The new aged care funding model explained

Carol Loggie, Anita Westera, Conrad Kobel and Kathy Eagar present this overview of the new funding instrument to be implemented for residential aged care, the Australian National Aged Care Classification (AN-ACC), developed at the Australian Health Services Research Institute.

A recurring theme within the aged care sector – particularly residential aged care – has been the inadequacy of funding available to provide safe and quality care. In part, this is due to the overall amount of funding available to the sector, as highlighted in the findings of the Royal Commission into Aged Care Quality and Safety. However, it is also due to the way funding is distributed to aged care providers.

Following endorsement by the Royal Commission, the Australian Government has confirmed that the Australian National Aged Care Classification (AN-ACC) will be implemented for residential aged care funding from October 2022, as part of the aged care reforms announced alongside the May 2021 budget.

The current funding model in residential aged care, the Aged Care Funding Instrument (ACFI), has been in place for more than a decade. During this time, there has been a significant shift in the care needs of people living in residential care. They are now older when they enter residential care (half are aged over 84), have more complex care needs, and many are approaching end of life (half of all residents die within two years).

Why the ACFI is being replaced

We conducted a review of aged care funding models and instruments in 2017, including a review of the ACFI (McNamee et al 2017). This review found that the ACFI assessment tool does not discriminate sufficiently between resident care needs and their associated costs, and it does not take into account the interactions between the different care needs.

Within ACFI, each resident is assessed against a number of items which are grouped into three domains (activities of daily living (ADLs), cognition and behaviour, and complex health care). Each domain is then rated to a funding level (high, medium, low, or nil). The subsidy paid is the combined amount that is payable for each of the three domains. This additive type model assumes that care needs are met item by item rather than in any sort of combination, which is not clinically plausible.

The review also found that the ACFI creates perverse incentives, effectively ‘rewarding’ providers with more funding for conditions/behaviours that are potentially able to be prevented or improved. It is administratively burdensome for clinicians and, importantly, it was found to result in funding disparities across different geographical areas. The review concluded that the ACFI was no longer fit for purpose. Furthermore, it found there was no existing model available that was suitable for use in Australia.

A new funding model

In 2018, researchers (including the authors) at the Australian Health Services Research Institute (AHSRI) at the University of Wollongong, NSW, were engaged by the Australian Government Department of Health to design a new funding model that could more appropriately capture the care needs of residents in aged care and the relative costs of providing care. Named the Resource Utilisation and Classification Study (RUCS), this research involved 1877 resident assessments and 315,029 staff time activity records collected by 1600 staff in 30 participating care homes (Eagar et al 2019a). Clinical advice was received from four expert clinical panels that were consulted throughout the study. The outcome was the development of the AN-ACC, which includes an assessment, resident classification and funding model.

A brief description of the AN-ACC

The AN-ACC represents a fundamental change in how funding for care is allocated, and offers many benefits for the funders, the providers and the recipients of residential aged care. It focuses on the resident and care home characteristics that influence the cost of providing care (the cost drivers), including those related to a resident’s individual care needs (variable costs) and those costs of care that benefit all residents (shared or fixed costs).

It comprises six key design elements and introduces some new concepts into residential aged care funding:

Assessment
1. Assessment of the resident for funding is separate from the assessment for care planning purposes.
2. Assessment for funding purposes is undertaken by independent external assessors, capturing only the information necessary to assign a resident to a particular class for funding.
3. Assessment for care planning purposes is undertaken by staff within the residential aged care home who know the resident well. This assessment should be comprehensive and person-centred, based on residents’ needs, strengths, preferences and appetite for risk.

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**Payment model**

4. A ‘variable’ payment per day for the costs of individualised care for each resident, which is based on their AN-ACC casemix class (casemix is explained in more detail later in the article).
5. A ‘fixed’ payment per day for the costs of care that are shared equally by all residents, which varies by location and other care home characteristics.
6. A ‘one-off adjustment’ payment is available for each new resident in recognition of the additional, but time-limited, resource requirements when someone initially enters residential care.

**AN-ACC assessment**

Assessment under AN-ACC differs considerably from the ACFI in two ways. The first key difference is that it is undertaken by an independent, skilled assessment workforce that is external to the care home. The second key difference is that the role of care planning is undertaken by staff within the care home who know the resident well. This solves the current problem where assessment is more focused on maximising funding than on planning for the care of residents.

