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1. Tell us about you

1.1 What is your full name?

-

1.2 What stakeholder category do you most identify with?
Service provider.

1.3 Are you providing a submission as an individual or on behalf of an organisation?
Organisation.

1.4 Do you identify with any special needs groups?
People from Aboriginal and/or Torres Strait Islander communities.

1.5 What is your organisation’s name?
Australian Unity.

1.6 Which category does your organisation most identify with?
Aged care provider.

1.7 Do we have your permission to publish parts of your response that are not personally identifiable?
Yes, publish all parts of my response except my name and email address.
2. Response to Criteria in the Legislation

2.1 Whether unmet demand for residential and home care places has been reduced

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<tr>
<th>Refers to Section 4(2)(a) in the Act</th>
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In this context, *unmet demand* means:

- a person who needs aged care services is unable to access the service they are eligible for
  e.g. a person with an Aged Care Assessment Team / Service (ACAT or ACAS) approval for residential care is unable to find an available place; or
- a person who needs home care services is able to access care, but not the level of care they need
  e.g. the person is eligible for a level 4 package but can only access a level 2 package.

Response provided:

*The allocation process by region for Home Care packages has been problematic and has lacked transparency. Clients that require a higher level of care have been unable to receive a level 3 or 4 package due to the lack of availability and have therefore been required to top up their care from their own funds or move to alternate care options. At the same time there are regions that have a surplus of packages that they cannot fill due to the current demographic of clients in those regions.*

*We understand that some of the portability issues with packages will be addressed when we move to a full CDC model in February 2017. This however does not address the transparency of access issues that providers and clients face now and into the future on how the allocation of care places and care type occurs. To provide comfort that the Federal Government is serious about addressing the needs of clients it would be beneficial for Providers and clients to have certainty on how packages and funds will be distributed and what reporting mechanisms are in place to provide transparency into this process.*

*In respect of Residential Aged Care Services we believe that during this year’s ACAR application process there were positive improvements made. For the first time the Government asked for feedback from Providers on what areas we should be focusing on and why, prior to the round opening. We were provided with a map when the ACAR round opened that prioritised areas based on statistics and categorised these accordingly. This year’s ACAR also stepped away from Aged Care Planning Region allocations and moved to a more state based approach whilst drilling down to regional needs through the use of SA3 demographics. These were all positive steps forward and we look forward to working with the Government to expand on these in 2017.*

2.2 Whether the number and mix of places for residential care and home care should continue to be controlled

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<tr>
<th>Refers to Section 4(2)(b) in the Act</th>
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In this context:

- the **number and mix of packages and places** refers to the number and location of residential aged care places and the number and level of home care packages allocated by Government; and
- **controlled** means the process by which the government sets the number of residential care places or home care packages available.

Response provided:

*Home Care Packages would work much better if not linked geographically or by volume, but driven by client need. It is recognised that there will always need to be some level of oversight or control in order to meet budget allocations, but this needs to be tempered by consumer demand. The February 2017 changes to home care packages should assist in relieving issues caused by regional allocations that don’t reflect consumer supply and demand. However, it remains to be seen if My Aged Care (and the national prioritisation queue and waitlist system) will be an effective mechanism to ensure equitable access to packages across regions and package levels.*

*To enable equitable access for our Residential Aged Care system we believe there still needs to be a certain level of control on how places and funds are distributed. That said as we move to a more consumer directed RACS market*
where over 60% of our current residents are paying for some proportion of their care through means tested care fees, we will see a shift in the expectation of the consumer on how, what and where they spend their money.

We are already seeing a shift where consumers are prepared to pay for a product that meets their lifestyle needs and wants, through the provision of additional service choice and a higher quality of product. Those entering RACS are expecting a better quality of lifestyle for themselves and for their loved ones and as means tested fees increase in alignment with the level of acuity many of these consumers will opt for unfunded care as a more affordable option. To ensure that these models of care are regulated the Government needs to consider how it manages this consumer driven change in our residential care market and how it changes to address these needs.

