



# Residential aged care funding reform

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# Overview

- ◆ Methodology
- ◆ Key issues
- ◆ 5 options
- ◆ Why we recommend Option 5
- ◆ A bit more detail about Option 5
- ◆ Other recommendations:
  - Blended payment
  - Resource utilisation study
  - Adjustment payment

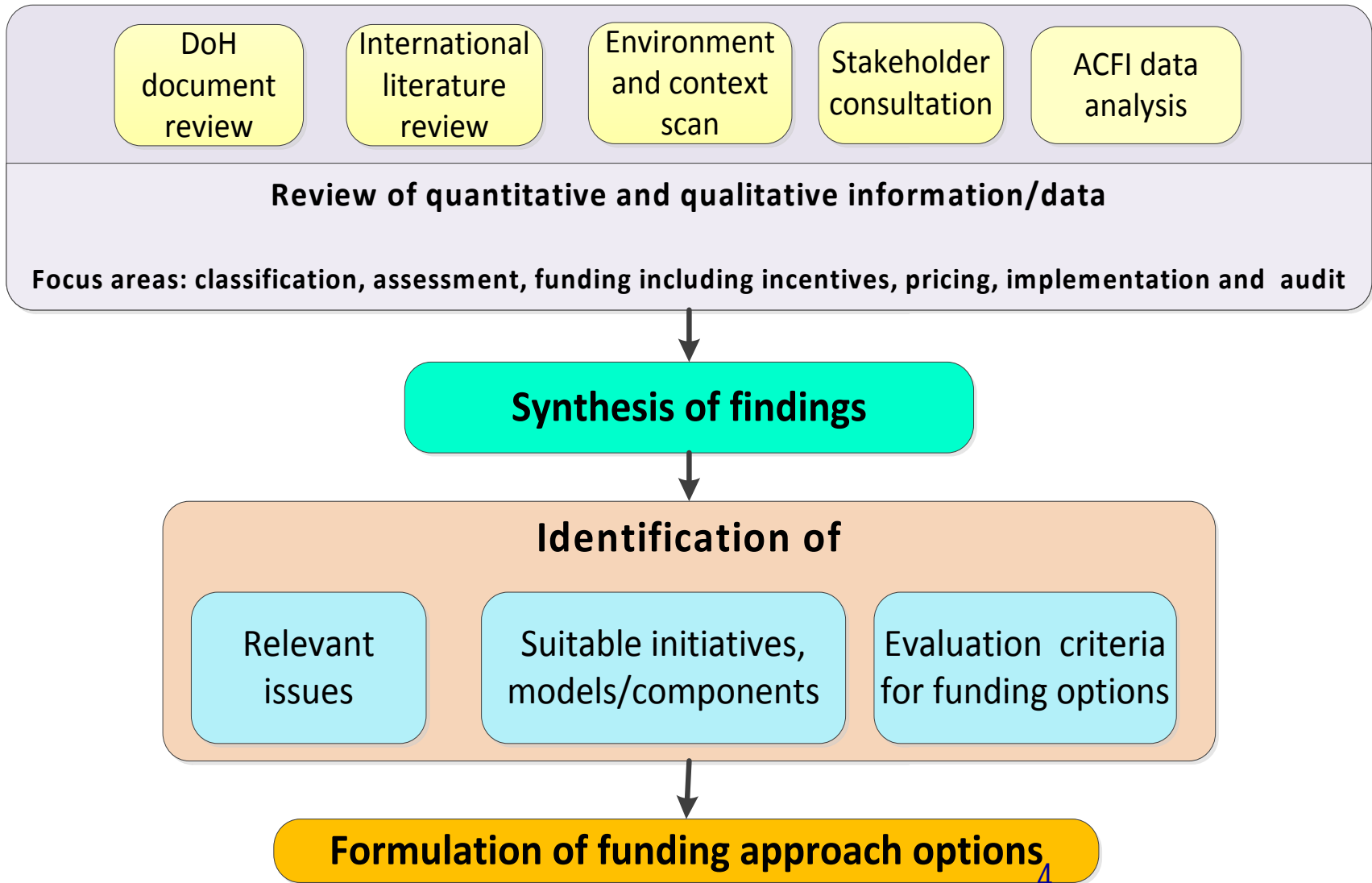
# But first – what we have not addressed (at this stage)

- ◆ Level of Government funding
- ◆ Resident contributions/fees
- ◆ Assessment – internal vs external
- ◆ Reassessment protocols

