AN-ACC questions and answers – Aged Care Funding Reforms Webinar #6

Overview

The Department of Health and Aged Care (the department) is holding a series of webinars to support the implementation of the aged care funding reforms, including the Australian National Aged Care Classification (AN-ACC) funding model which commenced on 1 October 2022.

The sixth aged care funding reform webinar in the series was held on 30 August 2022. This webinar gave providers an opportunity to ask questions about the AN-ACC funding model, with information to help with preparation and transition activities.

This document contains responses to some of the questions received that were not answered during the live event due to time limitations. Where appropriate, the department has simplified and consolidated similar questions to provide succinct responses to the sector.

Questions about AN-ACC can also be answered by looking at the AN-ACC funding guide. This guide sets out how to receive AN-ACC subsidies, including relevant compliance requirements that may apply.

Allied Health

How will allied health needs of residents be provided for and funded under AN-ACC? Is it still mandatory under the Aged Care Act 1997, including under the schedule of specified care and services?

It is the responsibility of an approved provider to determine how best to meet the care needs of their residents, in accordance with their obligations under the *Aged Care Act 1997*. This includes ensuring that the specified care and services detailed under Schedule 1 of the Quality of Care Principles 2014 are provided to all residents who need them.

Funding for allied health under the previous Aged Care Funding Instrument (ACFI) has been rolled into the AN-ACC funding allocation. This means providers are directly funded for and are required to provide allied health services to residents in accordance with Schedule 1 of the Quality of Care Principles 2014.

See the allied health fact sheet for more information.

Is there guidance on the types of allied health service, such as physiotherapy, that can be transitioned to and delivered under AN-ACC? What level of allied health service, such as pain management, is considered appropriate under the new model?

There is no specific guidance regarding transitioning ACFI Items to AN-ACC. As with ACFI, AN-ACC is guided by the individual residents identified care needs. However, under AN-ACC, allied health professionals are supported with the removal of the inbuilt incentives that exist within the ACFI to deliver specific allied health treatments. This allows providers and allied health professionals more freedom to provide the better targeted treatments that directly benefit the individual consistent with their individual care plan (for example, treating pain through an exercise program).

Are care minutes per resident defined for allied health clinicians?

Only care provided by registered nurses, enrolled nurses and personal care workers can count towards meeting the specified care minute targets when they become mandatory from 1 October 2023. Services delivered by allied health professionals are not counted.

While there are no mandated duration and frequency of the provision of allied health services under AN-ACC, providers are required to report care time provided by allied health professionals in the Quarterly Financial Report (QFR). This data will be used to provide the department with visibility on the use of allied health services to inform future policy decisions.

Assessments

If a resident can stand transfer only, are they classified as 'not mobile' or 'assisted mobility'?

The modified DeMorton Mobility Index (DEMMI) measures the mobility of older people across clinical settings, including four domains including Bed, Chair, Static balance (no gait aid) and Walking. Transfers are taken into account in the Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) and the Australian Functional Measure (AFM) tools.

What happens to residents who became permanent in September 2022?

An ACFI appraisal would need to be undertaken to ensure payment of resident days in September. From 1 October 2022, all assessments (including shadow assessments) for funding in Residential Aged Care Facilities (RACFs) will be undertaken by independent AN-ACC Assessors. Providers need to ensure records are maintained for residents' well-being and for the Aged Care Quality and Safety Commission (ACQSC). Access to all client records including (but not limited to) care plans, medication charts, weight and falls charts and progress notes are required to undertake the assessment.

Can providers look at the AN-ACC assessment results before the assessors leave?

Providers will not have access to the actual AN-ACC assessment. This is to ensure the independence of the AN-ACC assessment process. AN-ACC assessors are independent of the Government and are qualified clinicians in Registered Nursing, Occupational Therapy or Physiotherapy with experience in Aged Care. They undertake rigorous training and quality assurance processes.

The assessor uploads it to the Health provider portal which then generates a classification based on a proprietary algorithm. While the algorithm will not be publicly available, we can assure you that we are committed to ensuring high quality assessments as part of the integrity of the AN-ACC care funding model.

Are daily injections, such as insulin considered as a compounding factor? Where can providers find the definition of compounding factors?

Different compounding factors apply to different AN-ACC classes. Compounding factors may include activities of daily living, functional motor and cognitive independence, behaviour, risk of pressure sores, frailty, falls and technical nursing.
Placing a resident into a classification level depends on whether the resident has significant compounding factors. Which compounding factors are relevant for the classification decision varies based on the resident's circumstances as outlined in section 4A of the Classification Principles 2014.

Please note that compilations of Principles with changes that took effect on 1 October 2022 may take some time to be published on the Federal Register of Legislation. These compilations are produced by the Office of Parliamentary Counsel and the department cannot advise a date when they will be ready. Please regularly check www.legislation.gov.au at the specific links provided.

For 'specified care and services' what level of AN-ACC represents Low and High care?