2.3 Whether further steps could be taken to change key aged care services from a supply driven model to a consumer demand driven model

<table>
<thead>
<tr>
<th>Refers to Section 4(2)(c) in the Act</th>
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<tr>
<td>In this context:</td>
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<tr>
<td>- a supply driven model refers to the current system where the government controls the number, funding level and location of residential aged care places and the number and level of home care packages;</td>
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<tr>
<td>- a consumer demand driven model refers to a model where once a consumer is assessed as needing care, they will receive appropriate funding, and can choose services from a provider of their choice and also choose how, where and what services will be delivered.</td>
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Response provided:

The changes to NDIS and Home Services where CDC models are in the process of being introduced are positive steps forward. We believe providing flexible options where consumers have greater choice over their care and how they spend their funds increases independence and dignity. We need to ensure that for CDC models to be successful that we continue to review current practice, consult with the consumer and protect our most vulnerable. With the freedom that CDC provides there is an increased risk of exposure to our consumers by those with less than genuine intentions and the Government needs to ensure that frameworks are in place to mitigate the risk to our consumer of such inappropriate activities taking place.

As provided for in 2.3 we see a natural shift to CDC in RACS especially for those who have the ability to pay through the redistribution of funds using the means test fee and reduction. A fully functional CDC model in RACS would need careful consideration due to the higher physical and cognitive care requirements of the resident cohort and frequently changing care needs that come with a more acute needs based system. The changes adopted from the Living Longer Living Better Reforms have provided a platform for CDC in RACS to grow by enabling flexibility and choice in accommodation payment types and service models; providing security through the removal of the distinction between high and low care and creating opportunities for new care and service models to emerge through the ability to charge additional services outside of the requirements previously set through Extra Service provisions.
2.4 The effectiveness of means testing arrangements for aged care services, including an assessment of the alignment of charges across residential care and home care services

Refers to Section 4(2)(d) in the Act

In this context:

- **means testing arrangements** means the assessment process where:
  - the capacity of a person to contribute to their care or accommodation is assessed (their assessable income and assets are determined); and
  - the contribution that they should make to their care or accommodation is decided (their means or income tested care fee, and any accommodation payment or contribution is determined).

Response provided:

In respect of our home care customers we are finding a number of issues with the current income tested arrangements. Those who are currently on a CHSP service that are needing to transition to a Home Care Package due to an increase in their care needs are disadvantaged to do so due to the higher cost as a result of the Income Test Fee. As a result they are not getting the care they need as they feel they cannot afford it - this places an increased burden on our acute health systems as these people continue to try to manage at home on base level services which they top up through access to emergency departments and on call GP services as an alternative to preventative care.

As a Provider we have experienced issues related to the non-payment of income tested fees and the disconnect with the requirements in the Operational Manual for the Home Care Packages Programme that such fees should still be provided for in the client’s budget and cannot be deducted from the clients funding. This leads to confusion on the part of the client as they have the funds for care from the Government (the subsidy) but not the ability to pay for the component of care (Income Tested Fee) that the Government have assessed them as having the capacity to pay. Therefore, we are providing services based on the subsidy and the on charging to the resident of the Income Tested fee component, but the resident is not paying the income tested component and we as a Provider are left with a debt with no ability to enforce that the customer pay through the budget. This will potentially bankrupt smaller providers with lesser resources and outs both the Provider and Consumer at risk.

When the Government moved customers accessing RACS from Income Testing to Means Testing on 1 July 2014 there was a backlog of processing customer income and asset tests and accommodation payments and means tested determination letters. This caused a significant increase in vacancies as Providers waited for financial determinations to be given before admitting residents and is still an issue today with wait times for such determinations still on average 3 weeks. These periods of wait put additional pressure on the incoming residents, their families and the health system which takes both a financial and emotional toll in an already complex process.