# Methodology

- ◆ Review of current system and consideration of options for future addressing five key issues:
  - Classification and assessment tools
  - Funding models
  - Pricing
  - Implementation considerations (incl. resource & infrastructure implications)
  - Audit mechanisms
- ◆ Mixed methods including both qualitative and quantitative information

# Mixed methods



# Industry consultations

- ◆ Peak aged care and consumer organisations:  
Leading Aged Services Australia (LASA), Aged and Community Services Australia (ACSA); The Guild; Council on the Ageing (COTA) and National Aged Care Alliance (NACA)
- ◆ Aged care providers:  
Uniting (NSW); Presbyterian Care; Catholic Health Care
- ◆ Government appointed advisory groups:  
Aged Care Sector Committee; ACFI Review Group
- ◆ Australian Government Department of Health

# Context

- ◆ Residents older and frailer than when ACFI was developed
- ◆ Average age at entry now 85 years
- ◆ Half will stay for less than two years
- ◆ Annual mortality rate of 32%

# Major issues with ACFI

- ◆ Additive design – the sum of individual item scores ignores interactions
- ◆ Does not focus on what drives care costs
- ◆ Does not discriminate enough between residents
- ◆ Creates perverse incentives for income maximisation resulting in funding uncertainty
- ◆ One third of residents are classified to just one payment class
- ◆ **Conclusion:** ACFI is no longer fit for purpose



# Required attributes of a new model

- ◆ Transparent, sustainable and stable
- ◆ Clinically meaningful - based on what drives need for care
- ◆ Consistent with 'Roadmap' concepts of choice, wellness approach
- ◆ Focuses on needs that best predict level of resource use
- ◆ Funding equity between provider types
  - ◆ recognise fixed/variable costs
- ◆ Operational efficiency

# No existing model is entirely suitable

- ◆ Relevant features in international models
  - ABF-like approaches with use of RVUs/cost and service weights (US, Canada, Japan, France, Austria, Belgium)
  - use of fixed & variable payment components (Canada, US)
  - special arrangements for small facilities (Canada)
  - use of external assessment reducing the need for audit (Germany, Japan, Scotland, England)
  - use of evidence-based assessment tools & linking care planning (US, Canada, UK, Germany)
  
- ◆ There are some lessons from Australian health sector

# Five options developed

Option One	Refinement of current ACFI
Option Two	Simplified model with four funding levels aligned to home care packages
Option Three	Simplified model with four funding levels plus supplements subject to external assessment
Option Four	Activity based funding (ABF) model with branching classification
Option Five	Blended payment model. Two elements: (1) payment for fixed care costs and (2) variable payments linked to the individualised needs of each resident

# Option One - Refinement of the ACFI

- ◆ Retains the current overall design with refinement of the measures of need for care
- ◆ Offers continuity with minimal impact on resources
- ◆ Shortcomings are retained:
  - assumes that each measure and domain stands alone
  - not aligned with cost drivers and
  - doesn't fairly manage financial risks or funding equity

# Option Two - Four funding levels

- ◆ Four funding bands based on judgement of independent assessor
- ◆ Advantages - simple, aligns with home care approach, removes some incentives for gaming & need for audit
- ◆ Disadvantages - does not align funding with cost drivers and introduces significant heterogeneity (only four bands) resulting in financial risks

## Option Three - Option Two + supplements

- ◆ Additional issue: supplements shift focus from actual care needs to eligibility for supplements

# Option Four- An ABF-type model

- ◆ Builds on experience of ABF model in health and elsewhere
- ◆ Branching classification: residents with similar care needs & costs grouped into 'classes' based on assessment variables aligned with cost drivers
- ◆ Explicit relationship between cost and price informed by resource utilisation studies
- ◆ No fixed and variable payments
  - No recognition of fixed costs for small facilities
- ◆ Longer-term development timeframe

# Option Five- Blended model with casemix classification

- ◆ Variant of Option Four, with fixed and variable payments:
  - reflects cost structures in residential facilities - fixed (non-individualised) and variable (individualised) costs of care
- ◆ Branching classification based on resident characteristics that drive differences in care need and cost
- ◆ Initial adjustment payments for short-term additional care needs of new clients
- ◆ Resource utilisation studies to inform payments

# Option Five features

- ◆ Self-regulating with cost informing price
- ◆ Suitable for either internal or independent assessment
- ◆ The variability between residents may be captured in a small number of classes
- ◆ May be initially perceived as complex due to the lack of familiarity with concepts
- ◆ Longer-term development timeframe

