost to service – ongoing cycle.
11	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?	27	26-27	The advantages of the original NATSIFACP program is it has the capacity to be flexible to meet the needs of older Aboriginal people by integrating community and residential services in small populations. Similar to the MPS model, the flexibility of the service model is integral to the demonstrated needs of the community. Applying an activity-based funding framework to such a complex service delivery model will be challenging.
12	Any other comments	n/a		