ACCPA

Aged & Community Care Providers Association

In Home Aged Care Program Discussion Paper

ACCPA Submission

1 December 2022

Contents

About ACCPA

Aged and Community Care Providers Association (ACCPA) is the national Industry Association for aged care providers offering retirement living, seniors housing, residential care, home care, community care and related services.

ACCPA exists to unite aged care providers under a shared vision to enhance the wellbeing of older Australians through a high performing, trusted and sustainable aged care sector. We support our members to provide high quality care and services while amplifying their views and opinions through an authoritative and comprehensive voice to the government, community, and media.

Our sector serves to make better lives for older Australians, and so do we.

Introduction

ACCPA acknowledges the Commonwealth Government's commitment to the improvement of the current in-home aged care program in response to the recommendations of the Royal Commission into Aged Care Quality and Safety, supporting older Australians to remain living independently at home for longer. We support this commitment and seek to work together with the Commonwealth Government (the government) and other interested stakeholders to get the design and implementation of the new in-home aged care program right.

ACCPA also acknowledges the work of the Department of Health and Aged Care (the department) in progressing in-home aged care reforms. We acknowledge the extensive amount of work and stakeholder consultation the department has undertaken since the publication of the *Support at Home Program Overview* in January 2022, exploring with the sector options for how to realise a single in-home aged care program design. The request for feedback to the *Discussion Paper – A new program for in-home aged care* provides an invaluable opportunity for ACCPA and its Members to contribute to this reform activity.

As the national aged care service industry peak body, ACCPA envisions a future in which the design of the new in-home aged care program will be fit for purpose and future-proofed to provide continuing world class aged care that can support ageing in place for older Australians in the context of increasing care demands that extend beyond available workforce resources. We recognise these reforms must meet the challenges of the coming decades.

We also recognise that program design demands a visionary approach to in-home aged care reform, with strong investment and incentives for delivering high quality and safe person-centred care, promoting wellness and independence, supporting reablement and restoration, and encouraging innovation among service providers through the uptake of new technologies to help realise the aspirations of older Australians to remain living independently at home for longer.

ACCPA submits the following feedback in response to the discussion paper and thanks the government for this opportunity and our contributing Members for their input into the detail put forward in our submission. Please note we have interchangeably used the terms consumer, care-recipient, client, and people receiving care in seeking to make clear our views on the paper's indicative model with detailed consideration in supporting the realisation of responsive program design that can improve both care experience and outcomes for older Australians.

Program objectives: Creating a shared vision

ACCPA welcomes the specification of program objectives within the discussion paper in creating a shared vision among stakeholders to achieve a world-class in-home aged care system. We have reviewed the proposed program objectives specified in the discussion paper and recommend some adjustments be made to these objectives, including reference to program design supporting workforce and technology investment, to guide the final design of reforms. The proposed adjustments include:

- Older Australians should have timely access to a full range of services that meet their assessed aged care needs regardless of where they live.
- Reform of the in-home aged care program should include a robust funding design that facilitates workforce and technology investment to support equitable access to high quality care and supports for older Australians
- People who can afford to contribute to the cost of their care should do so, with a safety net in place for those who cannot.

- Older Australians should have choice and control over services that meet their assessed aged care needs consistent with their preferences.
- Regulation should be proportionate in setting quality and safety standards for the services and the providers of those services.
- Aged care expenditure over time should be predictable, fiscally sustainable, and equitable between taxpayers and clients.

Indicative model: Summary response

ACCPA welcomes the specification of program design features within the discussion paper in facilitating more detailed discussion with stakeholders in progressing reform of the in-home aged care program.

Strengths within the indicative model include:

- Separation of episodic and continuing care in the assessment and support plan generation.
- Maintaining separate assessments for goods, equipment, and assistive technology (GEAT), home modifications, and allied health services.
- Inclusion of full flexibility within a person's support plan to reallocate funds within each quarterly budget cycle. The only caveat being that there will be restrictions on swapping less important services for preferred services. For example, swapping out domestic assistance for clinical support that has been assessed as being needed in favour of extra cleaning or gardening.
- Recognition of the need for grant funding for thin markets, specialised support services, and services with high capital costs to address the unique cashflow challenges they experience.

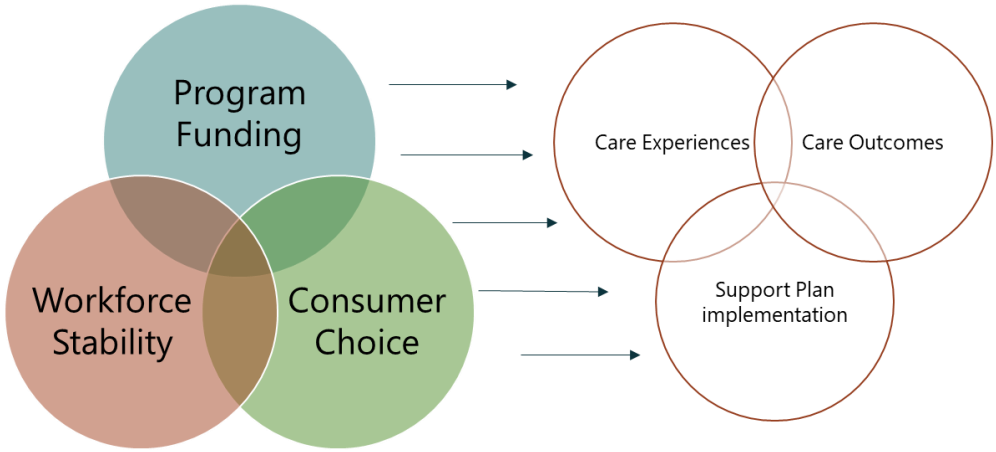
While there are some strengths within the indicative model, ACCPA believes there is still further work required to address some of the fundamental drivers for designing and implementing a world class in-home aged care program that can deliver the care outcomes and experiences being sought by older Australians. We have focused our submission in response to the discussion paper concerning the new in-home aged care program on these matters before responding to targeted design elements which were the focus of consultative questions put forward in the discussion paper and aligned to the indicative model.

Program inputs and outputs: Achieving the right balance

Balancing program funding, workforce stability and consumer choice will be key for the success of in-home aged care program reform. Each of these elements are interdependent in reform design and should not be addressed in isolation of each other. Rather, in-home aged care reform needs be designed and implemented, considering the combined impact of these interdependencies on support plan implementation and the care experiences and outcomes that are achieved.

If the design of the new in-home aged care program, through a comprehensive person-centred assessment process, can generate a robust support plan that correctly classifies a person's needs against the types and quantum of services required, then adequate program funding to support sufficient workforce supply will ensure providers have the capability to generate the right balance of quality services to be delivered, responsive to individualised consumer choice. The implementing of quality care and support services by providers in this context can then realise

high quality care experiences and outcomes that can be measured and made transparent to further support consumer choice of providers and services for the growing number of older Australians.