*This is the recommended option*

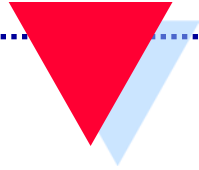


# Clinical benefits (Option Five)

- ◆ Allows a clinically meaningful description of the mix of residents
- ◆ Assessment tools capture those attributes of residents that drive their need for care inputs
  - Not comprehensive, not for care planning
- ◆ Greater flexibility and choice for providers and residents in the care to be delivered
  - Funding based on resident need, not prescribed care models
- ◆ Relativities between classes regarding the need for care preserved when cost (eg. salaries) change

# Business related benefits (Option Five)

- ◆ Explicit relationship between subsidies paid and actual costs
- ◆ Fixed payments reduce financial risk for small facilities
- ◆ Less vulnerable to gaming
- ◆ Conceptually sophisticated but simple to administer



# More about casemix-type systems

# A casemix approach – (resource utilisation classes)

- ◆ What do we mean?
  - Classifying residents based on those resident attributes that best predict the quantum of care resources they need
  - Classes comprise residents who use similar amounts of care resources
  - Cost weights assigned to classes to reflect relative resource use
  - Evidence based classification development with clinical validation
  - Classes would be residential aged care specific and look very different to classifications for hospital-based care

# Functional dependency and need for care

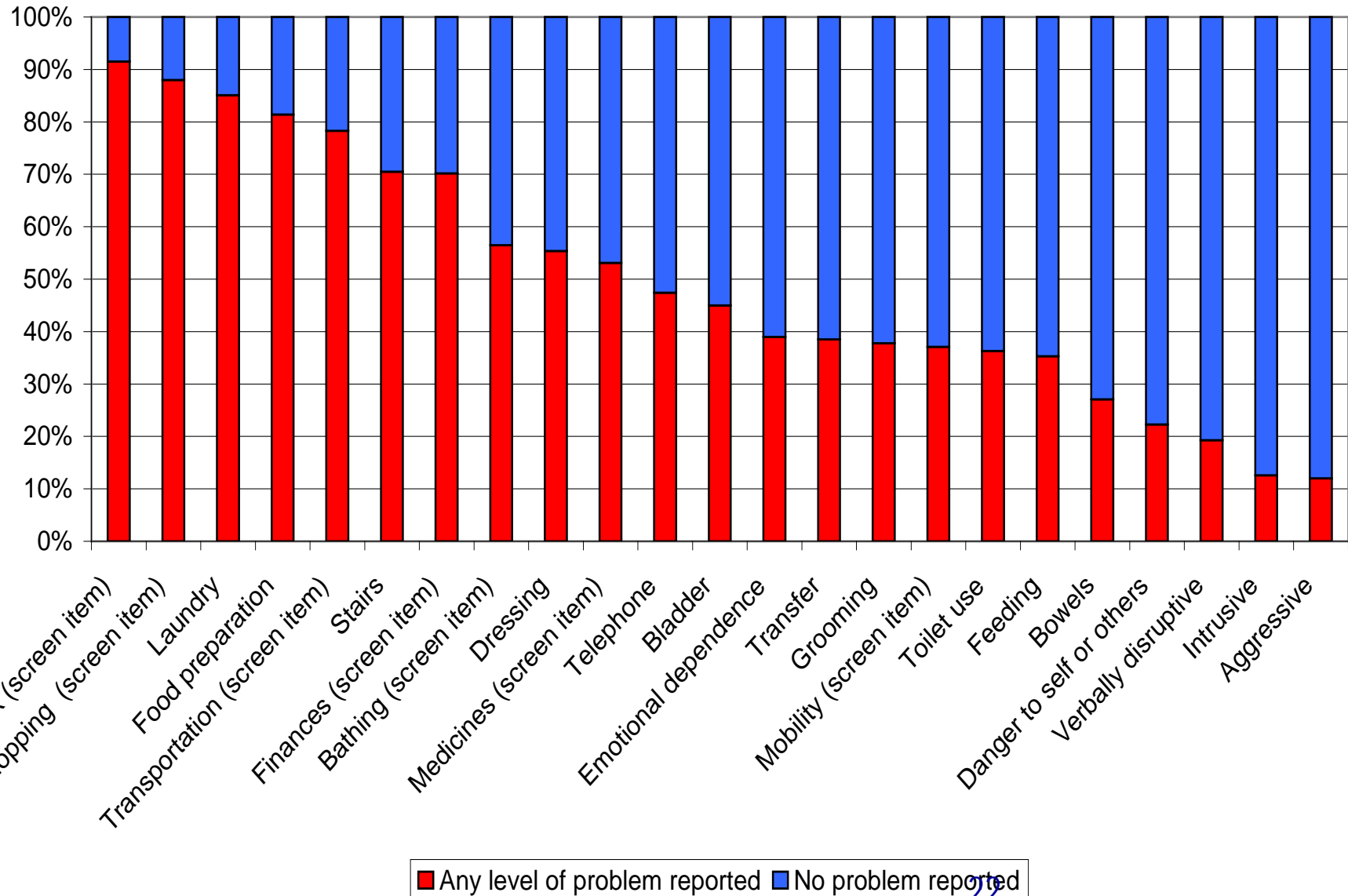
A measure of functional dependency is:

