Proposed Alternative Models for Allocating Residential Places

Response to Consultation Paper

Summary

Catholic Health Australia notes that both Models in the consultation paper would put at risk the availability of residential aged care services in outer regional, rural and remote communities and for certain special needs groups such as homeless older people, without the continuation, and enhancement in some circumstances, of current financial incentives to support residential aged care services in these areas.

Model 2, assigning residential places to consumers, would generate more incentives for providers to be responsive to consumer preferences and would reward providers with a reputation for providing quality services and for innovation.

However, increased competition under Model 2 has the potential to reduce occupancy across the sector, and thereby increase business risk for some providers. This is especially the case because current residential aged care funding arrangements allow providers with thin capitalisation to operate in the sector, which makes their viability sensitive to occupancy levels and reducing liquidity levels.

These business risks would be exacerbated by the current ACFI-related margin compression being experienced by the residential sector.

Catholic Health Australia (CHA) supports Model 2 because of its potential to support innovation and to reward providers delivering quality services that are responsive to consumer preferences. However, in order to achieve the full potential for service improvement while at the same time manage the transitional business and financial risks, CHA considers that the implementation of Model 2 must be accompanied by the following complementary reforms to the current system:

1) Uncapping the supply of subsidised residential aged care places.

   Uncapping subsidised residential places is extremely unlikely to result is a financial risk for the Commonwealth, but it would maximise provider flexibility to respond to consumer preferences, maximise consumer choice and avoid the need for complex and costly national prioritisation arrangements which would also add complexity for consumers accessing residential aged care.

   Uncapping supply should also trigger a review of the current policy basis for the 'equivalence' policy for accommodation payments and the MPIR, noting that the MPIR currently is not a reasonable reflection of the cost of capital and is negatively influencing capital financing as consumer preference for DAPs increases.

2) Measures to strengthen the financial viability of residential aged care providers, both in the short term in response to current cost/revenue pressures, and in the longer term through the implementation of a new residential aged care funding model to replace the current ACFI which:

a. provides for annual independent and publically available costing studies to inform prices, noting that reduced occupancy levels is likely to increase overall system costs, and includes fixed/variable funding components and protections to ease the transition to the new funding system,
b. recognises and funds the additional cost of providing services in rural and remote locations and for certain special needs groups such as older homeless people,
c. achieves funding neutrality between residential respite and permanent residents so that there is flexibility and scope for residential respite to develop as a business model to support people (and their informal carers) opting to receive care in their own homes for as long as possible, and
d. ensures sufficient funding for personal care and nursing to ensure access by low means consumers to quality residential services.

3) Reform and clarification of regulations governing fees for additional services, including flexibility concerning the level of the basic daily fee, so that there is greater capacity and incentive in an uncapped supply market for service innovation and differentiation beyond the basic specified care and services, noting that the service response will vary according to local market conditions and consumer expectations, but with all services subject to meeting the new quality standards.

4) Accommodation payments on behalf of low means residents are informed by and reflect market accommodation prices paid by non-supported residents in order to support continued investment in the residential care sector.

5) Implementation of strengthened prudential arrangements for lump sum payments, including strengthened Departmental capacity to assess and monitor financial risk and effective approved provider assessment processes.

6) Deferral of the introduction of the mandated retrospective levy until a post-transition equilibrium has been achieved. CHA notes that the current aged care system and provider landscape reflect the policies of successive governments. As such, CHA considers that the risk of RAD defaults associated with implementing the major structural change associated with Model 2 should not be borne collectively by providers.

Comments on Questions for Discussion Raised in the Consultation Paper

Current arrangements

What works well under the current residential aged care allocation and places management model for consumers and/or providers?

- The current allocation and management model reduces business risk commensurate with a low margin largely Government funded service sector based on high occupancy.

- It has worked well in the past for managing Commonwealth outlays.

- Reduced business risk and a managed market fosters greater stability in service provision.