Program funding

The discussion paper references an indicative model of program funding that assumes fixed-price, activity-based funding that is paid to providers on services delivered. The model further proposes that this will be accompanied by a "modular add-on" grant funding arrangement to address the needs of thin markets, specialised support services, and services with high capital costs to support fiscal sustainability in these areas.

The paper proposes that if activity-based payments are paid at prices set by Government, competition between providers will no longer be based on price as currently occurs. Instead, parallel reforms on transparency and quality will stimulate competition based on quality.

ACCPA questions this assertion, suggesting the fixed price approach to funding along with quality and transparency reforms will not stimulate competition on quality. People receiving care will be at risk of having to accept whatever services are available, given the workforce supply gaps that are being experienced, with quality being determined by the set price.

The proposed fixed price approach, in a workforce constrained context, will simply erode provider differentiation on quality within a government-subsidised funding environment matched by workforce supply constraints. Simply put, those people who pay for additional services outside of the government-subsidised in-home aged care program will be the ones who will be able to choose services based on price differentiation and their experience of quality relative to the price they pay, which risks creating a two-tier system.

ACCPA believes that dual transparency on flexible pricing and care quality as measured through care experience and outcome reporting (that has not yet been realised and tested) provides the best opportunity to stimulate competition across providers with account for local market conditions in achieving high quality care experiences and outcomes. This needs to be matched by the design of a flexible and integrated funding approach that will support service providers in responding to the operational demands of delivering stable workforce solutions responsive to consumer choice while measuring the outputs achieved relative to the inputs that are invested.

Workforce stability

The care and support workforce is one of Australia's largest and fastest growing workforce segments, with around 720,000 care and support workers expected to be needed by 2049- 50 across aged care, disability care, veterans care and mental health services. This equates to an overall supply demand increase of over 50 percent across the next 30 years from 460,000 in 2021.[1]

Growth in demand has, and continues to be, the single biggest challenge facing the aged care sector. This is in response to several significant and concurrent changes in the sector, including an ageing population, the introduction of the National Disability Insurance Scheme (NDIS) that draws on the same care and support workforce and the expansion of in-home aged care.

Forecasting indicates that demand for care and support services in Australia has already started to outpace the supply of care and support workers. In September 2021, modelling pointed to a workforce gap of almost 100,000 workers (headcount) by 2027-28, with a gap starting to emerge within the first years of the model's projections commencing 2021-22. This forecast then extends out to a supply gap of around 286,000 workers (headcount), that equates to 211,000 full-time equivalent positions across the care and support workforce by 2049-50.

In August 2022 an update on these care and support labour workforce projections was issued.[2] It highlighted that the current macro-economic backdrop is now much tighter than was estimated in September 2021, meaning that the originally forecast on care and support workforce gaps, where consumer demand exceeds workforce supply, would be both larger and emerge more quickly than anticipated. In fact, it is suggested that the workforce gaps in the model, anticipated as emerging "in the short-term" now exist. This in turn underscores the need for a range of interventions to retain existing workers and attract more people into the care and support workforce.

In this context, funding design needs to be calibrated against demands for a stable and expanding workforce supply while also seeking to be responsive to the needs and preferences of those people receiving care. The impacts of the interdependency of these program inputs will be measured by the outputs generated in terms of care experience and outcomes achieved through support plan implementation. The sophistication of output measurement will inform further refinement of design calibration.

Simply, responding to workforce supply constraints by preferencing a focus on providing people their support plan budget and allowing them to engage independent contractors (via gig-economy platforms) and workers in lieu of addressing this interdependency is considered less responsive to the preferences of consumers. Issues of quality assurance in supporting people to access an indirect workforce that ensures appropriate insurances, training and qualifications are in place when compared to quality assurance for direct workforce engagement will need to be carefully managed, particularly when service provided across both workforce segments will be funded at comparable levels. Registration of providers to deliver services under the new in-home aged care program will need to be risk-proportionate while also recognising that there is some level of risk in providing seemingly low-level care and support.

Additionally, the sourcing of bi-lingual and culturally and linguistically diverse (CALD) workers, and workforce development in regional and rural communities, marked by limited availability of workers and fierce competition from other labour segments highlights the level of sophistication in funding design that will be required in realising genuine consumer choice. This reiterates the

[1] https://www.nationalskillscommission.gov.au/sites/default/files/2022-10/Care%20Workforce%20Labour%20Market%20Study.pdf
[2] https://www.nationalskillscommission.gov.au/sites/default/files/2022-10/Care%20Workforce%20Labour%20Market%20Study%20-%20August%202022%20Update.pdf

importance of a flexible funding design to mobilise these workforce segments to support provider investment in workforce recruitment, upskilling and retention activities.

As such ACCPA recommends that a sufficiently robust and flexible funding design be implemented to support in-home aged care service providers to recruit, upskill and retain a stable direct care workforce relative to local market conditions (including competing with other care and support labour workforce segments). The funding and workforce interdependency should aim to provide a 'fit-for-purpose' response to current and emerging workforce supply gaps, future-proofing in-home aged care program design to incentivise growth and investment in response to future consumer demand and workforce supply challenges.

The feasibility of the proposed funding approach referenced in the indicative model to respond to these interdependencies is seriously questioned. ACCPA recommends a rethink by government on funding design for the in-home aged care program in this regard.

Consumer choice

The discussion paper outlines some key aspects of consumer choice to be supported in the program design. However, research suggests that the types of choice that prospective and current in-home aged care consumers are seeking may be broader than those accommodated within the indicative model.

The indicative model includes:

- The ability for consumers to choose a preferred provider with easy access to information of sufficient detail on provider services, the terms of service, and price transparency to make a choice;
- The establishment of a *Community Care Finder* service access infrastructure to assist consumers to select and engage a preferred provider;
- The ability for consumers to choose a *Care Partner* where a support plan approval includes an allocation of care management support;
- The ability for consumers to self-manage their scheduling of services aligned to their support plan services types and budget quantum; and
- The ability for consumers to swap services around within the limitations of support plan approvals.

Research on consumer choice

A core feature of the NDIS is it's making available to participants the choice to self-manage their care and service arrangements. While participants are given options in relation to the management of their supports, only 15 percent of older people in the NDIS elect full or partial self-management.[3]

This suggests most consumers of the new in-home aged care program will likely choose to have the support of a Care Partner, if offered, to manage their care and service arrangements matched to support plan classification type/quantum thresholds. Otherwise, they may be forced into a self-managed support plan arrangement that may not match their choice of how they want to access services.

[3] https://www.ndis.gov.au/about-us/publications/quarterly-reports

Additionally, research[4] has identified among a large sample of 10,000 Australian adults who are prospective consumers of future in-home aged care services that the most important determinants of consumer choice of service provider in accessing care and support services is the experience of:

- Respect and dignity in receiving services,
- Aged care staff having the skills and training needed to provide appropriate care and support, and
- The provisions of services and supports for daily living that assist older people's health and well-being.