From 1 October 2022 the Quality of Care Principles was amended to repeal subsections 7(4) to 7(6) of that instrument. These have permitted approved providers to charge additional fees to residents with historic 'low care' classifications made under Part 2.4 of the Act (that is, 'ACFI' classifications) for the provision of those care and services in Part 3 of Schedule 1 of the Quality of Care Principles. In parallel, all current references that 'fees may apply' for Part 3 care and services will also be repealed from Part 3 of Schedule 1 of the Quality of Care Principles from 1 October 2022.

This change is because the AN-ACC model, which relies on classifications made under Part 2.4A of the Act, does not include any concept of 'low' and 'high' resident classifications: AN-ACC funding linked to each classification is based on meeting the measured average costs of providing all the specified care and services as needed for the people in each class.

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What is the expected minimum time with the residents for an assessment when the assessor comes?

There is no set time allocation for talking with a resident. In some instances, it is not appropriate to speak with the resident. AN-ACC assessments are conducted using a range of sources—including speaking with staff and residents, observations, resident notes and care plans—to determine the variable component of the AN-ACC care funding model that will be paid to the resident aged care provider.

Should providers get the same company and assessor or would there be a different one for different visits?

The system automatically allocates a referral to an Assessment Management Organisation to be undertaken based on a market share approach. For new assessments, reconsiderations or reclassifications, this may then be the same or a different assessor.

Can I submit an ACFI appraisal after 1 October 2022?

Yes, but only for residents who entered into care on or before 30 September 2022. If you submit an ACFI appraisal to Services Australia where the entry/start date of care is on or after 1 October 2022, your submission will be rejected with a reason code of OTH – Other.

Are there costs involved if a reclassification does not result in a change of classification to the resident? If not, will there be fees in the future and what is the likely reason that fees would be applied?

No, there is no cost involved for requesting a reclassification regardless of the outcome unless otherwise advised at a future date. The application of fees will be a decision for government.

From when a resident entry is recorded in the Services Australia portal, what is the timeframe within which residents will be seen by an AN-ACC assessor?

Once a referral is received and accepted by an Assessment Management Organisation (AMO), it will be assigned to an assessor who will arrange for the AN-ACC assessment to be completed. From the date of referral:

- 90% of all accepted assessments will be completed within 28 calendar days; and
- 100% of all accepted assessments will be completed within 56 calendar days.

Providers are able to see the status of the referral in the My Aged Care Service and Support Portal.

If a provider has submitted an entry record and cannot see the referral for the resident, they should contact the My Aged Care service provider and assessor helpline:

Phone: 1800 836 799

The helpline is available from 8:00am to 8:00pm Monday to Friday and 10:00am to 2:00pm Saturday, local time across Australia.

For more information see The AN-ACC funding guide.

What information about how an AN-ACC class is derived, including the algorithm for compounding factors, will providers have to help them decide if they should request a reclassification?

Following an assessment, the assessor uploads it to the Health provider portal which then generates a classification based on a proprietary algorithm. While the algorithm will not be publicly available, the department is committed to ensuring high quality assessments as these are integral to maintaining the integrity of the AN-ACC care funding model.

Similarly, we use a proprietary algorithm to determine which of the many possible combinations of compounding factors, taken together, indicate that a care recipient has significant compounding factors. While the algorithm will not be publicly available, as a general rule, the more obviously ‘worse’ a resident’s combined status is against the possible compounding factors that apply to them, the more likely that the compounding factors will be found significant and that the resident will be allocated to a higher AN-ACC class.

So, to decide whether it is appropriate to request a reclassification, you should determine if there has been a ‘significant’ change in the resident’s care needs over time based on the reclassification request criteria.

A simpler way to consider a resident for reclassification is thinking about the following questions – has the resident’s needs increased? Are staff doing more for them? Has their care plan changed to increase the level of care required?

You can request reclassifications for permanent and respite care in the My Aged Care Services and Support Portal. Providers must request reconsiderations for the initial assessment or a reclassification completed record, within 28 days from the date when the classification was generated by the system.

Do providers need to change the Resident Agreement to reflect the three respite classifications as it is no longer high and low care?

Services may wish to seek independent legal advice about whether the changes to respite classifications require Resident Agreements to be updated.

Is a deterioration in mental state (e.g. resident with schizophrenia who is relapsing, or an increase in dementia-related BPSDs) grounds to request a reclassification?

An approved provider can request that the department reclassify a permanent resident if, since their existing classification took effect, any of the following criteria are met:

- there has been a change in the care recipient's cognitive ability, compounding factors, function, mobility, or pressure sore risk
- the care recipient has been an inpatient of a hospital for a total of at least 5 days
- the care recipient has been an inpatient of a hospital for a total of at least 2 days and was administered general anaesthetic while an inpatient
- for a care recipient with an existing classification level of Class 9, Class 10, Class 11, Class 12, or Class 13 – at least 6 months have passed
- for a care recipient with an existing classification level of Class 2, Class 3, Class 4, Class 5, Class 6, Class 7, or Class 8 – at least 12 months have passed.

