AN-ACC questions and answers – Aged Care Funding Reforms Webinar #7

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 seventh aged care funding reform webinar in the series was held on 17 November 2022. This webinar focussed on recent changes to the Australian National Aged Care Classification (AN-ACC) funding model and important information for aged care providers, including:

- monthly statements
- payments and claims processes
- clarification around the palliative care entry process
- 24/7 nursing requirement, exemption and supplement
- care minutes and funding sufficiency update.

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 Australian National Aged Care Classification (AN-ACC) Funding Guide which sets out how to receive AN-ACC subsidies, including relevant compliance requirements that may apply.

Information about the 24/7 registered nurse supplement for residential aged care and care minutes can also be found in the following documents:

- 24/7 registered nurse supplement for residential aged care
- Aged care 24/7 registered nurse requirement
- Care minutes and 24/7 nursing requirements guide

24/7 registered nurse requirement and supplement

1. **24/7 Registered Nurse (RN) exemptions: how was the exemption level of less than 30 beds worked out? Has this involved consultation with the aged care industry?**

The 24/7 exemption policy seeks to balance the need to increase RN coverage to address the understaffing issues highlighted by the Royal Commission, while also taking into consideration that workforce shortages in some areas will mean that a number of facilities will not be able to meet the 24/7 requirement.

Available data from the 2020 Aged Care Workforce Census indicated that smaller facilities currently have lower RN coverage than larger facilities, and that facilities in more rural and remote areas have lower RN coverage. The exemption to facilities of 30 beds or less in MMM 5-7 regions was developed on this basis and will cover 191 facilities out of approximately 364 in MMM 5-7 regions.

The department recognises that this threshold means that there will be some facilities that are ineligible for an exemption and may be unable to meet the 24/7 RN requirement (despite doing all in their power to attempt to recruit further RNs). The Aged Care Quality and Safety Commission has indicated that it will take a risk based and proportionate approach to regulating this new requirement. This will involve taking into consideration whether genuine attempts to recruit RNs have been made, and also the steps the provider is taking to ensure quality and safe care is being delivered during the times an RN is not onsite.

The government is undertaking work to further develop and refine the 24/7 RN requirement. This includes:

- exploring the feasibility of developing a model of aged care RN workforce shortages by region, that could be used to inform future exemption arrangements
- developing clinically appropriate alternative models of care to ensure safe and quality care is delivered when a RN is not available due to workforce shortages

Targeted consultation with a range of stakeholders will be undertaken over 2023 to inform this work.

2. **Do providers need to put an application in to receive the 24/7 RN supplement? Or is it automatic for over 30 but less than 30 beds?**

Eligible residential aged care services will automatically receive the supplement from Services Australia. Further information is available on the 24/7 registered nurse supplement for residential aged care webpage.

3. **What are the supplement funding amounts?**

The monthly supplement funding amounts can be found here: 24/7 registered nurse supplement for residential aged care.

4. **How does a provider complete the 24/7 RN reporting requirement? Is the reporting only required for providers that receive the supplement?**

From 1 July 2023, all approved providers of residential aged care services, including those that are granted a 12-month exemption from the 24/7 RN requirement, will be required to report monthly on the 24/7 RN requirement, through an online portal. Services will report monthly by exception on the times when a RN is not on-site and on duty. Where a service has an RN onsite and on duty at all times over the month, they will need to confirm this through the online portal.

The Commonwealth will use these reports to:

- monitor compliance with the 24/7 RN requirement
- determine eligibility for the 24/7 RN supplement.

Approved providers of residential age care services that have services that are co-located must submit individual monthly reports for each service. If co-located services combine, the approved provider of that service will only need to submit one monthly report.

More information and guidance on completing the 24/7 RN reporting will be available closer to the commencement of the first reporting period.

5. **If a registered nurse (on night shift for 24/7 nursing requirement) is sick after 4 hours into their shift and has to go home (with no replacement RN for the remainder of the shift), how does that impact the funding supplement for that month?**

The Department acknowledges that there will be some instances where a facility will not have an RN onsite due to sickness or other unexpected leave. The department is currently in the process of developing acceptable thresholds to account for unexpected leave before the supplement is impacted.

6. **Will facilities that are eligible for the 24/7 RN exemption, that already have 24/7 RNs, be paid the supplement?**

Services that qualify for an exemption but opt to not apply for the exemption and instead to provide 24-hour RN care will receive the supplement.

Exempt services will not receive the RN supplement. If an exempt service determines at some point throughout their 12-month exemption that they are able to deliver 24/7 RN care they will be able to opt out of the exemption and become eligible for the supplement.

7. **Should the criteria for reporting absence of RN be 'more than 30 minutes', otherwise should meal breaks of 30 minutes be reported where one RN is onsite?**

For the purpose of the 24/7 RN coverage and monthly reporting, meal breaks that form part of a continuous shift are not considered an absence and do not need to be reported, so long as the RN is onsite, and able to respond to any emergency that may occur during this period.