- Contributes to a more equitable geographic distribution of rationed services, including for lower yield markets, but whose provision in thin markets is still dependent on policies that support financial viability in any given location.
  Notwithstanding the potential contribution of the current allocation process to the equitable distribution of rationed services, CHA notes that there is considerable variation in the residential place provision ratio across the states and territories, from 83.3 in South Australia to 67 in Western Australia. Across ACPRs, the ratio varies from the low 60's through to several exceeding 110.

- Contributes to the provision of services that are targeted for special needs groups, but provision is also subject to and dependent on policies and incentives to sustain financial viability. In the main, there is limited government regulation and monitoring to ensure subsidised places targeted at special needs groups are used in accordance with approved conditions of allocation, except to the extent that financial controls allow eg viability supplements and capital grants linked to geography and means assessments of individual consumers. Any alternative models would need to maintain and/or adapt these features of the current system.

Are there other issue/s with the current model for the allocation and management of places for residential aged care that have not been covered in the discussion paper? If so, are these problems occurring at national level, or only in certain areas eg rural, remote and regional areas or for particular groups?

- CHA notes the issues identified in the consultation paper associated with the current model for the allocation and management of residential places viz.

    - the current process is seen as "a lucky dip" (noting also that value for money, invariably a key criterion for tender processes, does not apply for the ACAR);
    - it is sometimes used to crowd-out local competition;
    - it disadvantages smaller providers who do not have ready access to application writing skills; and
    - it does not support consumer choice and control or reward service excellence and innovation that is responsive to consumers.

- Other issues associated with the current process include:

    - the unpredictable incidence and timing of ACAR Rounds which is a barrier to efficient service planning by providers,
    - reliance on the purchase of allocated places on the secondary market when planning services which adds to the overall cost of the system, and
    - the tender process has spawned costly fee for service tender application writing services.

Design principles

Are the proposed design principles appropriate?

- CHA supports the design principles outlined in the consultation paper viz
    - provides opportunities for more consumer-driven and responsive aged care services,

- maintain or improve access to residential aged care and respite services, including in regional, rural and remote locations, in thin markets and for special needs groups,
- facilitate an adaptable, flexible and viable residential aged care sector that can attract financial investment,
- be financially sustainable for all stakeholders, and
- will complement future reforms.

Model 1. Improve the ACAR and places management

Overall model

What are your views on the suggested improvements under this model?

CHA's comments on the improvements to the current model suggested in the consultation paper are set out below.

- Reduce locational controls at the state/territory level:

  Model 1 would replace the current 73 ACPRs with 8 state/territories, which would increase the area within which there would be greater flexibility to relocate previously allocated places, including transfers between providers (except in the ACT). Unless the process is completely agnostic as to locational considerations, the level of flexibility would still be subject to assessment criteria for assessing proposals to relocate services. In practice, the main outcome of this change is to give the Department greater flexibility when assessing relocation applications, including ownership transfers.

  Putting aside any assessment criteria that may apply, and in the absence of any location-specific incentives or controls, this approach would reduce the government's ability to manage the distribution of subsidised places within each jurisdiction in order to achieve a more equitable distribution of rationed places 'held' by providers, and whose location is controlled by providers. As a result, while increased investment, competition and consumer choice of service may eventuate in more attractive regions, it would likely be at the expense of other locations, especially rural and remote locations and lower socio-economic status regions.

  There may be some increased flexibility for providers to manage the distribution of their allocated places across a larger area, including when planning and negotiating acquisitions in the secondary market. However their capacity to expand and innovate would still be substantially subject to providers' success in having been allocated places, rather than their success in attracting business through their reputation as a provider of quality aged care services and their capacity to access capital.

  Given that aged care is a nationally administered and funded program, CHA notes that the policy basis for restricting this flexibility to state/territory boundaries is not apparent. Subject to policies that would manage the above concerns regarding the equitable distribution of rationed services, the benefits of flexibility would be greater if Australia was treated as 'one region', rather than settle for fewer regions based on administrative boundaries that have no relevance to a national program (or to socio-economic linkages eg gold Coast/Northern Rivers; Sunraysia/Riverland; Albury/Wodonga).