We continue to experience huge areas of disconnect between Medicare, Pension Payment agencies (Centrelink/DVA) and Providers in respect of the timely calculation of Accommodation Means Tested Supplements, Means Tested Fee and Reduction Notifications and back dated adjustments. There seems to be a lack of continuity between Government departments which result in delayed, incorrect or nil payments to Providers and added confusion for Residents and their representatives when presented with large back dated accounts.

This can has cashflow impacts on businesses and is a risk to Providers that deal on a cash in and cash out basis to pay staff and other care costs. It also places extra administrative burdens on finance teams and services through the explanation of complex financial accounts to residents and their families and can result in unpaid debt on resident departure due to delayed DoH adjustments (currently there is no cap when the DoH can backdate an adjustment to) which can be significant dependent on the residents duration of stay and financial circumstance.

There are also significant issues with the annual and lifetime cap on means tested fees not being applied by Medicare. This has a flow on effect to means tested reductions continuing to occur despite the thresholds of $25k (annual) and $60k (lifetime) being realised. Recently for one site we had means tested reductions for 4 residents applied through our payment summary that was the equivalent of $400k+. This effectively meant that this site received no cash for that month whilst the issue was rectified with Medicare. We then had to prove our case by cutting and pasting relevant sections of the Act and Fee Principles in relation to the Mean’s testing CAP into an email for a determination to be made in our favour. We have experienced a number of similar issues in relation to Accommodation Payments where we are owed money and have waited months for this to be addressed, more
often than not receiving the money on behalf of the resident posthumously and in some cases having to chase the Estate for payment based on the outcome of Medicare’s assessment.

As a Provider of Home and Residential services we understand that Means testing will secure the financial viability of our services, but attention needs to be focused on those with limited capacity to pay for increasing levels of service as their condition deteriorates and the need for significant improvement to a co-ordinated mechanism for the calculation of fees, deductions and charges by Government services in a timely manner.

### 2.5 The effectiveness of arrangements for regulating prices for aged care accommodation

<table>
<thead>
<tr>
<th>Refers to Section 4(2)(e) in the Act</th>
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<tr>
<td>In this context:</td>
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<tr>
<td>• regulating prices for aged care accommodation means the legislation that controls how a residential aged care provider advertises their accommodation prices.</td>
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Response provided:

We believe that the process put in place to provide greater transparency into what prices providers are charging for their accommodation is working well. The Aged Care Pricing Commission is quick to respond to and action applications and has made significant improvements to this process since it’s commencement.

From a consumer perspective this process provides a more transparent approach into the different products and the associated costs related to these products. However a common complaint that we have is the lack of usability of the My Aged Care site and the amount of times the site is unavailable due to technical issues. The MAC site is not user friendly and does not meet the needs of the customer for clear, concise, comparable information provided in real time. Customers are often confused by the content and different areas and are contacting Providers directly for access to information. As a Provider the ability to make changes to the MAC site in respect of pricing and update room changes is arduous, with most changes needing to be made through the MAC help desk.

For the intent of the legislation to control how a RAC provider advertises their accommodation pricing to be realised then significant work needs to be done on the MAC site to become the tool that provides the platform for this to occur.
2.6 The effectiveness of arrangements for protecting equity of access to aged care services for different population groups

Refer to Section 4(2)(f) in the Act

In this context equity of access means that regardless of cultural or linguistic background, sexuality, life circumstance or location, consumers can access the care and support they need.

In this context different population groups could include:

- people from Aboriginal and/or Torres Strait Islander communities;
- people from culturally and linguistically diverse (CALD) backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- people who are veterans of the Australian Defence Force or an allied defence force including the spouse, widow or widower of a veteran;
- people who are homeless, or at risk of becoming homeless;
- people who are care leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations);
- parents separated from their children by forced adoption or removal; and/or
- people from lesbian, gay, bisexual, trans/transgender and intersex (LGBTI) communities.