This differs to care minutes reporting, where meal breaks cannot be reported as care minutes as direct care to residents is not being provided during this time.

ACFI

8. Has the Aged Care Funding Instrument (ACFI) funding validation now ceased?

The Department is not planning to continue a broad rolling program of Aged Care Funding Instrument (ACFI) reviews after 30 September 2022. However, if required, the Department may check ACFI claims and records of treatment after 1 October 2022 if they relate to ACFI claims for subsidy paid up until 30 September 2022.

While ACFI ended on 30 September 2022, providers will need to continue to meet their responsibilities under *The Aged Care Act 1997*, including meeting the requirements under the *Aged Care Quality Standards* as well as undertaking comprehensive assessment and care planning for residents.

Additionally, approved providers need to retain ACFI appraisal evidence requirements to support ACFI claims as set out under Division 88 of *The Aged Care Act 1997* and consistent with section 7 of the Records Principles 2014, for care provided up until 30 September 2022.

Assessments

9. How will the urgent assessments for AN-ACC reclassification be addressed in major regional centres where AMO staff are fly-in-fly-out?

The department continues to work with Assessment Management Organisations to ensure timely assessments are undertaken across the country.

10. Is there any update on the timeframe for new admissions being assessed, in particular for regional/remote areas?

There is no legislated timeframe for an initial AN-ACC assessment to be completed.

When a resident is new to the facility, assessments undertaken by the facility for care planning based on resident needs and details on the care given, provides some information to support AN-ACC assessments (it is not the only source to triangulate the assessment). Basically, what are the assessed care needs of the resident and what care is being provided to meet these needs (can be obtained from various forms of information such as staff, resident, admission notes).

Care planning assessments will take a sufficient amount of time to complete and with a lot more information than what is required for an AN-ACC assessment to be completed. Respite residents who become permanent would also most likely have ample documentation in place for an AN-ACC assessment to proceed.

Regarding scheduling, once a referral is received and accepted by an Assessment Management Organisation (AMO), it will assign the referral to an assessor who will arrange for the AN-ACC assessment to be completed. When an AMO contacts the service to arrange an assessor visit, ensure that the organisation is advised of what information is available for the resident to support an assessment in a timely manner to support funding.

All locations should be attended to within a 28-day timeframe (where possible), noting that the department is currently working with AMOs to clear a small number of assessments outside of this timeframe.

11. Now that AN-ACC has been implemented does that mean there is no HIGH or LOW classification of residents. For example, previously a low care resident could access the Continence Aids Payment Scheme (CAPS) funding for incontinence aids. Is it correct that they cannot do this anymore?

Yes, that is correct. The concept of high and low care under the previous Aged Care Funding Instrument has been removed and does not apply to the AN-ACC funding model. Under AN-ACC, funding is linked to each classification (1 – 13) based on the measured average costs of providing all the specified care and services as needed for the people in each class.

This means all care recipients who reside at a residential aged care home on a permanent basis will be required to receive continence products through their aged care home, based on need, and should not require financial assistance under CAPS. CAPS recipients entering a residential aged care home on a respite or short-term restorative care basis will not be impacted by these changes.

The *Continence Aids Payment Scheme 2020* instrument has been amended to align with AN-ACC and came into effect on 1 October 2022. Participants receiving CAPS prior to 1 October 2022, will remain eligible for CAPS until 30 June 2023. This is to ensure no one is disadvantaged. CAPS recipients impacted by this change will receive a letter from Services Australia about the changes to their CAPS eligibility in early 2023.

12. Why is Class 12 funded less than Class 11 when the care burden is more in Class 12? Is there more clarity on Class 13 compounding factors to help providers to make accurate decisions for reassessment requests?

The AN-ACC class funding is based on the relative total costs of caring for residents in each class from the Resource Utilisation and Classification Study undertaken by the University of Wollongong. These total costs include care delivered by Registered Nurses, Enrolled Nurses and personal care workers, as well as elements not captured by the care minutes requirements such as consumables, allied health care, recreation officer/diversional therapist time etc. Where there were differences in the relative composition of costs – for example higher costs of consumables – this could lead to a difference between funding outcomes and care minute requirements.

The relative funding levels for each class, and associated care minute requirements, will be refined over time based on advice from the Independent Health and Aged Care Pricing Authority (based on evidence from regular costing studies).

The AN-ACC care recipient classification model uses a branching case-mix procedure (refer s32 of the *Classification Principles 2014*), in which one step may be determining which of possible alternative classifications a care recipient is allocated to depends on whether the care recipient does or does not have “significant compounding factors” (refer s4A of the *Classification Principles 2014*).

