DEPARTMENT OF HEALTH AND AGEING: SUBMISSION TO THE COMMUNITY AFFAIRS COMMITTEE INQUIRY INTO THE AGED CARE AMENDMENT (RESIDENTIAL CARE) BILL 2007

BACKGROUND

The purpose of Aged Care Amendment (Residential Care) Bill 2007 (the Bill) is to amend the *Aged Care Act 1997* to introduce a new arrangement to allocate care subsidy in residential aged care.

The current arrangements

The Resident Classification Scale (RCS) is the method used currently to classify residents in order to allocate subsidy to approved providers of residential aged care. The RCS places residents into one of eight funding categories, with the basic subsidy varying from $0 (category 8) to around $122 per day (category 1). The RCS currently allocates approximately $5.5 billion per annum. Each resident is assessed on admission and then annually for funding purposes. Aged care home staff complete the RCS by rating a resident from A (no assistance) to D (significant assistance) against each of 20 RCS questions. The "scores" for all questions are totalled and this then determines the category. This is a self-assessment process carried out by the home and is therefore somewhat similar to the taxation system where the taxpayer self assesses and is subject to audit. RCS audits are based upon a review of the care planning documentation and progress notes produced by the aged care home to guide a resident's care. The *Aged Care Act 1997* provides the broad structure for the classification of residents and for the funding to be tied to that classification system. The detail of the RCS, including the 20 questions and the guidelines for rating care recipients is contained within the Classification Principles 1997.

Concerns about the RCS

In 2002, the (then) Minister for Ageing responded to industry concerns about the documentation and accountability requirements of the RCS by announcing that it would be reviewed. The recommendations from the review included that a new funding model and a reduced classification question set should be developed.

Concerns about the existing system focused particularly on its perceived documentation requirements and on the outcomes of the audit program (also called validation). A resident's RCS classification was intended to be drawn from the assessments and care plans and progress notes developed by care staff to guide their provision of care. However over time in many homes, care documentation has come to be driven by the RCS funding tool – both in resident assessment to ensure that maximum funding is obtained and in ongoing care documentation as a defensive measure to ensure that the classification can withstand departmental audit. Notwithstanding this investment in documentation, the audit program results in a significant rate of classification downgrade. Industry concerns about the current validation program include its stressful effects on aged care home staff, possible inconsistency in audit practice and the impact of retrospective recoveries on income planning.

Government decisions in response to industry concerns

As part of its response to the Pricing Review conducted by Professor Warren Hogan, the Government announced in the 2004 aged care package, *Investing in Australia's Aged Care: More Places, Better Care* that it would introduce a new funding arrangement with fewer

resident categories and two new supplements - for residents with complex health care needs, including palliative care, and for residents with challenging behaviours.

The new Aged Care Funding Instrument (ACFI) was developed to replace the RCS and to provide the basis for both basic care subsidy and the two new supplements. The ACFI has been designed to:

- better target funding towards the care of residents with higher needs; and
- reduce the volume of documentation completed in residential aged care facilities solely for funding purposes.

The arrangements for the two existing care related supplements (oxygen supplement and enteral feeding supplement) remain unchanged.

It was intended to introduce the new funding system in late 2006, however its implementation was delayed initially to 1 July 2007 and more recently to 20 March 2008 to allow detailed analysis of the financial impact of the ACFI to provide the aged care industry and software providers additional time to make their management systems compatible with the new funding instrument, and to introduce the ACFI at the same time as other related changes to aged care payments.