- ◆ An instrument that identifies areas in which a person requires assistance with daily living, and
- ◆ That quantifies the extent to which that person has to rely on someone else to help them carry out normal activities in their home and community.

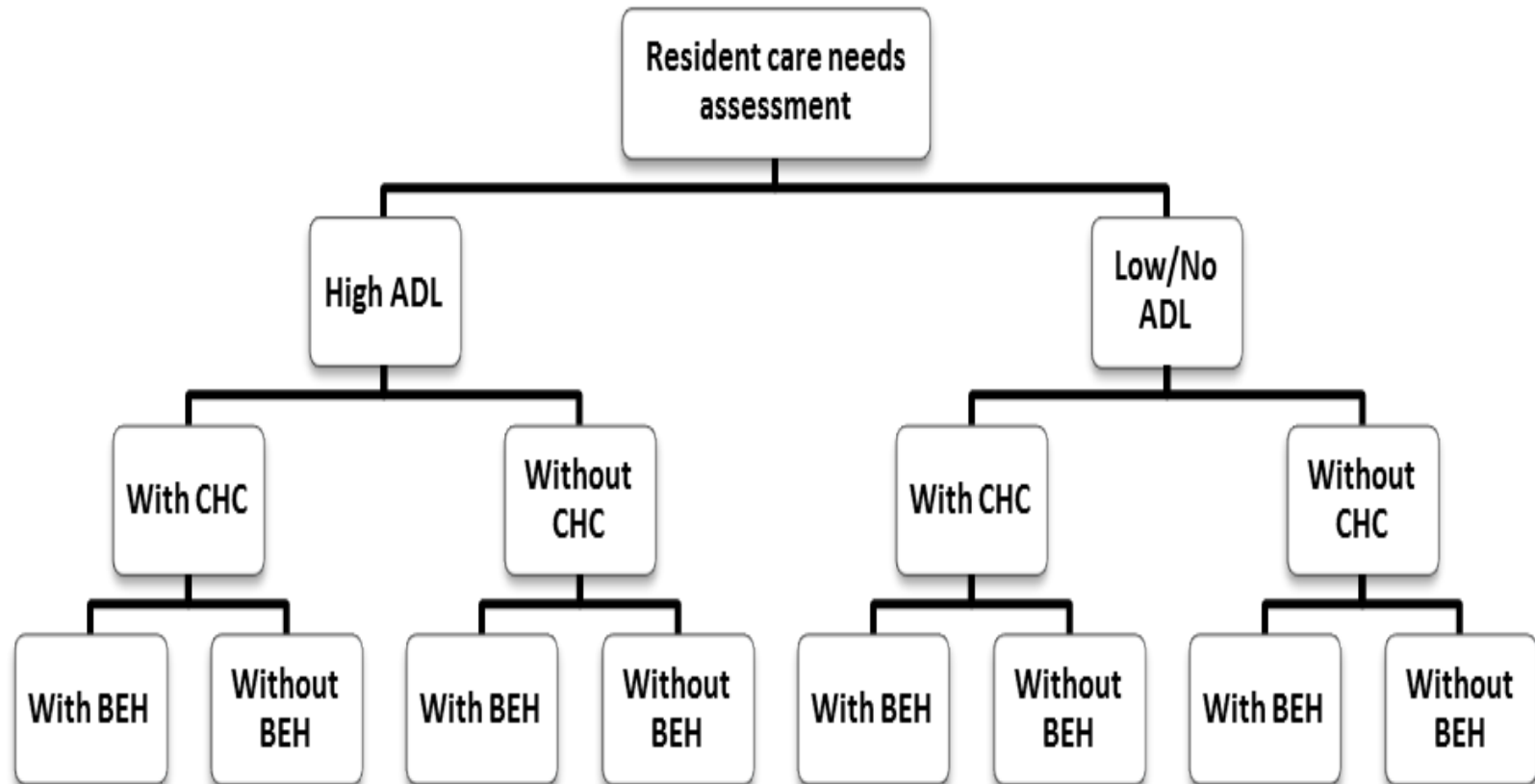
# Functional hierarchy - early loss and late loss ADLs