The compounding factors taken into consideration in determining whether a resident is Class 12 or Class 13 are:

- the care recipient’s AFM eating score;

- the care recipient's disruptiveness score;
- whether the care recipient has fallen in the last 12 months;
- whether the care recipient has lost more than 10% of their body weight in the last 12 months;
- whether the care recipient requires daily injections.

Whether compounding factors are deemed "significant" depends on whether the factors for the care recipient, considered together, indicate that the care recipient has significantly higher care needs relative to the needs of other care recipients.

The department uses a proprietary algorithm to determine which of the many possible combinations of compounding factors, taken together, indicate that a care recipient has significantly higher care needs. However, as a general rule, the "worse" a care recipient's combined results are, against the compounding factors that apply to them, the more likely that the compounding factors will be deemed significant and that the care recipient will be allocated to a higher classification level.

Care Minutes

13. What is required to be listed in the Position Descriptions (PDs) for positions that provide direct care minutes? If audited, what proof besides rosters and PDs will be required to substantiate care minutes worked?

Only direct 'clinical care' and 'personal care' activities provided by registered nurses (RN), enrolled nurses (EN), and personal care workers (including assistants in nursing) (PCW/AIN) can be counted for the purposes of meeting the care minutes targets and forthcoming care minutes requirements.

Definitions for these roles and the activities they can report as care minutes can be found in the Care minutes and 24/7 registered nurse requirements guide on the department's website.

Approved providers are required to report on care minutes delivered by registered nurses, enrolled nurses or personal care workers in the Quarterly Financial Report (QFR). Approved providers report on the total hours worked and the number of occupied beds (residents) in each of their services, these figures are used to determine the number of care minutes delivered. The information reported in the QFR is used to assess each service's performance against their care minutes targets and inform the Staffing Star Rating.

The department will be monitoring approved providers to ensure they meet care minutes and 24/7 registered nursing requirements. It is expected that providers will ensure their reporting accurately reflects staffing records such as payroll, rostering, and timesheets.

14. Is there any plan to have allied health care include in resident care minutes in the future? How is the recommendation of 22 allied health care minutes per day made by the Royal Commission being considered/implemented?

As per the recommendations of the Royal Commission, only "worked hours" of registered nurses, enrolled nurses and personal care workers including assistants in nursing can be counted towards direct care minutes totals. The department recognises the invaluable work of all staff in aged care including allied health professionals, however in keeping with the Royal Commission

recommendations direct care provided by allied health professionals cannot be counted towards care minutes.

Whilst the Royal Commission recommended care minute targets for direct care, for allied health their recommendation was to include a level of allied health care appropriate to each person's individual care needs.

With the annual Aged Care Financial Report and implementation of the Quarterly Financial Report the department has multiple avenues to collect information about where aged care providers spend their money at the service level, including direct care and staffing, as well as the diverse categories of allied health professionals. This data collection will give visibility over the use of allied health services and inform future policy discussions in residential aged care, which may include future consideration of allied health care minutes.

15. Which roles/ positions are included in the care minutes and which roles are not? Which roles or positions can be considered in the hybrid roles?

In line with the recommendations of the Royal Commission, only personal/direct care that is delivered from registered nurses, enrolled nurses and personal care workers can be counted towards care minutes.

Where a registered nurse, enrolled nurse or personal care worker is employed in a hybrid role, for example, providing both personal care and other activities such as rostering, social activities, catering and laundry, only the portion of the worker's time spent on direct/personal care can count towards care minutes.

Other activities that are performed in the context of other roles such as a care manager, lifestyle worker or laundry hand are outside of the roles of a registered nurse, enrolled nurse or personal care worker.

You can find out more information about the types of care staff that can be counted in the Care minutes and 24/7 registered nurse requirements guide on the department's website.

16. What is the Registered Nurse classification for care minutes, as in Victoria, Enrolled Nurses are known and registered as RN Division 2?

A RN must be registered with the Nursing and Midwifery Board of Australia (NMBA), which is regulated by the Australian Health Practitioner Regulation Agency (AHPRA) as a 'Division 1 – Registered Nurse'. A RN is someone that has obtained their qualification by completing a Bachelor of Nursing through a university to meet the RN standards for practice, or has obtained their Division 1 qualification when the course was a 3-hospital qualification or 3-year Diploma.

An EN must be registered with the NMBA, which is regulated by APHRA as a 'Division 2 – Enrolled Nurse'. While ENs are registered as 'RN Division 2' in Victoria, they are not RNs for the purpose of care minute reporting, who are registered as RN Division 1. An EN is someone that has typically completed a Diploma of Nursing through a vocational education provider, to meet the EN standards for practice. ENs work under the direct supervision of a RN and cannot act alone.

The Royal Commission recommendation was that Division 1 nurses (that is, registered nurses) are included in registered nurse minutes for care minute purposes and Division 2 (that is, enrolled nurses) are included in the 200 care minutes (non-RN time).