Will the AN-ACC assessors still attend during a COVID outbreak?

The Assessment Management Organisation will work with the provider if it is safe to attend a service. If there is low risk – for example the area is closed off to the remainder of the service, the assessor may enter the safe areas only. If the whole service is under lock-down, the assessor will reschedule the visit.

What will happen if a respite resident's care needs increase while in care and discharges prior to AN-ACC assessment?

If the respite resident's classification does not align their actual level of mobility (independently mobile, mobile with assistance or not mobile) the provider can request reclassification through the My Aged Care Service and Support Portal. The referral will be transferred to an ACAT assessor to be undertaken in the resident's home. Funding will be backdated to the date of reclassification request.

For existing residents that were in care prior to 1 October 2022 and haven't been assessed, will the service be required to request the assessment, or will it happen automatically as they are already admitted on Portal?

Residents who have not received an assessment by 1 October 2022 will receive a default class 99 (payment equivalent to a class 8). Residents will automatically be referred to an assessor for assessment and payment will be adjusted from 1 October or date of entry after that date.

Providers are able to see the status of the referral in the My Aged Care Service and Support Portal.

If a provider has submitted an entry record and cannot see the referral for the resident, they should contact the My Aged Care service provider and assessor helpline:

Phone: 1800 836 799

The helpline is available from 8:00am to 8:00pm Monday to Friday and 10:00am to 2:00pm Saturday, local time across Australia.

What information is needed to support AN-ACC assessments?

From 1 October all assessments (including shadow assessments) for funding in RACFs will be undertaken by Independent AN-ACC Assessors. Providers need to ensure records are maintained for residents' well-being and for the Aged Care Quality and Safety Commission (ACQSC). Access to all client records including (but not limited to) care plans, med charts, weight and falls charts and progress notes are required to undertake the assessment.

Will clinical and care information and eligibility for residential aged care (permanent or respite) still be communicated via the National Screening and Assessment Form (NSAF)?

Yes, as this is pre-entry into a Residential Aged Care Facility (RACF).

If a resident moves, how is the funding managed - any re-assessment and how do you balance up the old provider and new provider?

Providers do not need to submit a reclassification request for a resident who transfers into their care from another aged care service. If the resident already has an AN-ACC class, the new provider will receive payment based on that AN-ACC class. If the resident has not been assessed, an initial referral for AN-ACC assessment will be automatically issued.

Where a resident transfers to a new service and the receiving provider believes that, since their existing classification took effect, any of the reclassification criteria are met, the provider can request the department reclassify the resident.

Base Care Tariffs (BCT)

What is the funding basis for facilities located in MMM 1-5 (operational or occupied beds) and is there a specialised Aboriginal or Torres Strait Islander category for facilities located in these regions?

All residential aged care services in Modified Monash Model (MMM) 1-5 locations will be paid per occupied bed. There is no specific base care tariff for specialised services for Aboriginal or Torres Strait Islanders in MMM 1-5 locations (the specialised base care tariffs for the Aboriginal and Torres Strait Islander category applies for services in MMM 6 and MMM 7 locations only).

The table below summarises the different base care tariffs under AN-ACC and their different subsidies (called the National Weighted Activity Unit (NWAU)) and payment calculations, as well as eligibility criteria for specialised base care tariffs. Additional information on base care tariff funding is available in the specialised base care tariff webpage.

Table 1 BCTs under AN-ACC

BCT	NWAU	Funding Calculation	Provider eligibility requirements	Resident eligibility requirements
Standard MMM 1 – 4	0.49	Occupied bed	Service is located in MMM 1 – 4, and no other BCT applies	Not applicable
Standard MMM 5	0.55	Occupied bed	Service is located in MMM 5, and no other BCT applies	Not applicable
Standard MMM 6 or MMM 7	0.68 (rate for the first 29 beds) and 0.52	Operational bed	Service is located in MMM 6 – 7, and no other BCT applies	Not applicable

BCT	NWAU	Funding Calculation	Provider eligibility requirements	Resident eligibility requirements
	(rate for beds 30+)			
Specialised Homeless	0.92	Occupied bed	Service must provide evidence of delivering specialised homeless care	50% or more of residents have been assessed as homeless, with a relevant behavioural diagnosis
Specialised Aboriginal and Torres Strait Islander, located in MMM 6	0.78	Operational bed	Service must provide evidence of delivering specialised Aboriginal and Torres Strait Islander care	50% or more of residents identify as Aboriginal and Torres Strait Islander
Specialised Aboriginal and Torres Strait Islander, located in MMM 7	1.80	Operational bed	Service must provide evidence of delivering specialised Aboriginal and Torres Strait Islander care	50% or more of residents identify as Aboriginal and Torres Strait Islander

Care Minutes

If the Quarter 1 (Q1) Quarterly Financial Report (QFR) is submitted half-way through Quarter 2 (Q2), would this create a timing issue for a service to meets its Q2 care minutes targets?