These care quality attributes rated as more important than being supported to make one's own decisions about care and services which was identified as being among the less influential determinants of consumer choice of a service provider. As such, over emphasise of program design to accommodate consumer direction in funds and care management at the expense of the higher-valued attributes of care quality is cautioned.

Furthermore, granular research on consumer-directed care among a small sample of home care package recipients[5] identified a range of factors spanning consumer access to information, participation in service delivery and care management that are seen as being important to older people in accessing and receiving in-home aged care. These include:

Information

- Easy access to standardised provider information on services, sub-contracted services/supplies, the terms of service, and price transparency on these services/supplies and any additional fees and charges;
- Having access to information about the qualifications and experience of care managers and support workers with the option to choose care managers and support workers;
- Information about how many older people care managers are overseeing as well the quality of care management and service delivery; and
- Availability of additional care finder supports to assist in understanding this provider information in making informed decisions about accessing provider services.

Service Delivery

- Having access to person-centred care delivered by a local provider that includes access to support workers who are suitably trained, competent, trustworthy, punctual and empathetic;
- Having access to consistent support workers who can deliver services at regular and set times matched to consumer preference;
- Having sufficient time allocated for support workers to undertake the service tasks required;
- Having access to a regular advance roster of planned services and support workers;
- Having clear and direct communication between consumers and service providers to support care-coordination; and

[4] https://agedcare.royalcommission.gov.au/publications/research-paper-6-australias-aged-care-system-assessing-views-and-preferences-general-public-quality-care-and-future-funding
[5] http://www.agedcarematters.net.au/wp-content/uploads/2019/03/OlderPeopleLivingWellwithIn-HomeSupport.pdf

- Having flexibility to adjust the delivery of services to match consumer preferences and need in both a planned and unplanned capacity, with service ability to accommodate these changes.

Care Management

- Having access to care managers who are experienced, qualified and easy to contact with consistent use of mutually agreed means of communication (e.g. emails, messages, home phone or mobile); and
- Regular mandatory visits by care managers to include health/welfare checks, face-to-face conversations, and updates with the older person.

Importantly, the types of choice referenced in these research reports will be largely dependent on how program funding and workforce stability are attended to in the overall in-home aged care program design. Supporting genuine consumer choice will need to be addressed by ensuring sufficient program funding flexibility to support service provider's recruit, upskill and retain a stable direct care workforce relative to local market conditions in growing workforce supply responsive to increasing demand.

Design context: Care continuum positioning

ACCPA believes there is benefit in conceptualising the reform of in-home aged care in the context of the broader human service and health care continuums, distinguishing between: acute care, sub-acute and non-acute care.

At one level, the balance of program funding, workforce stability and consumer choice in tertiary health and residential aged care settings can be conceptualised as being consistent with acute and sub-acute care settings. In these settings, program funding is administered via case mix classification that supports funding being set relative to client needs while recognising the level of variability that exists in need, both within and between clients. The funding design supports provider agility to respond to this variability dynamic, supporting responsive care matched by workforce skill mix requirements and the level of consumer choice that can be accommodated.

At another level, the balance of program funding, workforce stability and consumer choice in primary health and home care package settings can be conceptualised as a non-acute care settings with high level complexity. In these settings, program funding is administered via a fixed subsidy and flexible pricing arrangement where subsidy and pricing is set relative to client needs, also recognising the level of variability in need, the workforce skill mix requirements and level of consumer choice that can be accommodated but via a different funding mechanism.

At the most basic level, the balance of program funding, workforce stability and consumer choice in the NDIS and Commonwealth Home Support Program (CHSP) can be conceptualised as a non-acute care setting with low level complexity. In these settings, program funding is administered via a fixed subsidy and pricing arrangement set by Government where the level of variability in need is low, the workforce skill mix requirements are not as variable, and the level of consumer choice can be more easily navigated via self-managed care arrangements.

In-home aged care reform needs to recognise the diversity of care needs and care trajectories that will need to be accommodated across a non-acute care setting with a diverse and dynamic range of low through high level complex care and support requirements.

Design responsiveness to care-recipients with high care needs

ACCPA preferences the implementation of a case-mix classification program funding design as a minimum requirement for the new in-home aged care program, noting this will provide the necessary consumer protections for people seeking care who have increasing and complex care

needs that want to age in place. Case mix classification program funding for in-home aged care recognises the level of variability and agility that will be required for daily response to complex care needs, the workforce skill mix requirements and the level of consumer choice that can be maintained with regards to:

- Care management support needs,
- Allied health-led reablement and restorative care needs,
- Chronic disease management support needs,
- Dementia care and support needs, and
- End of life care and support needs.

Some may argue that current demand for variable and fluid program funding arrangements atypical of the home care package program seems relatively small when compared with the more stable support needs of CHSP care-recipients who represent 80 percent of all older Australians receiving in-home aged care. ACCPA challenges this contention, arguing that what we as a nation accept as being adequate for this particular care cohort in terms of the interdependencies of program funding, workforce and consumer choice inputs will define how we value older Australians as a nation.

The ageing of the Australian population and the projected growth in demand warrants a forward-focused design lens to future proof in-home aged care program funding to be responsive to the challenges providers will need to grapple with in terms of creating a stable workforce supply chain responsive to consumer choice - how they want to receive care and support while ageing in place. Only through this forward-focused design lens can Australia realise the world class in-home aged care system that has been called out in the final report of the Royal Commission into Aged Care Quality and Safety.

Design responsiveness to sustain community care infrastructure

Existing in-home and community services account for over 1500 government-subsidised aged care services providers nationally. They are an integral part of the aged care system that supports older people to have the best possible life and care, facilitating ageing in place with account for a person's faith, culture, language, financial means, and geographical location.

Maintaining this essential community care infrastructure in transition to the new in-home aged care program should be a priority. Funding arrangements should aim to support these smaller community organisations, incentivising service scalability and sustainability, while providing sufficient certainty to promote long-term strategic planning, workforce succession, and infrastructure/resource planning and innovation at the provider level. The interdependency of program funding, workforce stability and consumer choice inputs demand it.

The impact on the cash flow of smaller community care providers of implementing the indicative model's fixed-price, activity-based funding paid to providers on services delivered is significant and cumulative. Smaller community organisations that lack cash reserves or unencumbered real assets to borrow against and that rely heavily on grant funded arrangements may find the restrictive nature of the proposed funding design too challenging.

Additionally, in-home care providers who struggle with the proposed funding restrictions while trying to maintain a commitment to achieving the fullness of consumer choice will likely see high rates of staff turnover while needing to refocus on volume and cost control to match the demands of the funding design. In the context of growing workforce gaps, retention of existing care and support staff needs to be supported and incentivised.