So, while enrolled nurses are called or registered as RN Division 2 nurses in Victoria, they are not that same as registered nurses, who are registered as RN Division 1, for the purpose of meeting the RN care minutes requirement.

17. Are registered nurses that do not have a Bachelor qualification, for example, those that are hospital trained, excluded for the purposes of care minutes?

No. Where a nurse does not have a Bachelor degree but has been registered with the Nursing and Midwifery Board of Australia (NMBA), which is regulated by the Australian Health Practitioner Regulation Agency (AHPRA) as a 'Division 1 – Registered Nurse' they are eligible for inclusion in care minutes.

18. What happens when a facility has staff outside of the definitions of aged care workers that provide paid care and assistance with daily living and emotional support to residents? How do the costs associated with the provision of this care be covered and accounted for and fit into this classification?

The care minutes and 24/7 registered nurse requirements guide provides definitions and examples of what staff activities count towards care minutes. Where care is provided but does not fit within these definitions it cannot be reported as care minutes (for example allied health and lifestyle services). The AN-ACC funding model provides residential aged care services with sufficient funding to deliver care to residents in line with what is required under Schedule 1 of the Quality-of-Care Principles 2014, including the provision of emotional support, allied health and lifestyle activities.

The department acknowledges that social and emotional support is a vital part of residential aged care. Consistent with the need to improve the standard of personal care in residential aged care, social and emotional support should enhance, not be at the expense of, personal assistance with daily living routines and direct care activities such as bathing and washing, dressing, feeding, getting in and out of bed, getting to and from the toilet and continence management.

19. Provide clarification of what is considered 'direct care' for residents per the care minutes criteria, and what can be included as care minutes.

There are a range of examples of "direct care" and activities that can and cannot be included as care minutes in The care minutes and 24/7 registered nurse requirements guide. This guide has recently been updated.

20. How are the 200 Minutes of Care Calculated for Aged Care Residents?

The care minutes and 24/7 registered nurse requirements guide has information about the initial target of 200 minutes per resident per day, introduced from 1 October 2022. This target includes a minimum of 40 minutes of RN time per day, averaged across the residential aged care sector.

The targets are explained in the diagram below:

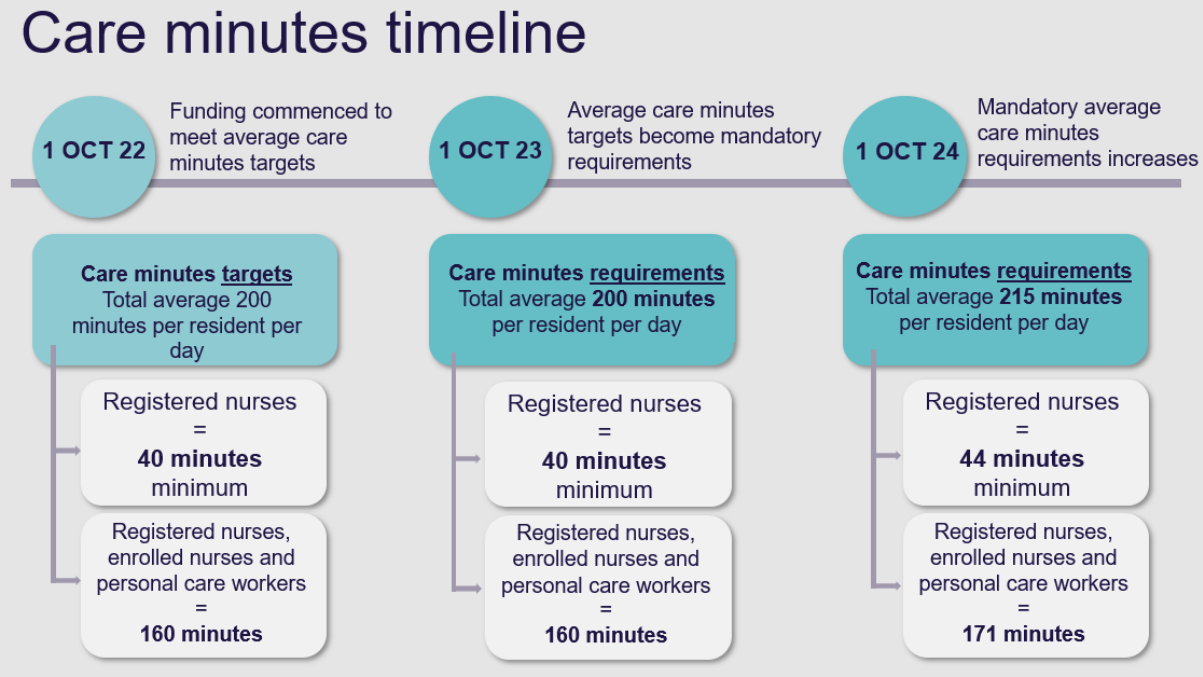

Figure 1 Care minutes timeline

The Royal Commission into Aged Care Quality and Safety (Royal Commission) identified that staffing levels are critical to the quality of residential care and recommended at least 200 minutes per resident per day for the average resident from registered nurses, enrolled nurses, and personal care workers.