Staffing information reported in the new Quarterly Financial Report (QFR) is not used to inform a service's care minutes targets. The information reported in the QFR will be used to determine how a provider performs against their care minute targets.

A service's care minutes targets for each quarter will be based on the service's resident casemix, that is, claims for residents that were in care, during the previous three months.

Are providers assessed against the indicative target each quarter, or assessed against the actual care minutes based on the actual resident AN-ACC profile for that quarter?

Each quarter providers will be required to deliver and report against an average care minutes target based on the resident casemix from the preceding quarter. Care minutes targets will be released on the 14th of the first month of each quarter.

Residents who did not have an AN-ACC class assigned during the calculation period will be excluded from the care minutes targets. These residents will be included in the calculation of the targets for the following quarter once they have been assigned an AN-ACC class. However, providers remain responsible for ensuring they meet the requirement to have sufficient staff on duty to meet the care needs of residents at all times.

Staffing levels should enable providers to meet the average care minutes target for all residents across the service, however it is up to providers to ensure that staffing levels also meet the actual needs (individual care minutes targets) of residents in the service at all times.

What is the implementation timeline and targets for care minutes?

Care minutes targets were introduced for all residential aged care services on 1 October 2022. Providers can see the quarterly care minutes targets for each service they operate in the My Aged Care Service and Support Portal.

The initial care minutes targets will:

- become mandatory from 1 October 2023
- increase to a mandatory sector wide average of 215 minutes (including 44 minutes of registered nurse time) from 1 October 2024.

Can administration staff be included in direct care minutes where they are assisting with resident admissions in much the same way as the care manager would assist with resident admissions?

No. In line with the recommendations of the Royal Commission, only direct care provided by the following types of care staff can be counted towards care minutes: registered nurses, enrolled nurses and personal care workers.

This excludes staff leave time and training and does not include activities that are administrative or not related directly to the care of individual residents (such as staff rostering, recruitment, and service level planning and reporting).

Are residents on hospital/social leave still included in the care minutes?

Yes, if the service is receiving funding for the resident and they are considered to be occupying a bed, they are still included in care minutes.

What consideration has the government given to the care minutes requirements and the current aged care recruitment challenges particularly for rural and remote providers?

The Government recognises the need to invest in the aged care system and its dedicated workforce. This is why the Government has committed to supporting claims for better pay for aged care workers at the Fair Work Commission and funding the outcomes of this case. Increasing the pay of our aged care workers will assist with attracting workers to the sector and retaining the existing workforce.

There are also a range of programs available to support growing, skilling and enabling of the aged care workforce, many of which have a focus on support for rural and regional areas. These include programs such as the:

- Workforce Advisory Service – access to free, independent and confidential advice to assist Providers with workforce planning
- Aged Care Registered Nurses Payment – a payment to registered nurses who work for the same aged care employer for 6 or 12 months
- Aged Care Nursing and Allied Health Dementia Care scholarships – funding for a range of scholarship opportunities
- Aged Care Transition to Practice Program – provides new aged care nurses with mentoring, training, and support
- Job Trainer and Fee Free TAFE – the government continues to work with states and territories to provide access to free or low-fee vocational education and training courses in aged care related qualifications.

If a personal care worker accompanying a resident on an outing, counts as care minutes, why does the same not apply for a Lifestyle Assistant qualified at the same level doing exactly the same task?

In line with the Royal Commission's recommendation, 'worked hours' of registered nurse (RN), enrolled nurse (EN), and personal care worker (PCW) staff will count towards the care minutes target when they are providing personal care to residents. If the PCW accompanies a resident to provide personal care, this counts towards the care minute target.

For residential aged care facilities with home care models (care staff provide medications, activities of daily living (ADLs), cleaning and kitchen tasks), does cleaning and kitchen tasks count as care minutes?

No. Hours worked in normally unrelated professions such as catering, hotel services, service and room cleaning, maintenance, gardening, lifestyle, recreation, activity, or service management are not to be reported as care minutes.

This is because it is not the intent of the care minutes policy or the Royal Commission recommendation.

How would pharmacists that are embedded into facilities from 2023 contribute to care minutes?

Pharmacists do not count towards a service's care minutes targets.

However, providers are funded for and required to provide allied health services, such as those services provided by pharmacists, to residents in accordance with their obligations under the *Aged Care Act 1997* and the associated Quality Standards.

Can lifestyle staff that assist with feeding during meal service, or assisting residents with mobility/transfer to activities, be counted towards care minutes?

The Department recognises the invaluable work of lifestyle staff in aged care, however in keeping with the Royal Commission recommendations, direct care provided by Lifestyle staff cannot be counted towards care minutes.