ACCPA's preference for the implementation of a case-mix classification program funding design as a minimum requirement for the new in-home aged care program will support service scalability and sustainability among these smaller community care organisations. The combination of capacity and activity payments calibrated to cost demands using a place-based service delivery approach provides an efficient means of recognising the variance and complexity of place, the differences in cost demands across communities, and supports funding flexibility to deliver culturally and socially appropriate services critical to achieving quality care and supporting human dignity.

Consultative questions

In responding to the practical challenges for the design aspects of the indicative model put forward in the discussion paper, ACCPA makes the following commentary. In doing so, ACCPA stipulates the need for consideration of the preceding high-level feedback as a precursor to the subsequent commentary concerning the technical detail of the indicative model.

A funding model that supports provider viability and offers value for money

- The indicative model proposes that service delivery be primarily funded via Activity Based Funding (ABF) where prices will be set against services items within each of several different service categories. The collective set of priced service items will be called a service list. Prices for the service list will initially be set by the department to commence 1 July 2024 with input from the Independent Health and Aged Care Pricing Authority (IHACPA).

  The ABF service list would be complimented by a grant program targeting thin markets where service providers will have additional service delivery costs and some service types that will need a degree of funding certainty.

  Indigenous providers are seeking an alternative funding model altogether that would be more flexible that the ABF/grant funding approach of the department's indicative model with further details on this funding approach to be made know in the coming months.

- ACCPA notes several key concerns with the funding approach proposed for the indicative model. The funding model reflects a fixed price, activity-based funding approach with payment on services delivered. It combines the fixed price funding approach currently being applied within the CHSP funding environment and the activity-based funding approach with payment on services delivered currently being applied within the Home Care Packages Program. ACCPA has considerable concern with this funding approach.

- Firstly, payment on delivery of services will result in providers not getting paid if a service isn't used. This will incentivise service providers to make use of a more casualised on-demand workforce, reducing the certainty and stability of workforce options for care-recipients. It will also make it difficult for small organisations to have certainty regarding cashflow and potentially bring about market failure in some communities, reducing the choice of service providers available, and disrupting care for a multitude of existing care recipients.

  In contrast residential care continues to be paid even if a person is absent from a bed for a short period of time, recognising that there are fixed costs and overheads. The same is true for in-home care service providers who maintain capacity to deliver services with a permanent direct care workforce. Allowing service payments to be made based on agreement to deliver a service against a support plan (albeit with some flexibility depending on the reason why a service isn't used) would provide much greater certainty and stability for small community organisations, their staff, and volunteers, as well as support the maintenance of a permanent direct care workforce.

- Secondly, fixed pricing against a definitive service list will deny consumer choice and encourage a focus on providers managing volume and cost control rather than responding to individualised consumer choice. This can already be observed in other fixed price markets where volume and cost control create perverse incentives to accommodating consumer preferences and incentivise cherry picking of service delivery against care-recipient support plans. ACCPA is hearing from our members that their experience of the CHSP fixed price approach is resulting in their not being able to afford to offer services at the same market price in comparable human service settings, with workforce moving across to focus exclusively on these settings. The introduction of fixed prices may particularly disincentivise providers delivering care and support to care-recipients with complex care needs, particularly if provider requirements against clinical care standards are set at a level consistent with residential care and where care quality requirements are not matched by funding flexibility as is applied in case mix classification within residential care.

  Additionally, with a future increase in demand for complex care in the context of an ageing population there is concern that the available supply and rate of growth in residential aged care beds may be insufficient to respond to this demand across the next decade. This may create challenges across home and residential aged care if flexible funding for high level in-home care is not incentivised. The likely outcome could then be an increase in hospital admissions among older Australians. Averting such a risk, demands a flexible in-home aged care funding approach to facilitate ageing in place, responsive to future demand.

Future-proofing the funding design

ACCPA suggests that alternate funding approaches be considered for the design of the in-home aged care program.

- ACCPA's first preference for an alternate funding approach to that proposed for the indicative model continues to be for a 'capacity and activity' case mix classification funding model as outlined in the Support at Home Alliance submission to the in-home aged care program discussion paper. ACCPA notes the Support at Home Alliance's submission and is fully supportive of progressing a case mix classification funding model, noting such an approach will be more responsive to the demands for flexible funding design to support ageing in place through to complex dementia and end of life in-home care consistent with the preferences of older Australians to age in place.

  In summary, a case mix classification model for in-home aged care will be conceptually more sophisticated than the proposed fixed price ABF approach specified in the indicative model but administratively simpler to implement, with provider price and volume contract arrangements specifying the total price and volume of activity to be delivered over a designated period. This them firms up provider capacity payments against the contract period and activity payments for services delivered across this period.

  Additionally, this funding approach will eliminate the need for a separate grant funding arrangement, enhancing the administrative simplicity of funding design. It will also be responsive to the needs of indigenous providers and their elders, as well as CALD providers and their communities, offering a flexible price and volume funding approach.

  It is important to note that as in residential aged care, funding within the case mix classification funding model can still follow the care-recipient who has a support plan with specified service types and quantum against which they can select care providers to deliver their care and supports. Price and volume contracts can then be acquitted against the volume of services delivered as is currently the arrangement for CHSP providers. This approach will support a single flexible funding design across the entire care continuum regales of accommodation setting where there will be one Nationally Weighted Activity Unit (NWAU) across both home, community, and residential aged care where all weighting classes will be relative to the value

of 1.00, being simple to administer and recalibrate through efficient pricing informed by the work of the IHACPA.

- ACCPA's second preference for an alternate funding approach to that proposed for the indicative model, being closer to the indicative model proposed by Government, is a Medicare type model with the department generating a service list with fixed subsidies allocated to service providers on agreement to deliver services but with providers having the option to flexibly set prices for these services for purchase by care-recipients. Flexible pricing will support providers to respond to local conditions for delivering care as marked by workforce stability and will also rewarding innovative models of care responsive to consumer choice and preference.
  Importantly, the gap between subsidy and a market sell price will drive the approach to care co-contributions whereby those care-recipients requiring a greater volume of care and support will need a volume-based supplement to cap the care-co-contribution. Providers could also be given the ability to decide on the level of care co-contribution relative to contribution caps in supporting providers to differentiate on price, noting this approach to setting up care co-contributions will only be effective if there is dual transparency on flexible pricing and care quality as measured through care experience and outcome reporting.

- Grant funding would also be required in this alternate funding approach, noting thin market service providers will have additional service delivery costs and some service types will need a higher degree of funding certainty to remain viable. For example, social support programs have high fixed costs and a payment in arrears type model will be difficult for them to sustain. Similarly, programs that provide services for populations with complexity or unique care and support needs (i.e. dementia advisory services, CALD services, chronic disease management supports etc.) will seek to provide person-centred supports where care requirements can be quite variable. Importantly, grant funding arrangements for these types of services will provide a more stable funding approach in supporting service sustainability, more so than the fixed price ABF model with payment on services delivered.