- Offline places:

The ACAR process, which is framed by the government target provision ratio, takes into account the current and projected number of offline places in the system, as well as the lead time to build and commission new services. Therefore little would be gained by strengthening the monitoring of offline places. Moreover, offline places affords the system some flexibility, in an otherwise rigid place allocation system, to plan service development and refurbishment, including through access to a secondary market for subsidised places.

- Capacity to 'top up' allocated places outside ACAR to address consumer demand:

  This approach would introduce an additional layer of regulation and administration that would add complexity to the allocation process, both for the government in terms of controlling the number of subsidised places allocated to providers and budgeting, and for providers in terms of service planning. This approach would also likely add to provider concerns about the lack of transparency under the current arrangements.

- Residential respite care:

  The supply of subsidised residential respite places should not be subject to allocation controls that are separate to those that apply for places for permanent residents.

  Subject to reforms to achieve funding neutrality between residential respite and permanent residents (as previously argued by CHA and proposed by the Aged Care Financing Authority), residential respite should be allowed the flexibility to become a viable business model in its own right to support the growing proportion of consumers (and their carers) accessing home-based aged care services.

  Moreover, CHA considers that, subject to appropriate consumer contributions being appropriately funded and regulations concerning eligibility and access, the supply of residential respite care should be uncapped so that providers can respond to consumer demand as home-based care expands.

Key design considerations

How can Model 1 ensure/encourage adequate supply of and equitable access to residential aged care and residential respite care (aside from increasing funding or revising the funding model), including in rural, regional and remote areas and thin markets or for consumers from vulnerable cohorts (such as special needs groups. Consumers living with dementia)?

- Model 1 will not result in a material improvement in overall consumer access to residential aged care and residential respite care without the support of appropriate funding arrangements. Indeed, allowing greater locational discretion within a framework where places are 'held' by, and whose location is controlled by providers, would create risks for equity of access, especially for rural and remote communities. Accordingly, Model 1 will require policies that support the provision of services in certain geographic locations and for certain special needs groups.

Are there variations to this model which should be included in the impact analysis?

- An alternative to using state/territory boundaries under Model 1 would be to base geographic areas on the Modified Monash Model for classifying remoteness. This alternative has more relevance to the administration of a national system as it would preserve the capacity to tailor policies, such as capital

grants programs and viability supplements, to specific geographic areas, rather than use administrative boundaries which have no significance from an aged care policy perspective.

It is also relevant that as amalgamations and structural adjustment in the sector progress, the number of providers operating across state/territory borders is increasing. Access by certain special needs groups would also need to be supported by tailored policies, such as capital grants for services targeting homeless older people and Indigenous communities.

What other key changes could be made to the existing ACAR and/or places management arrangements to encourage a more consumer driven and competitive residential aged care sector?

- One option that has been raised would be to conduct ACARs more frequently and carry over unsuccessful applications to the next ACAR. This would go some way to improving the timeliness of allocation decisions, but the process would still be subject to similar transparency and administrative/complexity issues that currently apply.

  That said, conducting ACARs to a firm timetable, rather than the current seemingly ad hoc approach which keeps the sector guessing, would help with certainty and service planning.

Exploring the potential impacts

In overview, what would be the potential impact of this model (consider benefits, costs and risks) on you or the stakeholder group or organisation you represent?

- Model 1 is unlikely to result in an overall improvement in consumer access without the incorporation of protections for 'thin' markets, especially rural and remote locations, older people with low means or special needs groups. Some elements of the proposed Model, such as the provision for 'top up' outside the ACAR, would add to administrative complexity and would do nothing to allay provider concerns about the vagaries of the current allocation process. Indeed, a 'top up' process outside the ACAR could further dilute the transparency and equity of the 'tender' process.

- Model 1 could give providers greater flexibility in service planning by allowing more scope to relocate allocated places they hold and any places they acquire on the secondary market.

What do you think might be the impact on the residential aged care sector overall?

- Because this model essentially preserves the main features of the existing process ie allocating a regulated supply of subsidised residential places to approved providers, its impact on improving consumer access, choice and control and stimulating innovation and higher quality services would be modest, and more likely confined to metropolitan areas.