Work that Lifestyle staff do is funded outside of care minutes (though funding is still distributed via AN-ACC) and the time and cost to provide lifestyle services is captured separately in the QFR.

Additional information on care minutes can be found in the What are care minutes factsheet.

Are lunch breaks for care staff counted as worked hours or do providers have to subtract that time from the care minutes?

Lunch breaks cannot be counted towards care minutes.

Do food and maintenance services provided direct to the residents constitute care and how is this funded?

Food and maintenance services cannot be included in care minutes. In line with the Royal Commission's recommendation, 'worked hours' of registered nurse (RN), enrolled nurse (EN), and personal care worker (PCW) staff count towards the care minutes target when they are providing personal care to residents.

Food and maintenance costs are considered non-direct care cost or hoteling costs. Hoteling costs are generally understood to be funded by the revenue stream provided by the consumer funded Basic Daily Fee (BDF), set at 85 per cent of the single Aged Pension daily payment, currently $56.87 per day. The introduction of the government funded 2021 BDF supplement was intended to

address the hotelling cost shortfall, however with the introduction of the AN-ACC, this supplement has ceased, and the funding has been rolled into the AN-ACC.

Do care staff administering medications count towards care minutes?

Yes. Administering medication in accordance with the Nursing and Midwifery Board of Australia Standards for Practice is considered direct care and can be counted towards care minutes.

Will there be compliance action if a provider is unable to deliver the required care minutes during the period from 1 October 2022 to 30 September 2023?

Provider performance against care minute targets is one of the measurable indicators used to inform a new star rating system to be published on the My Aged Care website from December 2022.

Star ratings will further increase residential aged care accountability and help consumers to make more informed choices by providing meaningful information about the quality of care provided by individual aged care homes.

Additionally, the Aged Care Quality and Safety Commission (ACQSC) will examine the data provided by the Department on care minutes and RN shift coverage alongside other regulatory intelligence held by the ACQSC to identify any risk relating to individual services and providers. Where the ACQSC has serious concerns about a service's compliance, the ACQSC may issue a non-compliance notice requiring the provider to take specific actions, and/or may take proportionate enforcement action.

The department's regulatory program will follow the ACQSC's risk-based and proportionate approach and will target services deemed to be at highest risk.

If the resident casemix for a service, changes throughout the quarter, should staffing change to align with actual casemix requirements or should the service continue to roster staff based on the quarterly care minutes targets?

The average care minutes target for each service for each quarter will be based on the service's resident casemix for the previous quarter. This is because targets cannot be set for a quarter that has not yet closed and where the resident profile may change.

This means that any changes to a service's resident casemix or residents occupancy levels during the quarter will not result in a change to the average care minutes targets for that quarter.

While providers should ensure that staffing levels are sufficient to meet the service's average care minutes targets, they must also ensure that staffing levels meet the actual needs of residents at all times.

Do the consumer experience interviews impact upon care minutes?

No. Consumer experience interviews do not impact care minutes, these interviews contribute towards the overall star ratings of a service.

What are the care minute requirements for Class 98, Class 99 and Class 100?

There are no care minutes requirements for these classes.

Will care minutes delivered by enrolled nurses be counted under the registered nurse care minutes?

No, care minutes delivered by enrolled nurses cannot be counted towards registered nurse care minutes. Care provided by an enrolled nurse count towards the total direct care received by a resident.

However, enrolled nurses (including endorsed enrolled nurses) have an important role in aged care providing clinical nursing services, under the supervision of registered nurses. Working as a team, the enrolled nurse role frees up registered nurses to work at the top of their scope of practice, providing more complex clinical care for residents.

Can employees that are working towards their qualifications be included in care minutes? For instance, a nurse completing their diploma - can they be included as an enrolled nurse?

If a nurse has been registered by the Australian Health Practitioner Regulation Agency (AHPRA) as either a Registered Nurse or Enrolled Nurse, they are eligible for inclusion in care minutes.

If an enrolled nurse is under the direct supervision of a registered nurse and present while care is being provided (for example, for 2 hours a day), is this counted as 2 hours of care or 4 hours of care (2 for the registered nurse and 2 for the enrolled nurse)?

If both the registered nurse and enrolled nurse are present and working to care for an individual resident, both their time would count towards care minutes. If only the enrolled nurse was providing care, while under the supervision of a registered nurse who was not present, only the enrolled nurse's time would count.

Does care provided to residents on a default class get included in the actual care minutes delivered calculation?

Yes. Care provided by a registered nurse, enrolled nurse and personal care worker to all residents should be included when reporting direct care.

If care minutes are not included in default classes, what happens when the resident's actual classification, when assigned, is backdated to the date of admission? Will the care minutes be backdated as well?

Care minutes targets are based on the AN-ACC classification of each resident and the number of days they occupied a bed in a quarter.