OVERVIEW OF THE BILL'S PROVISIONS

The Bill varies provisions in the *Aged Care Act 1997* to: reduce the number of funding categories for basic care from 8 to 3; introduce the new supplements; and to reduce the administrative burden on aged care staff. The details of the new funding arrangements and the manner in which specific levels of funding are calculated for residents with different care needs will be included in amendments to the *Residential Care Subsidy Principles 1997* and the *Classification Principles 1997*. **Attachment A** provides additional information on the proposed amendments to the *Aged Care Principles.*

Provisions to reduce administrative burden

A resident's classification for funding currently expires after twelve months and aged care providers are required to reappraise a resident's care needs to obtain further funding. Last year, over 60,000 annual reappraisals were completed by providers which resulted in no change in the amount of funding received by approved providers. To eliminate the need for these unnecessary reappraisals, it is proposed that as a general rule ACFI classification will not expire. However, providers will be given the option to reappraise a resident after twelve months. Additionally, it is intended that the *Classification Principles 1997* will be amended so that residents who enter aged care homes from hospital be reappraised after six months in recognition that their care needs can change more quickly than other residents. The current arrangements whereby residents returning from extended hospital leave (30 days or more) are reclassified on return and six months later and whereby residents who have a significant classification change to their classifications are reclassified again after six months will remain in place.

Each year, approximately 12,000 residents move from one aged care home to another. Currently, when the resident moves, their classification for funding expires. It is proposed that where a resident leaves one aged care home to live in another, the new aged care home may choose to accept the existing classification, rather than being required to submit a new classification application.

Removal of High Dependency Care Leave

A provision of the *Aged Care Act 1997* allows two aged care homes (the resident's home service and a second service which is able to provide a higher level of care temporarily for the resident) to both be paid subsidy for the same resident. This arrangement is called High Dependency Care Leave. Few residents qualify for this provision. It requires as a pre-requisite that the Aged Care Assessment Team (ACAT) has approved the resident for permanent high care, that the resident has been classified by the service as requiring only low care, and that a place is available in another service when the temporary need for higher care occurs. A resident utilising High Dependency Care Leave can be asked to pay fees to both providers. Not surprisingly, very few residents use these provisions. It is a vestige of the pre 1997 system under which there were separate legislative, regulatory and funding systems for hostels (low care) and nursing homes (high care). The 1997 reforms unified these systems and allow to allow residents to 'age in place' – that is, for a resident to move from low care to high care within the same home.

A review of utilisation of the High Dependency Care Leave provisions indicates that over the past few years only a small number of homes (around 20 in any given year) had accessed the arrangements, and that in six out of the eight states and territories, the provisions were not used at all.

It is proposed to repeal the provision. The ACFI Industry Reference Group (see below) has in its discussions supported the removal of this leave type.

More flexible arrangements for assisting homes which have difficulty in managing the classification system

The *Aged Care Act 1997* allows the Secretary to suspend an approved provider from appraising residents for funding purposes if they repeatedly fail to conduct their classification appraisals or reappraisals in a proper manner. It is proposed to allow the Secretary to stay the suspension, subject to the provider meeting certain obligations. These obligations may include appointing an adviser at the provider's cost, or providing approved training for its staff, or both. This gives the Secretary greater flexibility to encourage providers to conduct appraisals and reappraisals properly to avoid a suspension coming into effect. This Bill also includes an additional power for the Secretary to require a provider to appraise or reappraise some or all of their residents.

ADDITIONAL FUNDING TO SUPPORT THE TRANSITION TO THE NEW SYSTEM

The Government has announced that it will provide an additional $393.5 million over four years to assist homes manage the change to the ACFI. This includes:

- an additional $96 million for the new supplements on top of substantial existing funding for residents with complex care needs. This will amount to an extra $50 million per annum when all residents are being paid ACFI based subsidies;
- $268.3 million over four years so that no classification subsidies paid in respect of existing residents will be reduced as a result of the introduction of the ACFI;
- additional funding to support industry training in the use of the ACFI; and
- funding to establish a panel of independent business advisors to assist any homes which consider they may have difficulty in making the transition to the new arrangements.