- With the proposed grant funding arrangements listed within the discussion paper, it is not clear what criteria will be used to determine those providers who would qualify for grant funding, noting a competitive five-year grant process is proposed. It is also not clear whether the grant process targets competition within a market or between markets. There is also concern about the lead time requirements to implement a competitive grant process prior to July 2024 to minimise care disruption if providers who are unsuccessful in the competitive grant process consequently choose to exit service delivery. If the Government chooses to tender via regions, it is suggested that they stagger the grant tender process to ensure continuity of provider tender capability, stimulating greater competition. Regardless, further consideration of grant funding implementation across the immediate and longer term is required. In this regard, case mix classification funding provides a more integrated and flexible funding approach, accommodating the needs of both providers and their care-recipients in balancing service sustainability and value for money.

Important considerations in the funding design

- Grant funding or the type of funding certainty offered through a capacity and activity payment design of a case mix classification approach offers far greater service provider flexibility to respond to care-recipient care and support needs than the ABF approach put forward in the indicative model. This will be especially so in aged care where care-recipient trajectories for care and support will rapidly change as care needs increase relative to the stable care trajectories of younger care-recipients targeted within the NDIS' ABF funding design on which the indicative model is based.

- Staff morale is also expected to be higher in a grant funded or case mix classification funding environment, noting the expected contrast in focus from workers engaging in transactional-

based care under ABF in comparison to relationship-based care where flexible funding is applied. Increased staff morale will naturally lead to improved workforce stability.

- These alternative funding approaches will also better support innovation as there is scope and flexibly for providers to make an investment with less concern over funding stability. The ability for providers to work with care-recipients to self-determine their service approach and quality rather than being forced into a fixed price point that dictates quality is a far more responsive program design to accommodate the diversity of consumer choice.

Support that meets assessed needs, but is responsive to changes over time

- An improved assessment tool relative to the current National Screening and Assessment Form using validated assessment tools should better match service types and quantum to needs reducing the need for review and reassessment in the immediate period following support plan approval and implementation. In this context the proposed trial of the assessment tool from April – June 2023 with existing care-recipients should include clarification of the support plan fit against service types and quantum already being accessed. Where differences (errors) exist in the fit, this will need to be addressed in refining the assessment tools translation to the classification approach generating support plans.

- Noting the Government is moving towards a single assessment approach with no wrong entry point, the trial of the improved assessment tool should also include trialling how assessment of complex care and support needs for support class approvals (service types and quantum) compare with residential aged care assessment and classification. In particular, the April – June 2023 assessment trials should include cross-assessment validations i.e. comparing residential aged care assessments and classifications with high level in-home aged care assessments and classification to determine the level of consistency or variation that exists across the multiple support class determinations matched to care-recipient need.

- Ideally, the trial of the assessment tool should also be extended to include implementation of the support plan among a sample of care-recipients and their service providers and Care Partner to pre-emptively identify any issues of concern for resolution/risk mitigation in finalising the operation of support plan implementation prior to program commencement from July 2024. Participation in a support plan implementation trial should be included in a business case for funding across the FY23-24 with care-recipient and provider participation via expression of interest, much like the consumer directed care trials of 2015-17 in preparation for Increasing Choice in Home Care.

- So far, minimal detail has been released on the assessment tool which will be used to determine the types and quantum of supports people will get across low and high care need care-recipients, as well as care-recipients with diverse support needs. Similarly, there is no information on the governance arrangements for the assessment workforce approving support plan allocations. Governance arrangements will need to ensure people can appeal decisions, specifying timeframes for appeal if they think they have been under assessed or if they are concerned about re-assessment delays. This was clearly an issue in the implementation of the assessment, classification, and support plan approvals of the NDIS. The lack of visibility on the assessment tool limits the ability to consider the fit of this tool in an assessment and classification approach relative to considering the demands for a flexible funding approach when compared to the indicative model's application of fixed-price, activity-based funding that is paid to providers on services delivered.

- Some support classes (service types and quantum) will be co-dependent in the achievement of quality care experiences and outcomes. This will need to be accounted for in the translation of determining support class requirements as an outcome of an assessment and translating this to a support plan. For example, GEAT solutions will have the potential to support a

person to maintain a level of independence at home. However, there may be no restoration of a person's functional capacity by the application of GEAT in isolation of accessing complementary allied health services (or vice versa). Short Term Restorative Care (STRC) has had good outcomes as a preliminary and preventative measure, supporting people to remain independent, drawing on a range of complimentary care and support services, as far as is possible and emphasising restoration and rehabilitation. The single assessment tool must allow for the assessor to consider the combined benefit of multiple support classes (service types and quantum) in designing a support plan. Limitations in support thresholds and interdependencies within a support plan could be counterproductive. Thus, ACCPA's recommendation to trial support plan implementation prior to July 2024 commencement.

Flexible funding pool

- The flexible funding pool of the indicative model, much like the proposed grant arrangement, represents a modular add on to the ABF funding design. It will be largely responsive to care-recipients whose support needs are somewhat stable and well matched to the funding specifications of an assessor approved support plan. When such care-recipients have support needs that go slightly over budget or have a one-off specific need, the flexible funding pool will provide both providers and these care-recipients the mean by which to mitigate the risks of having unplanned support needs. However, there is a danger that this funding may be used for regular servicing or may be used excessively by a single provider in a multi-provider environment. A balance needs to be struck, and data maintained, on what is a regular planned service and what is a flexible unplanned service, how often these occur, and what approval or oversight is required.

- If a provider has many clients who have regular and stable service requirements that are fully funded through their support plan, then a flexible funding pool of 25 percent of total funding will likely be sufficient. However, if a provider has many clients with fluctuating service requirements, then the adequacy of the 25 percent flexible funding pool may be challenged. In such circumstances, the feasibility of this funding pool would need to be matched by timely access to the reassessment of care needs, with adjusted support plan approvals being issued to alleviate reliance on access to the funding pool on a continuing basis otherwise providers will be disincentivised to take on too many clients with fluctuating care and support needs.

- It is also suspected that where a Care Partner has not been funded there will be demands placed upon service providers to re-direct care-recipient enquiries relating to their support plan and service eligibility to My Aged Care and Community Care Finders as they will not be costed into provider service delivery under the indicative model's ABF funding approach. This brings into question the operation of the provider held flexible funding pool in such circumstances to support full cost recovery matched to unplanned care-recipient need. Can the flexible funding pool only be used to pay for additional units of service within a support plan or can it be used for other unplanned care-recipient costs? Unplanned care-recipient costs may not only include providing self-management support in the absence of a Care Partner but possibly unplanned costs such as responding to COVID related care impacts and/or bushfire or flood related impacts. This will be the difference between a person-centred funding approach to care and a transactional ABF approach to care.