- ◆ People lose functional abilities in the opposite order to which they acquire them
- ◆ 'Early loss' ADLs like housework, transport, handling money, managing medicines (domestic functioning) are gained last and lost first
- ◆ 'Late loss' ADLs like dressing, toileting, feeding and bed mobility (self-care) are gained 1st and lost last
- ◆ It is reasonable to assume that, if a person can do early loss ADLs, they can also do late loss (supports screening)

## Profile of the HACC population on the functional assessment



# A branching classification model





# Additive vs branching classes

## ◆ Additive (ACFI):

- care needs are priced as if they are managed independently, interactive effects not recognised
- payments increase in additive way, even if the costs do not

## ◆ Branching approach:

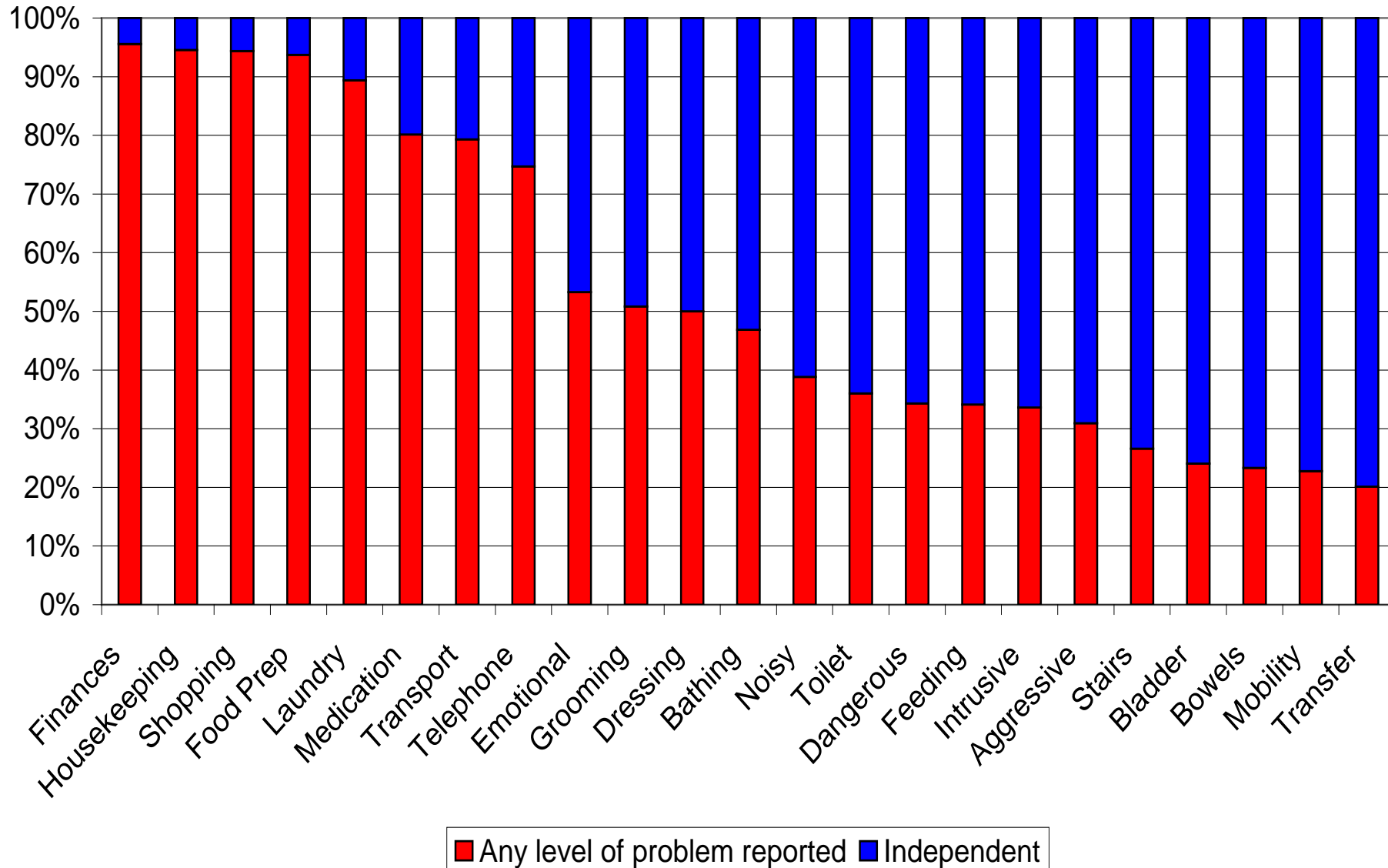
- cost drivers are applied in a hierarchical manner and each care related concept is dealt with only once
- the combined effect of multiple problems is reflected. Extra assessment items may not change the class
- each 'branch' of the classification is only created based on evidence that it can explain different needs for care