CONSULTATION WITH THE INDUSTRY IN THE DEVELOPMENT OF THE NEW ARRANGEMENTS

The aged care industry - both providers and peak bodies – has been actively involved in the development of the new funding arrangements. An ACFI Reference Group was established in August 2004 by the (then) Minister for Ageing to provide guidance and advice on the development and implementation of the ACFI. It has 15 non-Departmental members, and includes the chief executive officers from Aged Care Association of Australia (ACAA), Aged and Community Services Australia (ACSA), and the Aged Care Standards and Accreditation Agency, representatives from Catholic Health Australia, Baptist Care Australia, Anglicare, Australian Nursing Federation, Royal College of Nursing Australia, Council on the Ageing, Alzheimers Australia and two representatives from large private for profit aged care providers.

The Reference Group has met 12 times and has established, as well, a range of working groups to address specific issues. Its next meetings are scheduled for 16 May, 22 August and 21 November 2007, and 20 February 2008.

The ACFI was tested in a 2005 national trial in which 23% of all residential services participated. More recently 44 services were involved in the testing of the ACFI validation model and user guidelines.

MATTERS RAISED RECENTLY REGARDING ACFI IMPLEMENTATION

Introduction of the Bill

The Bill was introduced into the House of Representatives on 21 March 2007 and debate resumed briefly on 29 March and is now held over for resumption in the winter sitting.

In referring the Bill to the Community Affairs Committee, the Selection of Bills Committee identified the following reason for the referral:

"to examine the particular provisions of the bill, in particular to

a) determine the effect on documentation and record-keeping
b) consider the implications of the streamlining of the audit process
c) examine the proposed arrangements around the expiration of the classifications".

The effect of ACFI on documentation and record-keeping

The ACFI is shorter and less subjective than the RCS. ACFI focuses on measurable and objective resident characteristics – the core impairments which are the best predictors of difference in need for care. Unlike the RCS, the ACFI has defined documentation requirements. Services will complete and retain an ACFI Appraisal Pack (**Attachment B)** as the documentation underpinning their application for resident classification. This comprises the full documentation requirement for funding accountability. ACFI will reduce the production and maintenance of documentation for funding purposes. In the national trial, services took around an hour to complete an ACFI – even if this time doubled post implementation, it would still comprise a significant reduction in paperwork effort compared to the RCS.

There have been two studies commissioned by the provider peak bodies of the costs of RCS documentation to industry:

- an Australian Catholic University study commissioned by ACAA estimated that excessive RCS documentation costs the industry $142 million per annum; and
- a study entitled *People before Paper* undertaken by Australian HealthCare Associates at the request of ACSA found that 9% of care staff time was absorbed by the creation of RCS documentation.

Although ACFI is a funding assessment tool, not a care planning instrument, it has been designed to be consistent with good care planning. It will have no deleterious effect on documentation for other purposes (such as keeping clinical records and producing and maintaining care plans). Unlike the RCS it will not distort these records. In consultations around the ACFI documentation requirements, some stakeholders have raised issues regarding the documentation requirements for accreditation. In this context it should be noted that other than the self assessment that facilities complete as part of their application for accreditation (usually once every three years), the Aged Care Standards and Accreditation Agency does not expect any documentation other than that which would normally form part of a quality management system directed to providing quality services to residents of an aged care facility. The Agency does not require documentation based on the RCS questions.

The implications of the streamlining of the audit process

The most notable differences between the ACFI and the RCS in terms of validation are that the record keeping requirements for the ACFI (i.e. ACFI documentation) are defined and comprise the completed ACFI Appraisal Pack, and that validation will not involve audit of the ongoing record of care provision (the only exception being records of the delivery of complex health care procedures). ACFI validation visits may involve review of a sample of classifications; or a review process that focuses on specific ACFI questions, or a combination of both.