Residents on default rates at the end of the quarter will not be counted as part of the target for that quarter, however, they will be included for future quarter targets. The aged care service will be funded to provide appropriate care for the resident even while they are waiting for an AN-ACC class to be assigned.

Care minutes targets are backdated to the date a resident enters care if the AN-ACC classification is known at the time of calculation (that is, before the 14th of the first month of the following quarter). However, if the resident's classification is not known when the care minutes targets are calculated, they are not included in the quarter's calculation.

If a resident enters care on 1 January 2023 and is only assigned an actual AN-ACC class (class 11) on 29 January 2023, will the system calculate the care minutes target is respect to this resident from when the AN-ACC class as assigned and will be backdated to the date of entry?

Where the actual classification is known, it will apply for the entire time that the resident was in care. Care minutes targets are backdated to the date a resident enters care if the AN-ACC classification is known at the time of calculation (that is, before the 14th of the first month of the following quarter). However, if the resident's classification is not known when the care minutes targets are calculated, they are not included in the quarter's calculation.

In this example as the classification is known before the 14 February, the care minutes will be backdated to 1 January.

Registered Nurses

How do low care services with Class 1 – 4 residents report care minutes for registered nurses if they do not have any on staff?

From 1 July 2023, aged care services are required to have a registered nurse on site and on duty 24 hours a day, 7 days a week, and meeting mandatory registered nurse care minutes from 1 October 2023.

These are key components of the Government's plan to improve aged care. The care minutes recommendation by the Royal Commission was based on concerns that service staff were not spending enough time delivering care to residents. This resulted in a recommendation of an average care minutes standard for the sector that was deliberately set above current average levels of care delivery.

In residential aged care, registered nurses bring essential clinical skills and oversight and play a critical role. They provide clinical advice, preventive care and supervision and management of residents clinical and care needs.

Time spent by registered nurses developing and maintaining resident care plans and managing clinical and care needs is counted and should be reported as care minutes. These requirements are being introduced in stages to allow time to grow the aged care workforce.

Registered nurses are required to have a 3-year Bachelor qualification, however, there will be registered nurses still in the aged care system who have not gained this qualification and were trained via the hospital training system. Are these staff excluded from care minutes?

Where a nurse does not have a Bachelor degree but has been registered by the Australian Health Practitioner Regulation Agency (AHPRA) as a Registered Nurse, they are eligible for inclusion in care minutes.

If the service is continuously providing registered nurse massages to residents, will it count for care minutes?

Yes. A registered nurse providing a massage would count towards care minutes.

Do junior registered nurses count toward registered nurse care minutes?

Where a junior nurse has been registered by AHPRA as a Registered Nurse, they are eligible for inclusion in RN minutes.

Is the requirement to have a registered nurse onsite 16 hours a day changing to 24 hours per day from 1 July 2023?

Yes. The requirement to have a registered nurse onsite 24 hours a day commences from 1 July 2023.

Default rates

What happens if a resident dies before the AN-ACC assessment. Will the service be paid only the default rate?

Payment will be at the applicable default rate for all residents who die before an assessment is completed. The default rate for residents who enter to receive palliative care is the same as the rate for AN-ACC Class 1, while the default rate for all other residents is the equal to the average AN-ACC variable funding amount.

If a resident is coming in for palliative care and all required documentation is submitted, and does not need an AN-ACC assessment, why is there a default rate?

The default rate applies between the time that the resident enters care and the time that the Palliative Care Status Form is approved by the department.

Do the default classes have specific National Weighted Activity Units (NWAUs) attached to them? When will the rate for default classification (classes 98, 99 and 100) be available? If a respite resident is discharged before an ACAT or AN-ACC assessment is completed, will the default rate be claimed back?

The NWAUs and associated payment rates for default classes can be found in the schedule of subsidies and supplements.

If a respite resident without a respite class leaves the service before they are assessed and receive a respite classification, the default rate will be paid for their stay.

What does class 99 mean?

Class 99 is a default classification that will allow providers to receive funding for a resident who has not yet been assessed for AN-ACC. Once the resident has been assessed, the resident will be assigned an AN-ACC class and funding will be adjusted to reflect the actual AN-ACC class from the date of entry.

Are respite high care and low care on the same default of Class 100?

AN-ACC removes the distinction between respite high care and respite low care. Almost all people who are approved for respite care will receive an AN-ACC respite class at the time of their approval for respite care by an ACAT. The default class will only apply where the ACAT has indicated that they are unable to complete an assessment of the person (for example because the approval was conducted via telehealth).

Will the one-off payment be for permanent residents only or for both respite and permanent?

The initial entry payment applies only to permanent residents. In recognition of this, the daily payment rate for respite residents has been increased.

Funding

Will the Oxygen and Enteral Supplement Payments continue from 1 October 2022?

Yes. Providers will continue to receive these supplements, if eligible.

Will funding reduce if a resident is in hospital for an extended period, like under ACFI?