- On clarification of the operational parameters for provider access to the flexible funding pool and the total amount of pooled funds being made available, consideration may also need to be given to the need for targeted care-recipient communication and education strategies (above Community Care Finders) to ensure 'at risk' groups who regularly expend flexible funding understand their self-management responsibilities to help them more effectively manage activity-based payments and self-managed care. These types of care-recipients will be extremely hard to service and many providers under an ABF efficient pricing arrangement will likely steer away from providing services to such care-recipients, thus creating service inequity.

Care partners and self-managed care

- Care Partners providing care management support should be made available for everyone who cannot self-manage or for those who self-manage and demonstrate evidence of adverse/deteriorating impacts in care quality, noting proponents of dignity of risk may view some level in the deterioration of care quality as being acceptable.

- Assessment of consumer self-management needs to occur upfront during assessment in designing a support plan. Self-management assessment needs to give account to consumer readiness, importance, and capability to manage care and support service implementation matched to the support plan. Timely review of the need for care management support via a Care Partner will be important in circumstances where consumers take on self-management.

- With respect to self-managed care by a consumer, the ability to manage a budget will vary greatly from person to person. A capacity building framework will need to be developed to give older Australian's the best chance at successfully managing their own budgets if an assessment determines self-management as being feasible. Examples of capacity building activities within such a framework include information sessions and guidance on how to do this and an easy-to-use consumer application that includes tools to easily track budget expenditure. There could also be an option to fund consumer self-management to include budget support, training, and periodic oversight from a designated service/supplier. This could work like NDIS financial managers who are not funded as full Support Coordinators. Such an approach would offer a solution to self-managing consumers who are struggling in the implementation of their responsibilities and reduce the likelihood of mismanagement with flow on effects that impact service provider payments and care relationships.

- Where self-managing consumers do not remain in budget, or when a budget is insufficient to meet critical need, allowances should be made to ensure that providers and consumers are not adversely impacted by poor self-management and/or assessment. For example, under the current CHSP framework, the provider has control over the frequency and intensity of the services delivered, but if we move to a model where the consumer has a fixed self-managed budget there may be a risk of it being expended with an additional demand for support above the quantum of support allocated in a support plan. In such circumstances, providers should not be adversely impacted by consumer non-payment or over expenditure. Anecdotal evidence from members suggests that this process has created unnecessary financial risks for providers operating in the NDIS with responsibility for debt collection being passed on to providers where servicing to meet critical need is not being funded, disadvantaging both providers and consumers.

- Where self-management is assessed as being not feasible, a Care Partner should be assigned with funding attached commensurate with care management requirements matched to the support plan. The responsibility of selecting a Care Partner should sit with the consumer. This is in line with the principle of consumer choice and ensures that older Australians can make an informed decision based on the best fit for them, which should facilitate better care experiences and outcomes for the individual.

- Care Partners should be accountable for monitoring outcomes and changes in clinical and non-clinical care needs because this helps to hold service providers contributing to support plan implementation accountable for the quality of care that they are providing to the consumer. The Care Partner should be given an allocation of funding to provide regular check-ins (phone based or face to face) to monitor the consumers experience of care and support delivered. This could include an initial phone call after the initial appointment with a provider (high level check-in), and a review of outcomes in conjunction with the consumer/provider at the end of an episode of care. The Care Partner should have the responsibility of ensuring the intervention provided has been safe and effective in achieving the outlined goals of the consumer. The Care Partner

model needs these requirements to be built in to safeguard the consumer from receiving inappropriate or ineffective care where poor care experiences and/or outcomes may trigger transition of service delivery to a new service provider.

- ACCPA and its Members do have concerns with the introduction of Care Partners who are independent of service providers, noting the royal commission did recommend the care management function should remain with a 'lead' service provider in support plan implementation. Importantly, who will oversee the care quality of care management support services being delivered by independent Care Partners? Additionally, if Care Partners are independent of service providers, who may also be brokering services in the context of workforce gaps, you can develop a chain of care communication with increased risk of errors, associated costs and service failures. A common cause of adverse events is simply miscommunication and delays in communication exchange. This can exist in the same shift and same team in the same organisation, let alone a chain of 3-4 organisations, and some with non-clinical expertise. The multiple provider service structure with independent care coordination inherently builds in an increased risk profile for the delivery of care and supports against a support plan. This translates to the regulation of Care Partner responsibilities being potentially difficult to manage and maintain given the problems with co-ordination of multiple services and actioning changes in care and support that meets consumer preferences.

- ACCPA recommends that, at minimum, clear advice be issued to support informed decision-making among care-recipients for implementing support plans that include clinical services, comprising nursing and allied health services. This advice should highlight the risks of service fragmentation where service provision (including Care Partnering) extends across multiple providers, beyond a bundled service delivery approach provided through a single organisation. Clear direction will be needed in this guidance, offering impartial advice to care-recipients, in supporting their informed-decision in choosing an approach to support plan implementation that involves multiple providers, noting the personal risks this choice may introduce.

  Where support plans only include non-clinical supports, serve delivery across multiple providers supported by a Care Partner, may also be associated with risks of service fragmentation, however the risk profile for care-recipients can be more easily managed among providers across the tensions of duty of care and dignity of risk.

- Care Partners will need to have a detailed understanding of requirements for meeting the aged care quality standards should there be any expectation on them in relation to ensuring service providers delivering services against a support plan are meeting their responsibilities against the standards. While it is the primary responsibility of each service provider to adhere to the aged care quality standards when delivering a service, shortcomings can only be managed if accurately identified against the regulatory framework which must be simple to interpret and free from ambiguous interpretation. In this regard, the Care Partner can link any concerns raised by a consumer with the Aged Care Quality Standards and facilitate a consultation with the provider to clarify any aspect of the care being provided, supporting the consumer to take any subsequent action required.

  Clearly listed requirements for Care Partner engagement with service providers and expectations regarding the interpretation of the legislative and regulatory environment for support plan implementation needs to be carefully matched to workforce capability and supply with investment in workforce development for Care Partners being matched to projections in the demand for in-home care and support services.