Validation of an individual classification as part of an on site visit is potentially a three stage process comprising: a clerical check of the ACFI Appraisal Pack, a review of the consistency/congruency of the information in the pack, including meeting the resident; and any necessary clarification/issues resolution. This may include discussions with staff, observation of the resident, and possibly the application of one or more of the ACFI assessments or task assessments. The purpose of the validation process is to check that the classification reflects the ongoing care needs of the resident at the time the service appraised the resident for funding.

The ACFI national trial tested ACFI validation. The validation process in the trial (almost 2,000 validations) produced around 95% agreement for the 12 ACFI questions. In contrast, the current validation program currently downgrades 42% of all the classifications it reviews (October – December quarter 2006). It should be noted that, unlike the validations undertaken in the trial, the current classification review program is targeted on a risk assessment basis that takes into account the previous claiming history of a service and its previous validation record. However the indications are that the ACFI will result in fewer audit classification downgrades. The ACFI is less subjective compared to the RCS and therefore less likely to result in disputation about the interpretation of the intent of its questions.

In other words, properly applied, the ACFI will lower the risk to taxpayers, residents and providers of incorrect care payments and so provides greater certainty and less likelihood of disputation.

Proposed arrangements for expiry of classifications

The Bill changes the current arrangements in which classifications expire after twelve months. This removes the requirement for providers to submit unnecessary reappraisals, but gives providers the option to reappraise a resident after twelve months.

Most residents' care needs increase over time. The new system gives providers the option to reappraise a resident after 12 months although they will not be required to do so. The continuation of the validation program will deter services from systematic over-classification.

To protect government funding, specific and mandatory re-classifications requirements will be in place for those groups of residents whose care needs are more likely to reduce i.e. residents entering care from hospital, residents returning from extended hospital leave and residents who most recent reappraisal was for a significant change in care needs.

The objective has been to balance reductions in administrative burden on providers while maintaining appropriate protections for government funding.

Timing of ACFI implementation

As part of its 11 February 2007 announcement of the *Securing the future of aged care for Australians* package, the Government announced both additional funding to support the introduction of the Aged Care Funding Instrument (ACFI), and that its implementation would be deferred to 20 March 2008, aligned with the commencement of other significant elements of the package affecting residential aged care.

The suggestion from some in the industry that implementation should be further delayed to 1 July 2008 should be assessed against the following considerations. The proposed ACFI training program has been designed in consultation with the ACFI Reference Group to address ACFI readiness for both managers and staff. Specific manager training will be rolled out in September/October 2007 and will be followed by ACFI assessor training in early 2008. An ACFI "calculator" is being developed for early provision to managers. This is to assist managers to determine the potential ACFI classification profiles and assist in forward planning. An information strategy is already providing early information on the ACFI "business rules". Also, the transition from the Resident RCS to ACFI will not be sudden. For existing residents an ACFI appraisal will not be required until they reach their current RCS classification expiry date. In a given month in the first year of ACFI implementation an 80 bed service can expect to complete ACFIs for around 2 or 3 new residents and six existing residents whose RCSs will expire. The 20 March 2008 start will give service managers an opportunity to bed down their ACFI systems in advance of the commencement of the 2008-09 financial year. In addition, a delay defers the additional financial assistance that forms part of the package, include the additional funding for residents with the highest care needs.

ATTACHMENT A

RELATED AMENDMENTS TO THE *AGED CARE PRINCIPLES 1997*

BACKGROUND

The Aged Care Amendment (Residential Care) Bill 2007 amends the *Aged Care Act 1997* (the Act) to introduce new arrangements for allocating subsidy in residential aged care.

The Bill amends the Act to support proposed amendments to the *Aged Care Principles 1997* to replace the Resident Classification Scale (RCS) with the Aged Care Funding Instrument (ACFI) as the means of allocating subsidy to providers of residential aged care.

It is proposed that the ACFI will reduce the number of funding levels in residential aged care and provide payments for care recipients with complex health care needs, including palliative care, and for care recipients who have mental or behavioural conditions, including dementia. The ACFI has been designed to reduce the amount of documentation and record-keeping which aged care staff generate and maintain in order to justify the funding classification for each care recipient.