# A simple non-health example

Post school programs for school leavers  
with disabilities in NSW

## Summary functional profile of the NSW ATLAS population (n=1556)



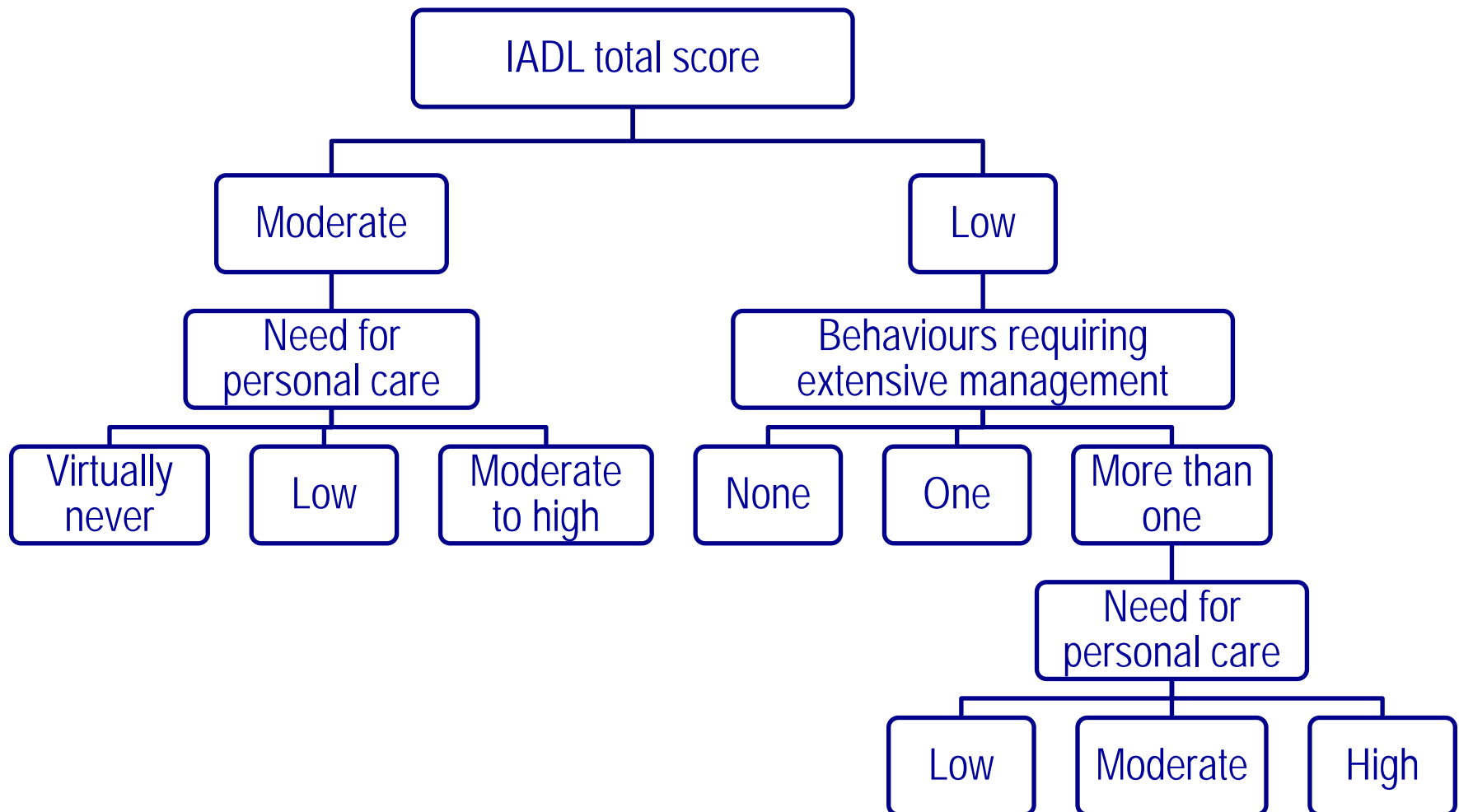


What attributes of school leavers  
best predict their need for support?