For residents who are on extended hospital leave, the subsidy amounts paid to the aged care service is reduced from the 29th day onward to an amount equal to the amount of BCT for the service (that is, providers will not be paid the funding linked to the resident's AN-ACC class).

When transferring residents, if the prior provider of service does not release the resident in a timely manner, how will this be addressed to ensure the receiving provider is funded from day of entry?

There will be a new obligation in the legislation for providers to notify Services Australia within 28 days when a resident has exited care. In addition, auto-departure system rules will be in place whereby an entry submitted by a provider who is delivering care for a resident who is transferring services, will automatically generate an exit from the previous service. This replaces the previous

arrangements were funding delays existed if a prior provider did not action the transfer in a timely manner.

Will AN-ACC funding be backdated to the day of admission or does the funding commence on the day Services Australia receive the Aged Care Entry Record (ACER)? For example, if the ACER is submitted one week after the actual admission?

AN-ACC funding starts on the day of a resident's admission into care. This means payment will be backdated to the day of admission.

My Aged Care Service and Support Portal

When do providers need to apply the minimum care minutes targets currently reported on the My Aged Care Service and Support Portal?

The average care minutes target for each service for each quarter will be based on the service's resident casemix for the previous quarter. This is because targets cannot be set for a quarter that has not yet closed and where the resident profile may change.

This means the care minutes targets available in the My Aged Care Service and Support Portal are based on the resident casemix for the service from the April-June 2022 quarter and will need to be met in the July -September quarter. The care minutes targets from the July -September quarter will need to be met in the October – December quarter and should be available shortly. On the 14th of October 2022, the average care minutes target based on the July- September quarter will be released. Facilities will deliver against the published care minute target during the October-December period.

What would be the reason that providers are unable to see a resident in the Care Recipient view?

The display of information in the My Aged Care Service and Support Portal is dependent on entry information having been submitted to Services Australia. Check that your entry information has been correctly submitted and if this does not resolve the issue, contact the My Aged Care service provider and assessor helpline:

Phone: 1800 836 799

The helpline is available from 8:00am to 8:00pm Monday to Friday and 10:00am to 2:00pm Saturday, local time across Australia.

What are the statuses that can be displayed in the Care Recipients' tab?

The statuses available include:

- Active classification – assessment completed
- Pending classification – awaiting outcome of assessment
- Default classification – awaiting assessment
- No classification – only applicable during shadow assessment period. No longer exists from 1 October 2022.

When will Respite classes be available in the My Aged Care Service and Support Portal?

Providers can view the respite classes for residents in their care now in the My Aged Care Service and Support Portal.

Will providers be able to export or download a spreadsheet of residents with their classifications from the My Aged Care Service and Support Portal?

The My Aged Care Service and Support Portal does not currently have functionality for users to download their classification data into a report. This is due to privacy and security issues to ensure that client data is protected. Future improvements are being considered as part of the Department's digital transformation agenda that will assist in making the linkages between Government and providers much easier.

The department has a duty of care to protect the information of all users. The department has systems and procedures in place to protect personal information from misuse and loss, and from unauthorised access, modification or disclosure. Further to this, there are Terms of use you may refer to that provide more information.

Where can providers see detailed assessment outcomes for residents?

The detailed assessment outcome is not visible as this relates to information captured by the independent assessment workforce.

However, providers can view a resident's current classification and classification history if applicable. To do this, go to the home page in the My Aged Care Service and Support portal, select the 'Residential Care' tile. You will be taken to the 'Care recipients' tab and from here you will be able to select the resident record to see their classification details.

Where can providers find care minutes targets?

Providers can see their care minutes target for each service they operate through the My Aged Care Service and Support Portal. From the home page select the 'Reports and documents' tile and then select the 'Care Minutes' tab to view the list of residential facilities to which you have access. Expand the relevant service and from there you will be able to view the current quarter care minute targets as well as a previous quarter targets. To view detailed steps on this process refer to Section 9 of the My Aged Care – Service and Support Portal User Guide - Part Two.

Is there a demonstration of the My Aged Care Service and Support Portal?

The My Aged Care – Service and Support Portal User Guide - Part Two contains detailed steps and screen shots to support portal navigation. The Department has published some short navigational videos for residential care functions in the portal including:

- Accessing care minutes targets
- Requesting reconsiderations and reclassifications
- Entry process for palliative care residents

Is there any field manual or practice guide?

Yes, there are many resources available on the Department of Health and Aged Care website. Click on the link to find out more: My Aged Care – Service and Support Portal Resources | Australian Government Department of Health and Aged Care

Will there be reconsideration button if a service disagrees with the classification that is similar to the reassessment button?

Yes. A 'Request Reconsideration' button is now available in the portal if the service does not agree with the resident's assigned classification. Providers will have 28 days after they receive the outcome of the resident's assessment to lodge a request for reconsideration of the assessment. If this is not requested within the 28-day timeframe, this option will not be available in the system.