Response provided:

A lot more needs to be done if we are to protect the equity of access to aged care services for our seniors population. Due to geographic limitations, cultural differences and language barriers our experience shows that those in rural and remote areas, of Aboriginal or Torres Strait Islander background, or those whose first language is not English are being seriously disadvantaged. CASE STUDY: Recently, our home services business sent 12 requests for assessment from a rural area, however only 4 were actioned for assessment. When we investigated, we found that the Assessment teams are only required to make 2 attempts to contact, and if they cannot reach the client in this time, they close the case. In significant areas of western NSW, the mobile coverage is so variable or unacceptable that it may take multiple calls in order to reach some of these clients, leaving them without services they really need.

To meet the changing needs of our community so that all Australians have an equity of access to care we need to continue to tailor services to meet the specific needs of consumers and factor in their social, physical and spiritual requirements. We need to ensure we have staff that have the capacity, education and tools to care for consumers of different backgrounds and a respect for their heritage and life experiences. There needs to be a mindset shift in how the Government supports and funds those with care requirements in our remote communities and how they can support Providers to deliver care through innovative staff training and recruitment programs, technology, cultural community centres and transport supplements.

We note the different population groups mentioned above do not consider those in our community with cognitive illness. As our population lives longer we are seeing a higher incidence of those coming into care with some form of degenerative cognitive disease and/or mental illness. The current funding does not provide for the care requirements of those with gero-psychiatric conditions as they age, with many ending up in mental health institutes that have little experience in the management of geriatric conditions. With better funding to educate staff and provide appropriate facilities many of these residents could reside in a residential environment that provides care to meet their geriatric and mental health requirements. This population group is often overlooked as too difficult but are equally as important as any other and needs to be treated with the same level of respect and dignity.
2.7 The effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers

Refers to Section 4(2)(g) in the Act

In this context aged care workers could include:

- paid direct-care workers including nurses personal care or community care workers, and allied health professionals such as physiotherapists and occupational therapists; and
- paid non-direct care workers including: managers who work in administration or ancillary workers who provide catering, cleaning, laundry, maintenance and gardening.

Response provided:

Both the number of workers required and the skill level of existing workers is a challenge to meet the on-going demand of delivering services across all regions. Across rural Australia, there is a shortage of Registered Nurses, Enrolled and Allied Health Professionals working in community and aged care settings.

In aiming for best practice in delivering high quality services, there are currently staff shortages everywhere, especially linking customers with staff with appropriate language skills and cultural backgrounds. Having sufficient skilled staff to provide services to special needs groups such as ATSI, CALD and those with mental health conditions in metropolitan areas is problematic, and even more difficult in rural areas, let alone remote.

The Government and Providers need to work together to address how we manage to fund Aged and Home care services whilst providing a career pathway and financially stable future for our staff that makes our industry attractive to the right type of employee.

2.8 The effectiveness of arrangements for protecting refundable deposits and accommodation bonds

Refers to Section 4(2)(h) in the Act

In this context:

- arrangements for protecting refundable deposits and accommodation bonds means the operation of the Aged Care Accommodation Bond Guarantee Scheme.

Response provided:

The intent of the scheme is working well, however the reality is slightly different. We currently have an issue where an Approved Provider that was declared bankrupt and shut down is fighting the bankruptcy case in court. As a result due to the outcome of the bankruptcy case still being undecided the funds cannot be distributed out of the Scheme to the Providers that the residents were transferred to at the time of closing. As a result Providers cannot be paid the transferred bond(s) attached to the residents they accepted in good faith under the scheme until the court case is settled. This is a significant failing in the system to the new Provider and we would recommend a review into the tightening of how and when funds are transferred in such circumstances moving forward.

2.9 The effectiveness of arrangements for facilitating access to aged care services

Refers to Section 4(2)(i) in the Act

In this context access to aged care services means:

- how aged care information is accessed; and
- how consumers access aged care services through the aged care assessment process.