The AN-ACC assessment tool has been purpose-designed to capture those resident characteristics that best predict the costs of care to meet resident needs. Importantly, our study showed that no specific medical diagnoses, including dementia, are cost drivers per se. Rather, cost is driven by the consequences and impacts of a person’s medical conditions and health issues. As an example, if someone has cognitive impairments, whether or not the underlying cause is dementia does not matter. What matters is the extent of the cognitive issues, what other care needs the resident has, and the effects this has on the care required.

The research underpinning the development of the AN-ACC showed clearly that the key cost drivers in residential aged care are needs due to: end of life, frailty, functional decline, cognition, behaviour, and technical nursing requirements. These needs may be related to one diagnosis, such as dementia, or multiple diagnoses.

The AN-ACC assessment comprises seven instruments, plus items related to palliative care, frailty and technical nursing. It is designed for use by independent clinical assessors to be completed in one session, with minimal burden on the resident. Importantly, the assessment captures the capacity of the resident, as this is what drives care needs and costs, taking into account:
- physical ability (including pain)
- cognitive ability (including the resident’s ability to communicate, sequence, socially interact and problem solve, and their memory)
- mental health issues (including depression and anxiety)
- behaviour (including cooperation, physical agitation, wandering, passive resistance, and verbal aggression).

**AN-ACC payment model**

The AN-ACC includes three funding components: two reflecting ‘daily’ costs of providing care and the third a one-off adjustment payment addressing the costs associated with entering care. The daily payment is made up of two components, each contributing around half the total payment. The first is the variable payment that covers the costs of individualised care for residents. The second is a base care tariff to cover the fixed costs of providing the care that all residents receive equally. Each funding component is explained below.

**Variable payment**

The variable payment is determined using a casemix classification. The AN-ACC Version 1.0 casemix classification comprises 13 payment classes (see Figure 1 p27). Each class groups together residents:
- with similar needs for care,
- who cost about the same to care for each day,
- and whose clinical risks and outcomes are similar.

The branching structure of a casemix classification ‘splits’ into the different classes using those characteristics that are found to drive individual care costs (Eagar et al 2020).

In the AN-ACC model, each resident is assigned to one of the 13 payment classes based on their assessed care needs using the AN-ACC assessment tool. This class determines the amount paid for the variable component of each resident’s care. This ensures funding is appropriately distributed to care homes according to the mix of residents within each care home.

The AN-ACC includes one class for ‘admit for palliative care’ and 12 other classes that are split across three branches based on the resident’s mobility (measured by the de Morton Mobility Index (DEMMI): ‘independent mobility’, ‘assisted mobility’ and ‘not mobile’ (see Figure 1 p27).

A number of other measures that explain differences in care needs are used in each of these branches (referred to as ‘compounding factors’), both as single items and in combination, to create the final branches of the classification. These include cognition, function, risk of pressure injury, behaviours, communication, and technical nursing requirements, among others.

**Fixed payment**

With the AN-ACC model, on average around half of the total daily payment is based on a fixed base care tariff that reflects the cost of care that is shared equally by all residents in a care home, such as infection control manager, quality manager, and dining room supervision. There are six different base care tariffs reflecting care home characteristics, including facility size, geographic location and specialisation (Indigenous or homeless services).

**One-off adjustment payment**

The funding model also includes a one-off adjustment payment for each new resident to cover the additional resources required when someone first enters residential aged care.

**The AN-ACC classification and funding model**

The assessment and payment details described above form part of a broader AN-ACC classification and funding model that includes 30 detailed recommendations to support implementation, operation and monitoring of the new model. These include protocols for reassessments, payment of supplements, ongoing system refinements etc, and can be found in AN-ACC: A National Classification and Funding Model for Residential Aged Care Synthesis and Consolidated Recommendations (Eagar et al 2019b).

The Australian Government has not committed to including the 30 recommendations in the new funding model.

**What does the AN-ACC mean for residential aged care?**

The AN-ACC is a fit-for-purpose model that is based on evidence, meaning that there is an explicit relationship between funding and the actual costs of providing resident care. The cost of caring for residents with underlying conditions, such as dementia, are reflected in the AN-ACC class to which each resident is assigned. Although it is a more sophisticated model than the ACFI, it is a streamlined model that is administratively simple. The variability between residents is captured in only a small number of classes, with the relativities between the classes informing the price paid.