In line with the recommendations of the Royal Commission, only personal/direct care that is delivered by registered nurses, enrolled nurses and personal care workers including assistants in nursing can be counted towards care minutes.

Activities that may be counted towards care minutes are outlined in The care minutes and 24/7 registered nurse requirements guide.

Aged care services are funded to meet their care minutes targets, with the targets a mandatory requirement from 1 October 2023. Approved providers are required to report on care minutes delivered by registered nurses, enrolled nurses, or personal care workers in the Quarterly Financial Report (QFR). Approved providers report on the total hours worked and the number of occupied beds (residents) in each of their services. The reported worked hours are used to determine providers' performance against their service-level specific care minutes targets.

21. Can you please confirm direct care provided by agency RNs is included in Residential Aged Care Facilities (RACF) care minutes?

Yes, if the agency RN is registered with the Nursing and Midwifery Board of Australia (NMBA), which is regulated by the Australian Health Practitioner Regulation Agency (AHPRA) as a 'Division 1 – Registered Nurse'. The agency RN should have obtained their qualification by completing a Bachelor of Nursing through a university to meet the RN standards for practice, or obtained their Division 1 qualification when the course was a 3-year hospital qualification or 3-year Diploma.

22. Is the AN-ACC funding matched to the cost of the staffing required to meet the care minutes targets?

Yes. Providers are funded through AN-ACC to have a sufficient mix of RNs, ENs and PCW/AINs on duty to meet the care needs of residents at all times. This is to ensure that safe and quality can be provided to residents living at all residential aged care services.

The AN-ACC funding model includes funding to cover the cost of providing direct care (through RNs, ENs and PCW/AINs) to residents, including the wages for these aged care workers. This includes a funding uplift of $5.4 billion over four years that commenced on 1 October 2022, to enable residential aged care services to meet the initial care minutes targets and mandatory requirement of a sector wide average of 200 minutes per resident per day.

An additional $1.9 billion ($0.8 billion in 2024-25, and $1.1 billion in 2025-26) was allocated in the October 2022-23 Budget to increase average care minutes to 215 minutes from 1 October 2024.

23. What is the definition of a personal care worker or assistant in nursing (PCW/AIN)?

A PCW/AIN is an employee classified under the Aged Care Award 2010 or an equivalent enterprise agreement (EA) as an Aged Care employee Level 2 (Grade 1 PCW) to Aged Care employee Level 7 (Grade 5 PCW) (excluding Aged care employee Level 6), or as an Assistant in Nursing (AIN) under the Nurses Award 2020, and works under the guidance of a nurse (RN/EN).

Activities of a PCW/AIN that can be reported as care minutes include assisting residents with:

- daily living routines and direct care activities (such as self-care or personal care) for example, assistance with eating and drinking, monitoring fluid intake, skin care, ambulation, bathing and washing, dressing, hair care, mouth care, positioning, shaving, bladder and bowel care (continence management), mobility and transfers (such as getting in and out of bed or to and from the toilet)
- social and emotional support for residents and their families, for example, supporting residents to be and feel connected, heard, valued and fulfilled
- regular monitoring and support of residents' health and wellbeing.

The relevant awards for aged care employees distinguish a PCW/AIN from other employees such as gardeners, drivers, food services assistants, cooks, chefs, clerical, cleaners, laundry hands, and lifestyle coordinators.

Activities not consistent with the PCW/AIN role include, but are not limited to, organising recreational/social activities, allied health (including exercise physiologists) and hotel services such as catering, cleaning, and laundry.

Examples of care workers and the activities they can report as care minutes, and further information on PCW/AINs can be found in The care minutes and 24/7 registered nurse requirements guide.

24. Under the personal care worker or assistant in nursing (PCW/AIN) definition for care minutes, does a counsellor with qualifications providing emotional and social care meet the definition of personal care worker for recording care minutes?

As detailed in the answer above, a PCW/AIN is an employee classified under the Aged Care Award 2010 or an equivalent enterprise agreement (EA) as an Aged Care employee Level 2 (Grade 1 PCW) to Aged Care employee Level 7 (Grade 5 PCW) (excluding Aged care employee Level 6), or as an Assistant in Nursing (AIN) under the Nurses Award 2020, and works under the guidance of a nurse (RN/EN). As such, a counsellor (not employed under one the above awards) providing emotional and social care would not meet the definition of a personal care worker.

25. Why can't the social and emotional support for residents and families provided by Leisure and Lifestyle staff be included in care minutes?

Care minutes refers to the minimum direct care time provided to residents by approved residential aged care services through registered nurses (RNs), enrolled nurses (ENs), and personal care workers including assistants in nursing (PCW/AINs) who are performing direct care activities (one-on-one care).