- Without compensating measures, Model 1 would have negative consequences for the provision of services for certain special needs groups, areas with thin markets and lower socio-economic status areas.

- To the extent that Model 1 might increase competition is some areas, the long lead times in developing new services, including the remaining vagaries and red tape of the place allocation processes, would mean that the impact on existing services would be felt in the medium term, and mainly by providers with older depreciated services, including services with ward-style configurations or institutional-style layouts.

- It could be argued that providers with better access to capital will benefit more as a result of this model, but this dynamic is already evident in the system when it comes to competing for new places under the ACAR.

If this model were to be implemented, what are the potential impact on, linkages or interdependencies with, other programs or reforms in aged care that might impact you or your stakeholder group or organisation that you represent?

- Because these changes would essentially maintain the key features of the existing aged care system, they would not, of themselves, necessarily require structural modifications to other aspects of the system. There would however need to be a review of the adequacy of current incentives and arrangements for supporting service development in rural and remote locations and for certain special needs groups, including the Multi-Purpose Services program.

Implementation and transition issues

How could implementation of this model maximise the benefits and minimise risks/disruptions?

What steps/sequencing and timeframes would be appropriate to facilitate a smooth transition?

What specific supports or enablers would be required to ensure the changes are understood by all stakeholders and successfully implemented?

- Measures to address the impact on special needs groups and rural and remote services would need to be in place before the changes are implemented, and clearly communicated to the sector.

Model 2. Assign residential care places to consumers

Overall model

Overall, what are your views on this proposed model?

- Model 2 would increase incentives for providers to be more responsive to consumer preferences and would reward providers with a reputation for providing quality services and for innovation.

- However, increased competition under Model 2 has the potential to reduce occupancy (more so in the short/medium term) across the sector, and thereby increase business risk for some providers. This is especially the case because current residential aged care funding arrangements allow providers with thin capitalisation to operate in the sector, which makes their viability sensitive to occupancy levels and reducing liquidity levels.

- In order to achieve the full potential for service improvement while at the same time manage the transitional business and financial risks, CHA considers that the implementation of Model 2 must be accompanied by complementary reforms, including in relation to care funding, fees for additional services, respite funding and prudential regulations.

- These business risks would be exacerbated by the current ACFI-related margin compression being experienced by the residential sector.

- Implementation of Model 2 would need to have regard to measures that reduce business risks during a transition period during which significant adjustment will need to occur.

- Model 2 will lead to further consolidation in the sector, which warrants government consideration of measures to ensure that consolidation proceeds in an orderly and planned manner.

- Models will require tailored measures to ensure access to services in thin markets and access by special needs groups, including low means residents. Improved comparative service information, well developed system navigator services and an effective quality regulatory system will also be required under both Models.

- CHA also observes that transition and sector adjustment over the medium term will be coinciding with increasing demand for residential aged care even given the current provision ratio due to the structural ageing of Australia's population. This should act to mitigate some of the adjustment pressures compared with, for example, adjustment were taking place in a contracting market.

- Overall, will result in higher quality and greater choice of residential aged care services, but this will come at higher overall system costs which will need to be recognised and appropriately funded.

Key design considerations

What are your views on the establishment of a queue to access subsidised residential aged care, if the demand from eligible persons exceeds the available places?

- The policy objective should be to avoid the need for a national prioritisation queue for subsidised residential care as it increases complexity for the aged care system, especially for consumers, and increases system overheads. The only reason for having a prioritisation queue is to facilitate Budget management by the Commonwealth if demand for residential care exceeds the supply of subsidised residential places budgeted for by the Commonwealth.