This paper outlines the associated changes related to proposed amendments to the *Aged Care Principles 1997* to replace the RCS with the ACFI.

OUTLINE

Classification Amendment Principles 2007

Classification level structure
The Classification Principles Schedules 1 and 2 (*see Attachment 1*) will be amended to include the ACFI questions and classification structure. The ACFI classification is based on 12 questions each having four ratings (A, B, C or D). A full description of the ACFI questions is in the ACFI User Guide available on the internet at the following address.
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-acfi-latestnews.htm

A care recipient's classification will comprise of one of three funded levels or a nil funded level within the three domains: Activities of Daily Living (ADL); Behaviour; and Complex Health Care (CHC).

- ADL domain is based on the ratings from ACFI questions 1 (Nutrition), 2 (Mobility), 3 (Personal Hygiene), 4 (Toileting), and 5 (Continence);
- Behaviour domain is based on the ratings from ACFI questions 6 (Cognitive Skills), 7 (Wandering), 8 (Verbal Behaviour), 9 (Physical Behaviour) and 10 (Depression); and
- CHC domain is based on the ratings from ACFI questions 11 (Medication) and 12 (Complex Health Care).

The levels within each domain are derived from the ratings for each question. The care recipient classification will be based on the combination of levels within each domain.

High and Low residential care definition

A new definition of a "high level of residential care" is introduced based on the ACFI classifications. Care recipients will be considered to receive a high level of residential care where they are classified at either one of the following:

- a medium or high level ADL category;
- a high level Behaviour category; or
- a medium or high level CHC category.

The existing definition of "low level of residential care" will be replaced with a new definition which reflects a level of residential care that is not a high level of care.

Procedure for determining classification levels

The Classification Principles will be amended to specify the procedure the Secretary will use to determine the appropriate classification level for a care recipient.

Step 1 – For the ADL and Behaviour domains, the Secretary must:

(a) identify the score for the rating for each question in the domain from the application for classification form completed by the aged care provider;
(b) add up the scores based on Parts 1 and 2 in Schedule 1 to work out a total score for each domain; and
(c) identify the domain category that the domain total score falls within using Schedule 2.

Step 2 – For the CHC domain, the Secretary must use the matrix in Part 3 of Schedule 1 to work out the domain category shown in Part 3 of Schedule 2.

Step 3 – The Secretary must determine the appropriate classification level for the care recipient according to the domain category identified for each domain.

Classification levels for respite care

The classification levels for care recipients being provided with residential care as respite care will be:

(a) a low level of residential care; and
(b) a high level of residential care.

Lowest applicable classification level

The Classification Principles will specify the lowest applicable classification level for a care recipient being provided with residential care as a classification that consists of nil in each of the ADL, Behaviour and CHC categories.

Alternative periods for appraisals

The Classification Principles will be amended to reflect changes to the Act which specify that seven days must have elapsed since the approved provider commenced providing care to the care recipient before an appraisal for all ACFI questions can commence. The Classification Principles will allow for circumstances where an appraisal can be made for a care recipient who received less than seven days care.

Significant change in care needs reappraisals

The Classification Principles will be amended to include a new definition where the care needs of a care recipient are taken to have changed significantly that is relevant to ACFI reappraisals.

Under an ACFI appraisal a significant change reappraisal will be allowed where a current classification level increases by a minimum of two categories across any or all of the three domains. For example, a care recipient classified as Low across all domains may be reclassified to High in a single domain or to Medium in two domains. An exception to this rule will be in cases where the care recipient is classified as High in the ADL domain and Medium in the CHC domain. A reappraisal may be submitted at any time in these cases to reclassify the resident to High in the CHC domain even if there is no change in any Behaviour supplement levels. This will allow for an increase in subsidy for those care recipients whose complex health care needs have increased due to palliative care.