- Successful care management would include:
    - Care Partners ensuring the approved services/funds in a consumer's support plan are managed effectively across each quarterly budget cycle (i.e. identified service types and quantum are delivered by providers)
    - Care Partner check-ins are completed to ensure all providers contributing to support plan implementation are meeting consumer expectations and service delivery requirements, are outcome focused, and are in line with requirements for the provision of safe and effective care against the Aged Care Quality Standards.
    - Care Partners are responding in a timely manner to consumer concerns about the delivery of services, including supporting consumers to change service providers if needed
    - Care Partners are assisting consumers to manage escalations or changes in service delivery in response to changes in care needs, including where changes occur in their clinical presentation
    - Care Partners are supporting the consumer by providing impartial information and advice about suitable services to meet their care needs as are identified in their support plan
    - Care Partners are supporting consumers that require a re-assessment of needs from an independent assessor, managing the delivery of unplanned interim support needs in the period leading up to the reassessment
    - Care Partners are support consumers with the managing of their budget as required, ensuring care and support expenditure in within budget with respect to facilitating planned service expenditure
    - Care Partners are contributing to the collection of service activity and outcome data in measuring care experiences and outcomes against support plan implementation matched to consumer goals specified within a support plan. Goal attainment scaling or standardised process indicator reporting on support plan implementation could be applied here.
- There are diverse consumer cohorts other than consumers with high care and support needs that may be at risk of not receiving safe and effective care and support without having access to a Care Partner to oversee the delivery of care management support services. This includes those consumers with low health literacy. Many of these consumers will have limited understanding of how to manage payment for their services and how to manage the financial information in their support plan in general. This will pose challenges. The risk for these consumers is an underutilisation of supports available in plans or misunderstanding of what they are eligible for, resulting in additional non-billable support costs to providers. This may then indirectly create a perverse incentive for delivering care and support services to these consumer cohorts in the absence of their being approved a Care Partner to oversee the implementation of their support plan.

Transparency and regulation in a multi-provider environment

- With respect to different providers delivering different services against a consumer's support plan and the responsibilities of each provider to communicate with other service providers and the Care Partner, providers should have an upfront ability to identify who is involved and contributing to providing supports against a consumer's support plan (i.e. via My Aged Care or via the Care Partner with up-to-date contact details of each provider being listed to facilitate communication). One of the biggest shortcomings in care collaboration across multiple providers is service fragmentation and poor communication in care transition between service providers. In the NDIS operational environment, participants do not have to share their assessment and support plan with service providers, even if the services being requested are

in response to high intensity/complex care and support needs. One provider has indicated that they have experienced NDIS Support Coordinators, being the equivalent to Care Partners, encouraging NDIS participants to not share their support plan and/or assessment. This approach creates considerable risk for service providers that are contributing to support plan implementation in navigating tensions across duty of care and dignity of risk responsibilities. Providers are often needing to do their own assessment in an unfunded capacity to ensure they are providing responsive care while navigating a broader disconnection from contributing to integrated and collaborative care delivered by multiple providers.

- Observations of direct care workers following their delivery of services could be communicated to a Care Partner via a central portal, application or outlet (i.e. My Aged Care). Unless there is a central system where the Care Partner and providers can exchange communications, as well as see reports, incidents and outcomes associated with the delivery of services against a consumer's support plan care, then it's hard to see how providers can be responsible for clinical outcomes without control and review of what is being delivered. Providers simply checking in with Care Partners may be inadequate, particularly where care needs and services being delivered are changing. Push notifications of documentation changes to all service providers delivering services against a support plan will be important in a centralised information repository. Limitations in information sharing, with respect to privacy and confidentiality will also need to be considered in using a single system to share information. Without a streamlined approach to support stakeholder engagement in a multiple provider service delivery environment, administrative overheads are likely to be significant. This will be a sizeable cost impost in a consumer's quarterly support plan budget if the indicative model intends to set unit level prices matched to full cost recovery.

- Where there is a change in a consumer's clinical presentation or where there is a significant change in circumstance identified when a service is delivered by a provider, it will be the responsibility of that service provider to pass on that information to the Care Partner in a timely manner (or the consumer/representative if a Care Partner has not been assigned). The Care Partner or consumer/representative will then be required to provide the relevant information to the other providers involved in the care. Issues of duty of care and dignity of risk will be paramount where a Care Partner has not been assigned. Administration costs and communication needs should be billable with respect to requirements for multi-provider communications to support full cost recovery against these requirements once specified.

- Providers in a multi-provider environment will inevitably face the challenge of ensuring there are adequate funds available in the support plan to deliver the services agreed upon in the absence of clear visibility of a centralised real-time support plan ICT schedule that can accommodate both planned and unplanned scheduling functions and adjustments. This typically has happened via a central roster ICT coordination platform managed at the provider level. In a multi-provider environment this would need to be replicated with centralised real time services delivery registrations and push notifications across the multi-provider support plan service system to give an accurate account of services delivered and funds expended against a unit-level support plan specifying types and quantum in a consumer's quarterly budget cycle.

  If multiple providers are utilising support plan funds in a single service type category, there is the risk that funds may be expended above unit expenditure availability, and a provider may unknowingly deliver a service which cannot be paid for. Mechanisms for multi-provider operations need to be specified at commencement of service delivery against a support plan. Where issues emerge, this can then be resolved by referring to the agreement on service commencement. Agreements may include the ring fencing of budget segments between providers. By design, this would then limit flexibility and choice. In turn, this may lead to

unspent funds and lower service utilisation while also increasing administrative burden in a multi-provider environment.

- There is also the challenge of duplication of services being delivered across multiple providers based on the information being gathered from consumers in the process. To overcome this, case conferencing among service providers contributing to support plan implementation will be necessary.

  The above considerations highlight the challenges of delivering services to a consumer across multiple providers within the parameters of a support plan that has a quarterly budget that is based on fixed price unit-level service types and quantum. There are real risks of over servicing and provider losses in such a multi-provider environment. Such a design appears administratively complex and somewhat impractical for facilitating safe and effective service delivery and care coordination against support plan implementation intended to represent value for money. Place based services using price and volume contracts, as per the case mix classification funding approach, is recommended. While such a funding approach appears conceptually sophisticated it will provide a much more administratively simpler and cost-effective approach to implementing and reporting on services involving multiple providers.

- Some Members have suggested that whoever is responsible for organising and coordinating services delivered against a support plan should also be responsible for the delivery of care outcomes, making attribution of outcomes and quality possible in the proposed program design. ACCPA, however, questions the attribution of care outcomes and quality to a single provider or the Care Partner in a support plan where multiple providers contribute to service delivery. If at all, care experiences can be captured to reflect the contribution of each contributing service provider, but care outcomes and quality as measured by quality indicators can only be attributable to integrated service offerings delivered against support plans. In addition to this, it is also unclear how program design will diffuse the responsibility for care outcomes across the assessor and service providers in generating and implementing a support plan, as well as the potential fragmentation/loss of continuity of care between different providers where multiple providers contribute to support plans. Clear delineations will be required if we are to capture meaningful data that can measure quality, being made transparent to support consumer choice.

Innovation, investment, and practice improvement

- The funding approach of the indicative model does not provide a strong basis from which to incentivise sector investment in innovation. Focusing exclusively on competition based on quality in the context of fixed unit level pricing may create perverse incentives among providers, restricting a commitment to team-based care and collaboration in a multi-provider environment to implement better practice service delivery – a consequence of transaction-based funding approach to support plan implementation. Instead, providers may simply be incentivised to meet their required standards of practice for implementing the services they are contracted to deliver.