Allied health and lifestyle services are excluded from care minutes reporting and funded separately under the AN-ACC funding model. The ACC funding model delivers residential aged care services with sufficient funding to provide residents with allied health treatment and lifestyle services consistent with their individual care plans, including rehabilitation support and therapy services.

Allied health and lifestyle services are an important component of residential aged care. Providers must continue to provide these services to residents who need them consistent with the *Aged Care Act (1997)* and the Quality Standards. This includes specified care and services that must be provided without cost to residents who need them, as detailed in Schedule 1 of the Quality of Care Principles 2014.

Running group lifestyle activities that would usually be run by a lifestyle coordinator (for example painting, singing, bingo, excursions, etc.) does not count towards care minutes but a PCW/AIN personally assisting a resident to take part in these activities does count.

26. How are the current workforce shortages in the aged care industry being addressed?

The Government recognises the need to invest in the aged care system and its dedicated workforce, and 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 aged care workers will assist with attracting workers to the sector and retaining the existing workforce. A range of programs are also 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 – 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
- Rural Locum Assistance Program – provides locums so that rural health professionals can attend continuing professional development or take vacation leave
- Rural Health Multidisciplinary Training program – offers health students the opportunity to train in rural and remote communities
- Aged Care Research and Industry Innovation Australia – translates research into practice and develops stronger workforce capability through training and growing knowledge
- 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.

Enrolled Nurses

27. Why can't care minutes by Enrolled Nurses be counted towards Registered Nurses' care minutes?

The Royal Commission into Aged Care Quality and Safety (Royal Commission) identified that registered nurse numbers are particularly important for ensuring the delivery of quality care, and so specifically recommended that 40 minutes of the 200 care minutes should be delivered by registered nurses (not enrolled nurses). Enrolled nurse time counts to the overall care minutes in line with the Royal Commission recommendation.

Funding to support providers to increase direct care to meet these new requirements commenced from 1 October 2022 under the AN-ACC funding model (a funding uplift of $5.4 billion over four years). This funding uplift was calculated based on supporting providers to increase their registered nurse care time to meet the 40 minutes requirement, and also increasing personal care worker and enrolled nurse minutes proportionally to meet the remaining 160 minutes.

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.

Independent Health and Aged Care Pricing Authority (IHACPA)

28. Will the Independent Health and Aged Care Pricing Authority determine indexation for other subsidies and supplements or just for the AN-ACC price?

The Independent Health and Aged Care Pricing Authority (IHACPA) will provide advice to the Government about pricing and funding of residential aged care and respite care using AN-ACC. The Government will take IHACPA's advice into consideration in setting both the AN-ACC price and supplements.

The Modified Monash Model (MMM)

29. Has the MMM model changed under AN-ACC? How do providers get their MMM location reviewed?

The MMM is a measure of remoteness and population size used by the department to define whether a location is a city, regional, rural, remote, or very remote. Locations are categorised from MMM 1 – MMM 7, with MMM 1 denoting a major city and MMM 7 a very remote location.

The MMM was introduced by the department in 2015 (and updated in 2019) to better target health workforce programs, in recognition of the challenges in attracting health professionals to regional, rural and remote parts of Australia. As the MMM is purely a data based geographical classification system, discretionary changes cannot be made to the MMM classification of an area.

AN-ACC uses 2019 MMM categories to determine the fixed (base care tariff) component of AN-ACC funding. No 2019 MMM categories changed as a result of AN-ACC being implemented, although the MMM classification of some services may be different under 2019 MMMs compared with 2015 MMMs.

Analysts review and update the MMM after each Census. The Australian Bureau of Statistics (ABS) conducts the national Census every 5 years. If MMM boundaries change as a result of new Census data becoming available, and affect base care tariff eligibility for any services, providers will be notified of the effective date of the change at least six months in advance.

Providers can find the MMM category of their aged care service by typing the street address into the department's health workforce locator tool and selecting 2019 as the MMM classification filter.

Information on AN-ACC in relation to the Base Care Tariff (BCT) subsidy and MMM locations can be found in the AN-ACC funding guide.

National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC)

30. Does the 24/7 RN requirement apply to National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) funded residential aged care services?

The 24/7 RN requirement does not currently apply to Multi-Purpose Services (MPS) and NATSIFAC but will be considered in ongoing aged care reform work.

Palliative care

31. We need to know which AMO to contact if a customer is deteriorating and has not been assessed. Can we please have transparency in the portal regarding which AMO is assigned?

The department is currently reviewing the current systems in place for when a resident has an event that sees the resident at imminent end of life. In the interim, services can email ANACCAssessments@health.gov.au when this urgent matter arises and engagement will be made to have an assessor to the site as soon as possible. However, if a resident is naturally declining,

normal reclassification requests should be made via the Provider Portal to have an assessor arrive and assess within the 28-day timeframe.