Requirements for applications for the lifting of suspensions
The Classification Principles will include a section on the requirements to lift suspensions of approved providers made under section 25-4C of the Act, from making ACFI appraisals or reappraisals. Such an application must include details of the action taken, consultations held with staff, care recipients or the relatives of care recipients or proposed action by the approved provider in relation to the giving of false, misleading or inaccurate information in appraisals or reappraisals.

Quality of Care Amendment Principles 2007

Entitlement to high level residential care specified care and services
The Quality of Care Principles will be amended to ensure the continuity of entitlement to specified care and services provided to high care residents who were eligible for these services before the commencement of the ACFI.

Records Amendment Principles 2007

Appraisal Records
The Records Principles will be amended to specify records that must be kept for ACFI appraisals and reappraisals. This includes the 'Answer appraisal pack' and ACFI 'Assessment Pack'. This will reduce the amount of documentation and record-keeping needed to justify the funding received for each resident.

Approval of Care Recipients Amendment Principles 2007

Lapsing of residential care approval
A new rule will be added to the Approval of Care Recipients Principles so that the care recipient's approval for residential care will not lapse in the cases where a care recipient transfers to another care service under item 1 of the table in new subsection 27-2(1) of the Act.

Resident Classification Scale (RCS) - ACFI Transitional Rules

Expired RCS classification on or after ACFI classification
A threshold limit on the daily basic subsidy of $15 will be placed on care recipients making the transition from RCS to ACFI classifications.

For a care recipient whose RCS classification expires on or after commencement of the ACFI, if the daily basic subsidy amount payable for a care recipient classified under ACFI is not at least $15 more than the daily basic subsidy amount payable for the care recipient's expired RCS classification, the daily basic subsidy amount payable will remain as the existing amount for the care recipient's expired RCS classification.

Significant change classification transition
Where the care needs of a care recipient who was classified before the commencement of ACFI are taken to have changed significantly, the Secretary may renew the classification of the care recipient only if the daily basic subsidy amount for the care recipient under the ACFI classification is at least $30 more than the daily basic subsidy amount of the existing RCS classification.

Classification Amendment Principles 2007
Schedule 1
Scores for question ratings

Question	Rating	Score
Part 1 Activities of daily living domain		
1 Nutrition	A	0
	B	6.69
	C	13.39
	D	20.09
2 Mobility	A	0
	B	6.88
	C	13.76
	D	20.65
3 Personal hygiene	A	0
	B	7.89
	C	15.75
	D	23.63
4 Toileting	A	0
	B	6.11
	C	12.21
	D	18.31
5 Continence	A	0
	B	5.79
	C	11.53
	D	17.31
Part 2 Behaviour domain		
6 Cognitive Skills	A	0
	B	6.98
	C	13.91
	D	20.88
7 Wandering	A	0
	B	5.91
	C	11.82
	D	17.72
8 Verbal Behaviour	A	0
	B	7.04
	C	14.10
	D	21.14
9 Physical Behaviour	A	0
	B	7.70
	C	15.40
	D	23.11
10 Depression	A	0
	B	5.71
	C	11.43
	D	17.15

Part 3 Complex health care domain

Question 11 Medication	Question 12 Complex Health Care			
Rating	A	B	C	D
A	0	0	2	2
B	0	1	2	3
C	1	1	2	3
D	2	2	3	3

Schedule 2 Domain categories

Domain	Domain aggregate range	Domain category
Part 1 Activities of daily living domain	0-17.99	Nil
	18-61.99	Low ADL
	62-87.99	Medium ADL
	88-100	High ADL
Part 2 Behaviour domain	0-12.99	Nil behaviour
	13-29.99	Low behaviour
	30-49.99	Medium behaviour
	50-100	High behaviour
Part 3 Complex health care domain	0	Nil CHC
	1	Low CHC
	2	Medium CHC
	3	High CHC