- The guarding of innovative practice by larger providers who may have sufficient scale and infrastructure to engage with ‘innovation partners’ selected from leading agencies and academic institutions will also likely emerge in a drive to compete based on quality. This may in turn create risks, restricting knowledge translation and sector wide capacity building to realise better practice improvement and the benefits of collaborative team-based care where multi-provider service models are being implemented.

- Inequity in innovation and practice improvement will also likely generate variable care experiences and outcomes in the context of continuing workforce supply constraints, where incentivising knowledge translation and capacity building for some providers will be required to redress this. Initiatives such as *End of Life Directions in Aged Care* (ELDAC), having established workforce investment and innovation activity above issuing evidence-based home

care guidance and toolkits, provides an example of how to support a national approach to sector wide knowledge translation and practice improvement.[6]

- It should be noted that the indicative model's funding approach will be particularly inhibitive to investment in innovative practices among smaller or more regional providers where constraints in scale and volume with a focus on cost control may stifle investment in innovation. Targeted additional financial supports via innovation grants will be required for these providers to encourage their uptake of knowledge translation and capacity building activities.
- Noting the expanding workforce gaps the sector is contending with and opportunities for rapid advancements in technology to supplement these workforce gaps, innovation funding must be made available upfront, preferably as part of an integrated funding design rather than via modular-add on quality payment or grant funding activities. Pressures for innovation will be immediate in balancing workforce challenges and responsiveness to consumer choice. In this context, ACCPA's preference for a case mix classification funding approach provides a more robust, integrated, and flexible solution through which to stimulate collaborative care innovations and investment.
- Universal mechanisms are required within program funding design to incentivise the sector to invest upfront in innovation and practice improvement. Flexible funding with dual transparency on price and quality should be an immediate priority. Performance based payments for the achievement of quality could extend this further. The introduction of these quality payments should promote care collaboration as well as the sharing of knowledge and learning at a sector-wide level.

Transitioning providers and their care-recipients

The paper does not provide any indicative details on how existing care-recipients would be transitioned to the new in-home aged care program, or when key steps for their transition will likely occur, including any appeals processes on transition outcomes.

With only 18 months until commencement, finalisation of the design of the new in-home aged care program has been announced for government's consideration in March 2023. Budget announcements are expected to follow, confirming financial investment in reform transition across FY23-24. This will leave a very short 12-month timeframe to facilitate implementation transition for some one million existing in-home care-recipients. Some key considerations that need to be accounted for in this transition include:

- Ensuring people who are registered as receiving CHSP services have their service types and quantum updated in My Aged Care to accurately reflect support plan allocations prior to transition over to the new in-home aged care program, acknowledging the work currently underway to realise the completeness of this data set. Lead times across the FY23-24 period will need to be sufficient in this process to support early CHSP provider and care-recipient transition communications for the identification and resolution of any issues of concern prior to July 2024 commencement.
- People on interim HCPs will need to be assigned a HCP at their approved level prior to transition to the new program to ensure their support plan under the new in-home aged care program can be matched to existing services being delivered against assessed needs. Noting new HCPs will continue to be released through to June 2023, additional funding may need to be allocated across FY23-24 to ensure people on interim HCPs can access care at their approved level prior

[6] https://www.eldac.com.au/

to the July 2024 commencement. This will avoid any unnecessary demand for reassessment in the new program of recipients of interim HCPs caught up in the transition.

- Some CHSP care-recipients strongly appreciate the varied elements of unfunded care management they receive while accessing their services in a block funded arrangement. While the introduction of nationally fixed unit level pricing from July 2022 may have required providers to adjust their approach to offering care management support, further consideration needs to be given to how CHSP care-recipients will be assessed for care management support in the transition to the new in-home aged care program. Advanced notice of the removal of this service in transition to the new program needs to be matched by their being provided access to timely reassessment of care management support needs where appropriate in supporting continuous care as an extension of transition to the new program.

- During the last few years home care providers and their business partners have encountered incremental changes in business operations across both the home care package program and CHSP. The indicative model suggests the next stage of reform will change operations again for both groups of home care providers. Government needs to recognise the considerable costs that home care providers have already incurred and will again incur in their transition to the new in-home aged care program. Without adequate transition funding support across FY23-24 and FY24-25, many home care providers will be unable to address the needs of the community it serves, reducing service access and the quality of services being offered as they contend with unfunded transition costs.

- ACCPA is supportive of department advice to refrain from introducing a new payment platform and interface with My Aged Care/B2G provider software. The proposed ICT changes referenced in the January 2022 Program Overview seemed expensive to build, costly to implement for providers, and unreliable in a way that would have caused service disruption when systems were down. The adequacy of provider and software vendor lead times in designing an alternate payment approach for application within the context of existing ICT and B2G infrastructure systems will be important as will be consultation with providers in confirming that design across the coming months. ACCPA recommends that on confirmation of the funding approach to be utilised, co-design of a fit-for-purpose payment approach be expedited across FY23-24 and include the engagement of providers and their software vendors to ensure sufficient lead time prior to commencement.

- Similarly, the design and testing of a centralised information repository for the implementation of support plan documentation across multiple providers with secure API linkages from provider client management systems into a central portal will need to be progressed prior to July 2024. Co-design of a fit-for-purpose centralised information management repository will need to be expedited across FY23-24 and include the engagement of providers and their software vendors to ensure sufficient lead time prior to commencement.

- Transition timeframes need to allow time to facilitate continuing consumer care arrangements where providers may choose to exit the delivery of existing services across the next 18-months in the lead up to commencing the new in-home aged care program in July 2024. CHSP providers are about to receive an offer of extension on current grant funding for the period FY23-24. They will be assessing their ability to continue to offer CHSP services at the nationally consistent prices set in their grant agreements across this period. With the indicative model proposing a fixed price, activity-based payment on services delivered funding model, many of these CHSP providers will be considering their future beyond June 2024. If they exit CHSP service delivery, workforce supply constraints may delay the timely transition of continuous care in such circumstances to another care provider. CHSP provider are already reporting on their exit in the Victorian operational context, having seen the transition of services and care-recipients to new providers as not being as successful as they had hoped for. In some of the affected regions, wait lists for people seeking new CHSP services closed as the incoming CHSP

providers have attempted to establish a workforce to respond to existing care-recipient service demands. These issues need to be managed, with sufficient lead time to minimise care disruption.

- There is a need for improved and considered communications from DHAC to build sector confidence in progressing the new in-home age care program design and its implementation, with account for stakeholder feedback. This includes more education for care-recipients, noting greater transparency is required from the Government in supporting care-recipients prepare for transition and any adjustment to their care and services that will be required. This will be important so they can clearly understand what will be available to them and what they will need to contribute in the context of changed future program arrangements.