32. Some palliative care residents pass away early prior to the assessor reaching them. We have seen that once a resident becomes palliative, their life expectancy is only 7- 10 days. This is not enough time for the assessors to come on-site and do an AN-ACC reassessment. Why can't we use the Palliative Care Status Form for existing residents as well to enable efficient funding in this scenario?

Residents are only eligible for Class 1 if they enter a facility for the purpose of receiving palliative care and meet the Class 1 eligibility requirements before they enter care.

If a resident needs palliative care providers must, under the Aged Care Act 1997, deliver that care. Where there is a significant change in care needs for a resident who did not enter for planned palliative care, but who becomes palliative after entry, the provider can request a reclassification of that resident.

The Government has requested that the Independent Health and Aged Care Pricing Authority conduct a costing study to refine the pricing of the initial entry of new residents into aged care, and any other key periods in the resident's journey where costs may vary. This would include a consideration of end-of-life costs.

33. What if the person doesn't meet the patient criteria to be classed as AN-ACC Class 1 Admit for Palliative Care?

If the client is palliative but does not meet the eligibility requirements (for example they have an AKPS score of 50 or have a life expectancy of more than 3 months), the client will be considered to be a standard permanent resident and the process for standard permanent entry applies. This process includes an AN-ACC assessment to determine the resident's AN-ACC classification. A person in such circumstances may receive the highest AN-ACC class, Class 13, which provides funding equivalent to Class 1.

34. What happens if the person dies before the decision is made?

If a new resident enters a facility for the purposes of receiving palliative care, and he or she passes away or leaves the facility prior to their Class 1 palliative care status being confirmed, the provider will receive the default rate for the AN-ACC variable funding component for the entire period the resident was in their care. This default rate is the same as the Class 1 rate for palliative care.

35. What happens if an existing resident becomes palliative?

If there is a significant change in care needs for a resident who did not enter for planned palliative care, but who becomes palliative after entry, the provider or resident can request a reclassification of that resident. A resident in such circumstances may receive a higher classification, for example, Class 13, which provides equivalent funding to Class 1.

36. Will there be a pathway for an existing resident who becomes palliative to be assessed quickly?

If a resident has had an episode or event that leads to imminent end of life, the service provider can request a reclassification. The provider should then contact the department by emailing

ANACCAssessments@health.gov.au with details. The department will then engage with the Assessment Management Organisations in the area to have the resident assessed as soon as possible.

37. Can a Nurse Practitioner employed by the provider complete the Palliative Care form?

No, the Palliative care status form needs to be completed by an independent medical practitioner or nurse practitioner who is independent of the provider/service.

Parts A and B of the form need to be completed by an independent medical practitioner or nurse practitioner, to evidence the person's life expectancy and their Australia-modified Karnofsky Performance Status (AKPS) score. Parts C and D of the form needs to be completed by the person (or representative) and the person's aged care provider. These parts attest that the person is permanently entering the provider's residential aged care service to receive planned palliative care.

38. Is there a process for a Palliative client going into respite rather than permanent?

AN-ACC Class 1 is for permanent entry only.

A resident can enter for respite care and later transfer to permanent care and enter as Class 1 while remaining in the same facility, but Class 1 funding only pertains to the time that they were in permanent care.

39. If someone meets the criteria of the palliative care status form, do they also need an ACAT approval to enter residential care?

Yes, an ACAT assessment and approval is also required for the person to enter residential aged care.

40. Does the provider need to request a reclassification if the resident's ANACC Classification is 5 but they have started palliative care?

Yes. You can request for reclassification through the My Aged Care Provider Portal.

41. Why is there no back payment available for palliative residents who pass away before the assessors review them? There are already significant delays in review assessments when the resident has deteriorated and a reassessment has been requested.

The department is currently reviewing the current systems in place for when a resident has an event that sees the resident at imminent end of life. In the interim, services can email ANACCAssessments@health.gov.au when this urgent matter arises and engagement will be made to have an assessor to the site as soon as possible. However, if a resident is naturally declining, normal reclassification requests should be made via the Provider Portal to have an assessor arrive and assess within the 28-day timeframe.

The Government has requested that the Independent Health and Aged Care Pricing Authority conduct a costing study to refine the pricing of the initial entry of new residents into aged care, and any other key periods in the resident's journey where costs may vary. This would include a consideration of end-of-life costs.

Serious Incident Response Scheme (SIRS)

42. For providers who deal with Commonwealth Home Support Programme (CHSP) funding, do we still need to register ourselves as aged care providers to implement the Serious Incident Response Scheme (SIRS)?

Since 1 December 2022, the Serious Incident Response Scheme (SIRS) now includes residential aged care and providers of home and flexible aged care provided in home or community settings. The Aged Care Quality and Safety Commission administers the SIRS.