# Post school programs casemix classification development

- ◆ One month study, 20 services
- ◆ Client data:
  - Age, sex, disability profile, work aspirations etc
  - HACCC functional assessments
    - ◆ Self-care, instrumental, behaviour
- ◆ Service utilisation data
  - Client attributable, non-client attributable
- ◆ Cost data

# Post school programs classification



<b>Class</b>	<b>Class description</b>	<b>Cost Band</b>	<b>Cost weight</b>
1	Moderate instrumental functioning, virtually no need for personal care	Cost Band 1	1
2	Moderate instrumental functioning, low need for personal care	Cost Band 2	1.16
3	Moderate instrumental functioning, moderate to high need for personal care	Cost Band 3	1.43
4	Low instrumental functioning, no complex behaviour issues	Cost Band 3	1.43
5	Low instrumental functioning, one complex behaviour issue	Cost Band 2	1.16
6	Low instrumental functioning, more than one complex behaviour issues, low need for assistance with personal care	Cost Band 2	1.16
7	Low instrumental functioning, more than one complex behaviour issues, moderate need for assistance with personal care	Cost Band 3	1.43
8	Low instrumental functioning, more than one complex behaviour issues, high need for assistance with personal care	Cost Band 4	1.81

# A blended model (fixed and variable payments)



# What are 'fixed' costs?

- ◆ Care costs that are not tailored to individual resident needs.
- ◆ Care costs that are not affected by changes in the needs of individual residents:
  - clinical educators, care co-ordinators, quality managers, infection control, night staffing, dining room supervision, salary loadings for remote, staff leave.
- ◆ May vary based on location, size, specialisation of facility
- ◆ Actual proportions of fixed and variable cost will come from a resource utilisation study

# What benefits of fixed payments?

- ◆ Small RACFs have higher fixed cost proportions, particularly in rural settings
  - ABF systems rely on critical volumes and relatively low fixed costs
- ◆ Unavoidable costs of factors such as location and size are considered separately from the costs of providing individualised care.
- ◆ Increased funding security and stability for government and sector

# Adjustment payment

- ◆ One-off initial payment
- ◆ Time-limited costs involved with residents transitioning into care, eg:
  - Time spent getting to know the resident and their family
  - Individualised care planning
  - Behaviour management
  - Health care assessments
  - Facilitating health care arising from assessments:
    - ◆ Pain control, dental care, palliative care etc
  - Developing an advanced care directive in partnership with the resident and their family

# What does the initial resource utilisation study (RUS) involve?

- ◆ Sampling strategy, staggered data collection
- ◆ Resident-specific data collection involving all care providers for a limited period;
  - resident assessment variables
  - resident and provider-type specific care inputs
- ◆ Expenses data by type (salary by type, drugs etc)
- ◆ Allocation of expense data to residents using inputs as relative value units.