The key benefit of the AN-ACC is that it provides, for the first time, a clinically meaningful description of the residents...
living in care homes, and better data to understand their profile and their changing needs and costs. This can also be used to inform staffing requirements that are adjusted to reflect the needs of the mix of residents within a care home. For example, a care home which has an average of high-cost residents will receive more funding and have higher staffing requirements than a care home with a mix of residents with lower-cost care needs.

The classification system supports quality improvement and benchmarking between comparable services, for example national quality indicators such as pressure sores can be adjusted for the complexity of the residents. This will also support decision-making for consumers regarding their choice of care home.

Importantly for providers, the AN-ACC will also assist in the future planning and management of services. Aged care providers will have greater certainty regarding their funding, due to the approximate 50% of funding that is provided through the fixed payment component. Aged care clinicians working in care homes will be relieved from the administrative burden associated with ACFI and instead be able to focus on applying their skills in care planning, clinical leadership and supervision, and direct care provision.

An overview of the key changes is presented in Table 1 (see p28).

**Conclusion**

As a funding model, the AN-ACC provides greater stability for government and care providers. It provides the means for addressing critical issues around care quality, including appropriate staffing and more transparent and equitable funding. It puts the focus of funding in aged care directly back on the care needs of the residents, and supports other much-needed reforms, including the initiatives around minimum staff time with residents and five star public reporting, which have also been announced by the Government.

We recommended that the five star reporting system be underpinned by automated payroll data submission of nursing, allied health and personal care hours by providers to government. The Government has chosen not to implement this system, rather it will rely on providers submitting their data independently.

The implementation of AN-ACC is a first step towards achieving sustainable aged care reform. However, to really benefit from the opportunities the AN-ACC presents, we argue that a far more comprehensive reform agenda is required, one that truly integrates aged care with health, guarantees supply of an appropriately skilled workforce (including allied health), and regulates to ensure AN-ACC funding is used for the purposes it is intended – that is, delivery of care to residents.

**Acknowledgments**

The authors would like to thank the residents, care staff and management of the participating aged care homes, as well as the members of the RUCS project team.

The research project was funded by the Australian Government Department of Health. The views expressed in this article do not necessarily reflect the views of the Australian Government.

**References**


**What’s next?**

The Australian Government has announced that the AN-ACC will be used for residential aged care funding from October 2022.

Developments are already well underway for the commencement of the new model, with a budget commitment of $189.3 million over four years from 2020-21 for implementation. These include the passage of relevant legislation, and completion of a ‘shadow’ assessment period between April 2021 and September 2022, during which AN-ACC assessments will be completed for all aged care residents (excluding those with palliative care) by a trained workforce of experienced aged care clinicians.

The AN-ACC assessment and classifications will be used to determine the Government subsidies paid to care homes from 1 October 2022, replacing the ACFI from that date.
Table 1: Summary of key changes

<table>
<thead>
<tr>
<th>AN-ACC feature</th>
<th>Key change in aged care practice from current ACFI system</th>
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<tbody>
<tr>
<td>External assessment for funding</td>
<td>No ACFI assessments, documentation, audits.</td>
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<tr>
<td>Internal assessment care planning</td>
<td>Staff focus on care planning and delivery, monitoring and clinical leadership.</td>
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<tr>
<td>Reassessment protocols</td>
<td>No requirement for resident reassessment once admitted (annual ‘cost of care’ studies will pick up changes in costs per class); reassessment allowed for ‘significant’ increase in care needs – hospitalisation, mobility, standard time period.</td>
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<tr>
<td>Incentives</td>
<td>Evidence-based care driven by resident need, not as prescribed by the funding instrument.</td>
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<td>Funding certainty</td>
<td>Base care tariff component (~50%), system stability, transparency.</td>
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<tr>
<td>Quality improvement</td>
<td>Comparing ‘like’ with ‘like’ using casemix classification.</td>
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<td>Accountability</td>
<td>Facilitates comparable public reporting.</td>
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From left: Carol Loggie is a Research Fellow (Health Services Research), Anita Westera is a Research Fellow (Health Services Research), Dr Conrad Kobel (not pictured) is a Senior Research Fellow (Applied Statistics), all with the Centre for Health Service Development at the Australian Health Services Research Institute (AHSRI), University of Wollongong; Professor Kathy Eagar is Director, AHSRI. To follow up on this article, contact Carol Loggie at cloggie@uow.edu.au

† (Accessed 01/03/2021).