Response provided:

There is currently a disconnect between the requirements for all aged care customers to go through the MAC portal, the capacity for this group to be able to do this and the time it takes for MAC staff and RAS/ACAT staff to organise, conduct and process assessments to enable services to start.
Whilst we agree with the objective of access to aged care services through MAC, it is currently a bottle neck that is delaying the time to take up a service and resulting in incorrect information being communicated to both the consumer and the Provider.

Improvements are essential to ensure that the time between first point of contact with the consumer and MAC and date the consumer receives their service is greatly reduced and the process more streamlined. Consumers with special needs should be provided with alternative methods of access to care until MAC can provide adequate resources to address language, cultural and health barriers.
3. Other comments

Response provided:

Comment 1 - Security of Tenure Provisions

Issue

Section 56-1(f) of the Aged Care Act 1997 (the Act) and paragraph 6 of the User Rights Principles 2014 (URP) lack clarity regarding the process to be followed where an approved provider makes the decision to ask a resident to leave under paragraph 6(2) of the URP – particularly for the scenarios described by paragraphs 6(2)(d) and (e) which are in the resident’s or their representative’s control.

Currently, consent must be obtained to enable the assessment of a care recipients’ long term care needs to establish whether suitable alternative accommodation (SAA) is available for that resident. Care recipients or their representatives who do not wish to leave the service or choose to be obstructive can and have rendered this process unworkable by refusing to provide consent to any assessment being conducted or refusing to provide consent for the assessment report to be released to the approved provider.

In instances where the circumstances detailed in paragraph 6(2)(e) of the URP are present (the resident is causing serious damage or injury) other care recipients and staff of a service are left vulnerable to injury or harassment.

In instances where the circumstances detailed in paragraph 6(2)(d) of the URP are present (the resident failing to pay agreed fees), the approved provider is exposed to unnecessary cash flow and prudential risk as residents are not contributing to their costs of care but the operator must continue to service that resident and, if the service is newly acquired or built, make repayments to financiers. Also, this situation is unfair on other residents who are ‘paying their way’ and make their payments as required.

Suggested solution

The URP should be clarified to allow approved providers to rely on existing Aged Care Assessment Team (ACAT) reports even if that report was the report used by the resident to enter the service in the event that the resident refuses to obtain a new ACAT report within 60 days of request from the approved provider.

Comment 2 - Security of Tenure Provisions

Issue

The process for giving notice to a resident to leave the service needs reform. There is confusion about when an approved provider may request a resident to leave the service and necessary discussions about the resident leaving the service can be seen as contravening paragraph 6(3) of the URPs.

We recognise that the intent of paragraph 6(3) of the URPs is to prohibit approved providers from threatening residents with eviction from the service however the process outlined in the URPs necessarily involves discussions about future actions of the approved provider were the resident not to co-operate as well as options available to the resident should they fail to observe their obligations under the Act and their resident agreement.

Suggested Solution

The wording of paragraph 6(3) and it’s interaction with the notice requirements in paragraph 7 require review. It would be helpful if the sequencing of notices to the resident and the identification of SAA (as well as the communication to the resident that SAA is available) were set out in chronological order.

Also, the responsibilities between resident and approved provider for identifying and then securing SAA each need to be made explicit.

Comment 3 - Ability to require deposits from residents prior to entry into newly developed services

Issue

Section 52-F(3)(g)(i) of the Aged Care Act 1997 (the Act) precludes approved providers from requiring any accommodation payments being paid prior to 6 months from a care recipient’s date of entry.

Suggested Solution
Part 3A.2 of the Act should be amended to permit approved providers who have a newly built service to take deposits from prospective residents who would like to secure a place in the service prior to its completion or opening. This provides certainty for both operators and residents. The amendment should provide for a clear process whereby approved providers are permitted to take deposits, retain them in a trust account and refund the deposit within 14 days of a request for a refund being made by a resident or their representative or being retained and put towards any Refundable Accommodation Deposit or Daily Accommodation Payments once the resident has entered the Service.