- CHA notes that the risk of a surge in demand for residential aged care in excess of the current target provision ratio is not great. In this regard, CHA would highlight the following:

    - the preference of most older people is to remain living in their own home for as long as possible. Despite 73% of people on the home care package queue also having approval for residential care, average occupancy rates in residential care continue to gradually fall, from 96.7% in 2002 to 90.3% in 2017,

    - the supply of home care packages has increased from 20 packages per 1,000 people aged 70 and over to about 35 since 2004, on the way to 45 by 2021-22, which will give more older people the option to select home-based care and thereby reduce demand for residential care, and

    - the reduction in overall occupancy in residential care has occurred despite the provision ratio for residential places having been reduced from 88 per 1,000 people aged seventy and over in 2004 to 78 currently.

- As is clearly demonstrated by the issues and discussion points posed in the discussion paper, a national prioritisation queue would introduce considerable complexity into the system for consumers, providers and the Department. Issues include how to determine a person's priority, the validity period for assigned

places, arrangements for allowing people to leave and re-join the queue (noting that many older people take their time before deciding to enter residential care, including using respite care) and how to manage a queue for changes in individual circumstances. Overall system complexity would be increased further if, as likely, the prioritisation system and queue has to comprehend both residential care and home-based care.

What additional information or supports would consumers need to assist them in selecting a preferred aged care home?

- Consumers will require ready access to comparative information on the quality and scope of services offered by each provider that is easy to understand, and their cost. Easily accessible 'navigator' supports will also need to be available, especially supports that target vulnerable older people. Arguably, these features are essential under either Model, and under the current Model.

What features in the model, or the broader system, would be required to support providers to operate sustainably in a competitive market? For example, how could innovation and differentiation in service and accommodation offerings be facilitated?

- CHA recognises that Model 2 represents a significant structural change to the current aged care system. CHA considers that the implementation of Model 2 has to be complemented by the implementation of the following reforms in order to support an orderly transition to a more competitive, responsive and innovative business environment which supports increased investment:

    - Uncapping the supply of subsidised residential aged care places. Uncapping subsidised residential places is extremely unlikely to result is a financial risk for the Commonwealth, but it would maximise provider flexibility to respond to consumer preferences, maximise consumer choice and avoid the need for complex and costly national prioritisation arrangements which would also add complexity for consumers accessing residential aged care.

      Uncapping supply should also trigger a review of the current policy basis for the 'equivalence' policy and the MPIR, noting that the MPIR currently is not a reasonable reflection of the cost of capital and is negatively influencing capital financing as consumer preference for DAPs increases.

    - Measures to strengthen the financial viability of residential aged care providers in the short term in response to the current ACFI-related margin pressures, and in the longer term through the implementation of a new funding model to replace the current ACFI which:

        - provides for annual independent and publically available costing studies to inform prices; fixed/variable funding components; and protections to ease the transition to the new funding system,

        - recognises and funds the additional cost of providing services in rural and remote locations and for certain special needs groups such as older homeless people,

        - achieves funding neutrality between residential respite and permanent residents, and

        - provides sufficient care funding to ensure access to services for low means residents.

- Reform and clarification of regulations governing fees for additional services, including greater flexibility concerning the level of the basic daily fee, so that there is greater capacity and incentive in a deregulated supply market for providers to innovate and respond to consumer preferences beyond the specified care and services, noting that the service response will vary according to market conditions and consumer expectations at the local level, subject to services meeting the new quality standards.

- Accommodation payments for low means residents are informed by and reflect market accommodation prices paid by non-supported residents in order to support continued investment in the residential care sector.

- Deferral of the mandated retrospective levy in the event of RAD defaults until a post-transition equilibrium has been achieved, and strengthened prudential arrangements for lump sum payments have been implemented. CHA notes that because the current aged care system and provider landscape derives from the policies of successive governments, transitional prudential risks associated with major structural change intended to achieve higher quality aged care services and greater consumer choice should not be borne by providers.

- Improvements in comparative information to inform consumer choice, including consumer experience information and information about service quality, scope and price.

<u>For those providers who are dependent on capital financing, what role does the ACAR system play in supporting their ability to obtain that financing?</u>

- The ACAR system, together with provision ratios that regulate supply, reduces business risk by diluting competition and helping to maintain occupancy rates. A lower risk business environment can support a lower cost of capital/debt. The latter is also materially supported by the lump sum payment regime that applies in residential care. Notwithstanding this, advice from the major banks is that even under current arrangements, two-thirds of current providers are “unbankable”.