From 1 December 2022, home services providers (including Commonwealth Home Support Programme services and flexible care services through which short-term restorative care is provided in a home care setting) will also need to notify the Aged Care Quality and Safety Commission when 8 types of reportable incidents occur.

Providers must have an Incident Management System in place. These reportable incidents must be lodged on the SIRS tile on the My Aged Care Provider Portal.

See SIRS information on the Department of Health and Aged Care website and SIRS provider resources | Aged Care Quality and Safety Commission for more information.

Services Australia and Aged Care Provider Portal

43. Could providers get a notification when the CSV file is updated?

Notification of changes to the CSV file will be sent from the Services Australia's Developer Liaison mailbox.

44. How is the advance payment is calculated under AN-ACC model? The November 2022 advance payment received on 2 November is about 10% lower than previous months.

AN-ACC component of Advances is included from December 2022. Advance is calculated based on the prior two months' base claim. However, the November claim includes AN-ACC top up once the claim is finalised and approved.

45. Will the payment statements be available in PDF format?

Yes, the payment statement is now available as a PDF.

46. Would the 24/7 RN supplement be paid and included in provider monthly claims payment statement?

Yes.

47. Payment Statements – will the Rate Effective Date be brought back for the funding change, for example, Means Tested Funding or the Accommodation supplement?

There is further development of the payment statement underway, which includes displaying the start date for Means Tested Funding (MTF) and the other payment types.

48. Medicare currently does not fix any issues where providers lost money in the September 2022 payment statement. Is there a process to follow ensuring that errors are being corrected and money refunded in a timely manner to providers?

The payment processes under the Aged Care Funding Instrument (ACFI) will continue under AN-ACC. Providers will continue to be paid in advance on a monthly calendar basis. Advances are calculated on an aged care service's entitlement for the period 2 months before the month in which the advance is paid. It is pro-rated for the number of calendar days in that month. Services Australia will make any relevant adjustments once providers have lodged their claim for the month the advance was paid.

However, if providers believe that they have been paid incorrectly, call the Services Australia Provider line so that the issue can be investigated further.

49. How has the advance payment received on the 3 November 2022 been calculated?

The November advance payment was based on September claims which was under the Aged Care Funding Instrument (ACFI) funding. The payment processes under ACFI will continue under AN-ACC. The first advance that will be based on October claims will be paid in December 2022.

Providers will continue to be paid in advance on a monthly calendar basis. Advances are calculated on an aged care service's entitlement for the period 2 months before the month in which the advance is paid. It is pro-rated for the number of calendar days in that month. Services Australia will make any relevant adjustments once providers have lodged their claim for the month the advance was paid.

Star ratings

50. We understand that star ratings are based on number of care minutes. Could you advise the corresponding care minutes to each star rating please?

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.

The Staffing Rating will be based on the care minutes provided by personal care workers, enrolled nurses and registered nurses as reported in the QFR. This information will directly inform the performance of services against their service-level care minutes targets and will contribute to a service's overall Star Rating.

51. As there is no Star Ratings exemption at the moment, is this still being considered given the RN workforce issues?

The government is undertaking work to further develop and refine Star Ratings, care minutes and the 24/7 RN requirement. This includes:

- exploring the feasibility of developing a model of aged care RN workforce shortages by region, that could be used to inform future exemption arrangements
- developing clinically appropriate alternative models of care to ensure safe and quality care is delivered when a RN is not available due to workforce shortages

- determining if or how to include the 24/7 RN requirement into the Staffing Star Ratings
- improvements to care minutes data collection in the Aged Care Financial Report (ACFR) and Quarterly Financial Report (QFR)
- developing audits of 24/7 registered nurse and care minutes reporting.

Targeted consultation may be undertaken with a range of stakeholders on the proposed approaches in 2023 to ensure that they are appropriate for different workforce situations, particularly for services located in rural and remote areas.

Supported resident rule

52. How will the supported resident ratio be measured from 1 October 2022?

A 40% supported resident rule in relation to accommodation supplement for permanent residents commenced on 1 October 2022.

From 1 October 2022, the assessment of the proportion of care that has been provided to the cohort of 'supported residents' will be made on a calendar month basis rather than on a per day basis and the requirement will be 40% or more (rather than more than 40%).

For example, a service that has 10 places occupied by approved permanent care recipients each day during a 30-day calendar month will have provided 300 care days in total to approved permanent care recipients during that calendar month.

300 x 40% = 120. Therefore, if in total, 120 or more of the care days that were provided by that service in that calendar month were provided to 'supported residents' then the service will have satisfied the 40% supported resident rule in relation to accommodation supplement for that entire calendar month (post 1 October 2022) even if the service did not achieve a 40% supported resident ratio on individual days during that calendar month.

Also, for the purpose of this example, the cohort of 'supported residents' is comprised of residents who are eligible for either concessional resident supplement or accommodation supplement.