Can providers get a copy of the provider journey graphic?

The presentation used during the webinar can be found here including the provider journey graphic. A provider process map is also available here.

Palliative care

What happens if a resident who entered for palliative care is still in care after 3 months?

The resident will remain in AN-ACC Class 1 until they leave care, or the resident or provider requests a reclassification.

The Palliative Care Status Form says part A and Part B need to be filled by the independent medical practitioner "prior to the date" of entry to the service. Does this mean the service needs to request the form to be attended by the doctor from a hospital (if the new resident is coming from the hospital) as part of pre-admission process?

Yes, where a resident is entering from a hospital to receive palliative care (and meets the criteria) a medical practitioner or nurse practitioner from the hospital can complete the form. This can in fact be on the same day as entry as long as it is before actual entry. The department will consider the wording of the form when it is next reviewed.

What do providers need to do if a resident entered a service as a non-palliative resident and becomes palliative while in care?

Where a resident's care needs have increased due to their deterioration a service can request a reassessment through the My Aged Care Provider Portal.

What will happen if the resident receiving palliative care passed away (for example) two or three days after their palliative care status was approved?

The service will receive AN-ACC funding at the highest rate (Class 1) for the period that the resident was in care, as well as the entire initial entry payment.

Will hospitals be provided information on Class 1 and the required documentation?

Information about Class 1 and required documentation can be found at: AN-ACC Class 1 – admit for palliative care | Australian Government Department of Health and Aged Care.

Services Australia Aged Care Provider Portal

Where is the resources page and e-learning for Services Australia resources?

The Health Professional Education Resources can be found at: Health Professional Education Resources (servicesaustralia.gov.au)

Providers were able to download the payment report to PDF under the old payment system. Is there a way we can do this with the new reports? For example, if providers are unable to open using CSV or XML?

PDF view for payment statements will be available towards the end of this year. Users will be able to print to PDF version. As a temporary process, please use the print page function in your web browser.

Star ratings

What are the Star Rating weightings?

There is one overall star rating and four sub-categories, each with their own star rating. A rigorous process of development and consultation was undertaken to determine the fundamental design of the star rating model, including sub-category weightings in the overall Star Rating.

The proposed sub-category weightings are Consumer Experience Reports weighted the highest (33%), followed by Service Compliance Ratings (30%), Care Minutes (22%), and Quality Indicators (15%).

The final Star Ratings design will be communicated in detail when available.

Will star ratings be negatively impacted if all attempts are made to staff to the care minute targets but adequate resources cannot be found? Will providers have the opportunity to provide commentary around the care minutes reported?

Star Ratings are proposed to take a rules-based approach and present consistent quality measures across residential aged care services.

The multi-dimensional nature of Star Ratings provides an opportunity for services to attain high overall and subcategory ratings, despite highlighting an area for improvement.

Star Ratings is one piece of information available on My Aged Care to help older Australians make informed decisions about their care. Service providers have the opportunity to add information about their service in the 'Service description' free text field in the My Aged Care provider portal. This information is displayed on the provider's individual results page on the 'Find a Provider' tool on the My Aged Care website.

Providers will have 2 weeks to review the Star Rating outcome before they are published on the My Aged Care website.

Transition Fund

If an aged care facility believes it is eligible for the Transition fund, can they apply if they have not received an invitation?

Providers that have not received an invitation to apply but believe their organisation is eligible, can contact the department to request a review of their facilities eligibility. Providers may contact the department at AN-ACCTFGrant@health.gov.au.

For further information, please see the AN-ACC Funding Guide for guidance on how to calculate funding and What is the AN-ACC Transition Fund fact sheet.

Who are eligible providers for the transition fund grant?

An eligible provider is an approved provider under the Aged Care Quality and Safety Commission Act 2018 that:

- provides residential care services
- existed prior to 1 July 2022
- is a body corporate
- has received an invitation to apply from the department.

Is the AN-ACC Transition Fund designed for the providers who are not ready for AN-ACC?

No, the purpose of the Transition Fund is to assist providers who may need financial support to adjust to the new funding arrangements under the AN-ACC without impacting on their ability to provide personal and clinical care to their residents.

Can providers be given their base ACFI so they can assess they are eligible for the AN-ACC Transition Fund?

Providers may determine their facilities average ACFI per bed day (PBD) amount from ACFI claims submitted from 1 November 2021 – 31 January 2022 (based on the claims for this period processed prior to 1 July 2022 and with the amount indexed up by the same rate ACFI is indexed by in July 2022) and includes the homeless, viability and basic daily fee supplements and the adjusted subsidy reduction.

Will the ACFI reviews conducted by the department continue after AN-ACC commences?

While we are not planning to continue a broad rolling program of ACFI reviews after 30 September 2022, if required, the Department may potentially check any ACFI claims and records of treatment after 1 October 2022 if they relate to ACFI claims for subsidy paid up until 30 September 2022.