- CHA also notes that investment in residential aged care is also reliant on the availability and level of accommodation payments paid on behalf of low means residents.

<u>What might be required to ensure the residential aged care sector remains an attractive investment for financiers and lenders?</u>

- As well as achieving returns commensurate with the risk profile of the aged care sector, greater clarity and certainty about future reform directions and sequencing is important to secure investor confidence in the sector.

- As is currently the case, investment in residential aged care is also reliant on the availability and level of accommodation payments paid on behalf of low means residents.

- There is a case for government support to support structural change in the sector, noting that increased competition will not materialise overnight, but will build overtime. The impact of greater

competition will be felt most by older services, including those built as hostels or that have more institutional or hospital-like layouts.

How can adequate availability of residential aged care services be supported (aside from increasing funding or revising the funding model) in rural regional and remote areas and other thin markets and for consumers from vulnerable cohorts (such as special needs groups and consumers living with dementia)?

- As is currently the case, the availability of residential aged care services in rural and remote areas and other thin markets and for special needs groups can only be assured through the use of targeted incentives such as viability supplements and capital grants that support investment and ongoing viability.

Is it possible to attach conditions to being an approved provider, and could these conditions be specific to locations or particular groups?

- The provision of incentives is a more effective means for ensuring services in particular locations or for special need groups, than the use of restrictive regulatory conditions.

Exploring the potential impacts

What would be the potential overall impact of this model (consider benefits, costs, and risks) on you or your organisation or stakeholder group that you represent?

- May lead to some service disruption until an equilibrium is achieved, but level of disruption would be mitigated by the lead time in commissioning new services and the fact that reform is being implemented in a market which is expanding significantly due to demographic factors.

What do you think might be the impact on the residential aged care sector overall?

- After a period of transition, and if implemented in parallel with complementary reforms, would result in a more competitive and flexible service environment that is more responsive to meeting consumer preferences.

If this model were implemented, what are the potential impacts on, linkages or interdependencies with, other programs or reforms in aged care that might impact you or your stakeholder group or organisation you represent?

- See previous list of complementary reforms that will be required.

How could residential respite care places be distributed, and to whom, if residential aged care places no longer exist?

- As noted earlier, by uncapping the supply of subsidised respite and permanent resident places, and ensuring funding neutrality between the two modes.

What are your views on how to manage extra service status under this model?

- CHA notes that the Government has placed a freeze on the release of extra service places since the *Living Longer Living Better* (LLLB) package was introduced which, inter alia, extended lump sum

payments to all subsidised residential aged care, thereby removing one of the primary incentives for providers to seek extra service status.

The expectation was that the other incentive for having extra service status, fees for extra services, would be accommodated within existing arrangements allowing providers to charge fees for services that are additional to those described in the Schedule of Specified Care and Services. However, the latter has proved problematic because the regulations governing the latter are uncertain at best, and are also more restrictive than those that apply for additional services in facilities with extra service status.

- So the relevant question in this context is not so much how to manage extra service status under Model 2, but how to clarify and improve the regulations currently governing the charging of fees for additional services in non-extra service facilities so that they allow providers flexibility to be more responsive to consumer expectations.

- The future value of extra service status will therefore be determined by policies on fees for additional services. If the latter is appropriately addressed, the earlier trend for providers to phase out extra service status services is likely to resume.

<u>How might the allocation, eligibility criteria and/or administrative provisions (eg terms of repayment) for capital grants allocated through the ACAR need to change to best support the needs and objectives of a more market based model?</u>

- The existing capital grants program for remote services and services for certain special needs groups should be retained, but first reviewed as to targeting and the adequacy of the level of capital grants available for allocation. The review should also take into account the future role of the Multi-Purpose Service program, including whether its effectiveness could be improved by aligning its funding basis and operational guidelines with Aged Care Act-funded services, including with regard to the new AN-ACC.

Catholic Health Australia

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