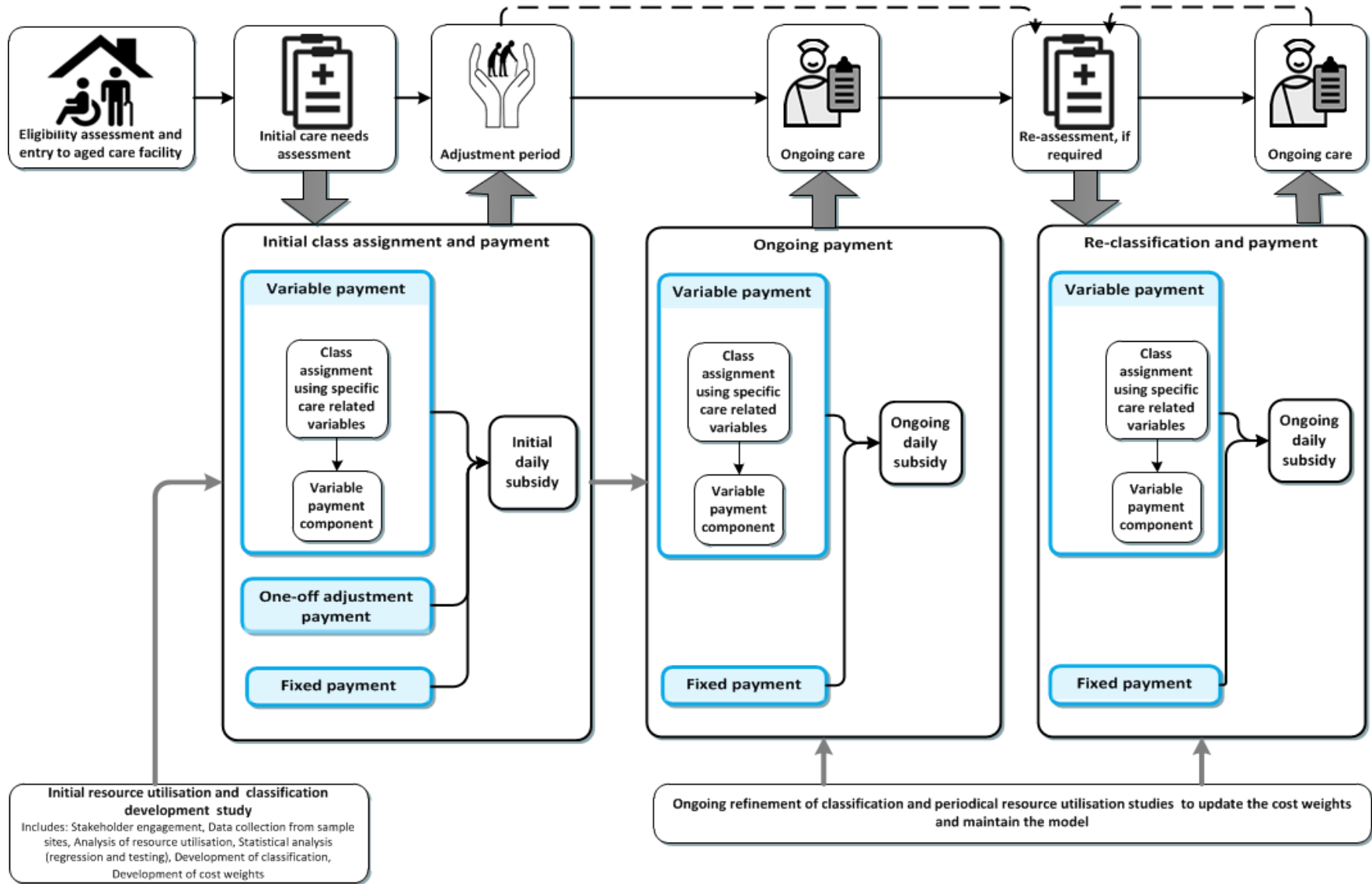
# What does a RUS provide?

- ◆ Evidence base for classification development
- ◆ Types and amounts of direct care inputs delivered to each individual resident (staffing and materials)
- ◆ The cost of non-attributable care activities undertaken that benefit all residents, and their resource inputs
- ◆ The total costs of all inputs
- ◆ The proportion of costs that are fixed vs variable

# How is a classification developed?

- ◆ An iterative process of statistical analysis and clinical review
- ◆ Which attributes of residents best explain differences in care inputs (cost)?
- ◆ Do additional characteristics provide further cost explanation?
- ◆ Goal is that each class contains residents with similar resource requirements (class homogeneity - CV) and that classes are different from each other (RIV)

# Care payment model



# What else can this type of system deliver?

- ◆ Better data to understand client profile and changing needs and costs
- ◆ If resource utilisation classes contain residents with similar needs, they can be used to measure quality and outcomes in meaningful ways
  - eg, hospital transfer rates adjusted for casemix
  - eg, rates of functional decline adjusted for class at entry
  - eg, rates of adverse events – falls, medication errors, injuries – adjusted for casemix



# Implementation considerations

- ◆ Value for money
- ◆ Need for staged approach
- ◆ Replacement assessment tools to be rolled-out
  - tools selected should have good psychometric properties, be well known and in common use
  - will likely include domains currently in ACFI but different tools
  - variables used in the classification should not create additional data burden

# Implementation considerations (cont)

- ◆ May be workforce implications with external assessment
- ◆ May need a review of IT capacity within the sector
  - IT infrastructure and applications will be common but not currently present in all facilities

# System maintenance

- ◆ Initial follow-up studies may be required within two years as part of a transition process
- ◆ Ongoing maintenance of the system will require infrequent further studies and involve:
  - RUS to ensure validity of cost weights
  - review of assessment variables and classification to ensure clinical currency
  - do not expect significant rates of practice change

# Care payment model

