Home Care Packages Program Assurance

Review No. 2 - Unspent Funds (Commonwealth Portion)

Summary Report

September 2023


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COTTAGE

Contents

Executive Summary	**4**
Why was this Review undertaken?	4
How did we conduct the Review?	5
Review findings	5
Out of scope observations	7
Conclusion	7
Why was this Review undertaken?	**9**
How did we conduct the Review?	**10**
Provider selection	11
The Review process	14
Requested documentation	14
Analysis of submitted information	15
Provider reports	15
Procedural fairness	15
Review Findings	**17**
Accuracy of reported Commonwealth Unspent Funds	18
Financial capacity to return Unspent Funds (Commonwealth portion)	21
Incidental findings	**23**
Potential excluded items noted in monthly statements	23
Large purchases	25
Using HCP subsidy for meals	25
Care and/or package management charged where no services delivered	25
Contingency Funds	26
Possible errors or misrepresentations in monthly statements	26
Provider Engagement	**27**
Provider Feedback	27
Next steps	**29**
Keeping individual providers accountable	**29**
Supporting continuous improvement of providers	**29**
Webinar	30
HCP Community of Practice	30
HCP Program Assurance Reviews	30
Conclusion	**31**

This public summary report is based on the findings and observations of the Home Care Packages Program Assurance Review of Unspent Funds (Commonwealth Portion) – Review No 2. No commercial-in-confidence or personal information is included.

Executive Summary

The Home Care Packages (HCP) Program supports older people with complex needs to live independently in their own homes. As at 31 March 2023, there were 248,957 people receiving a home care package and 931 approved providers (providers) of home care. Demand is increasing with expected expenditure for 2023-24 to be approximately $7.7 billion.[1]

HCP Program Assurance Reviews aim to protect the integrity of HCP Program funding[2]. Program assurance reviews are underpinned by Part 6.8 of the *Aged Care Act 1997.* HCP Program assurance underpins the Government's plan to improve aged care and boost transparency and accountability in the sector.

Why was this Review undertaken?

Since the introduction of Phase 2 of the Improved Payment Arrangements (IPA) in September 2021, the amount of unspent funds held by providers has decreased proportionately, however, the total balance of unspent funds is still increasing. Departmental data shows that as at May 2023 there was around $2.8 billion of HCP unspent funds, with around $700 million held by providers and $2.1 billion held by Services Australia. The majority of the $700 million held by providers is the Commonwealth portion[3].

The HCP Program Assurance Review of Unspent Funds (Commonwealth portion) (the Review) commenced in September 2022. The Review helped assure the amount and accuracy of the unspent funds recorded by Services Australia. It confirmed whether selected providers have the financial capacity to cover amounts owing to the Commonwealth (when care recipients exit the HCP Program) or make such funds available to care recipients to use for care and services.

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[1] Home Care Packages Program Data Report 1 January - 31 March 2023 (released September 2023).

[2] Under section 95BA-1, the Secretary of the Department of Health and Aged Care may conduct assurance reviews for the purposes of a) assuring arrangements for the delivery and administration of home care are effective and efficient; and b) informing development of home care policy and education of approved providers in relation to home care services. A Framework articulating risks and benefits to be expected from such reviews and Annual Plan guide review activities.

[3] HCP unspent funds are the remaining portion from the total amount of subsidy, supplements, and fees the Australian Government allocates to a person based on their assessed care needs, and which have not been spent or committed to a person's care. Unspent funds are held by either the provider – split into the Commonwealth (subsidy and supplements) and care recipient (fees) portions; or the Government – in a Home Care Account for the care recipient held by Services Australia.

How did we conduct the Review?

Fifty providers[4] comprising of 9 government (voluntary participation) and 41 non-government (legally bound participation) were selected. Only 3 government providers voluntarily participated in the Review, reducing the number of reviewed providers to 44. The Review team appreciates the participation of the 44 providers.

Accredited and independent (to the program area) Review officers conducted the Review in 2 phases. The Review team was mindful of additional workload the Review would have on the selected providers and requested existing documentation where possible. For phase 1, providers were asked to provide evidence of the total unspent funds amounts (Commonwealth portion) they reported to Services Australia (as part of the IPA) no later than 31 December 2021 and a list of all care recipients covered by the reported amount. Monthly statements for up to 20 care recipients per provider were requested for the period of July to December 2021. The Review team compared the amounts of what was reported to the Review with information recorded by Services Australia.

For phase 2, existing financial statements (audited where available) for 2021-22 were requested (the Review team allowed until 15 November 2022 to provide these) and a formal assurance from the provider's designated officer of the provider's financial capacity to return these funds.

All participating providers received a detailed report with findings and required actions as appropriate. In addition, the Review team issued a public summary report (this report). Following the public release of the report, a public webinar and a live online Community of Practice session will be held to support the Review.

Review findings

The Review set out to answer 2 key questions:

1) *Did providers accurately report the amount of the Commonwealth portion of unspent funds to Services Australia?*

The Review initially found that 37 out of 44 (84%) providers had variances ranging from -$211,987 to +$409,350 from what was recorded by Services Australia.[5] Out of the 37 providers that initially had variances, 24 providers had less than 6% variance. Some of these variances were also due to incorrect data being supplied initially to the Review (for example claims data was provided rather than actual unspent funds balance). At the end of the Review, 24 providers had no variances. All 44 providers

[4] Under the *Aged Care Act 1997* (the Act), providers that are corporations (non-government providers) are legally bound to participate in the assurance reviews while participation by government operated providers is voluntary. The Review team issued legally binding Notices (made under section 95BA-5 of the Act) to 41 selected (non-government) providers. A non-legally binding Letter inviting participation in the Review was sent to 9 government providers.

[5] The negative amount indicates that the providers reported less to the Review than what was recorded by Services Australia.

were able to justify how they calculated the total balance (Commonwealth portion) of unspent funds for care recipients.

To help assure the accuracy of reported unspent amounts, 4,890 monthly statements for 815[6] care recipients were examined. Initially 618 of 815 (76%) care recipients' unspent funds amounts had no variances. Working with the relevant providers, the Review team helped increase the number of care recipients with no variances to 702 out of 815 (86%).

At the conclusion of the Review, 20 of the 44 providers still had variances. However, consequent to the Review effort, the variance range reduced significantly to -$17,885 to +$150,927[7] (from -$211,987 to +$409,350). These providers were asked to continue reconciling their records and engage with Services Australia to rectify the reported Commonwealth portion of unspent funds and provide the Review team with evidence of having done so within 4 weeks of receiving their final reports. The Program Assurance Compliance team is following up with the providers who did not respond to the Review team.

2) *Do providers have the financial capacity to return the unspent funds (Commonwealth portion)?*

The Review team requested financial documentation from providers, including existing annual financial statements for 2021-22 and formal written assurance. All 44 providers provided written assurance that they could return unspent funds (Commonwealth portion) if required.

Forty-three[8] of 44 providers provided financial statements to support their claims that they could repay the unspent funds (Commonwealth portion) recorded by Services Australia.

The Review team developed 2 key measures to assist with the analysis:

- a cash coverage ratio (cash / unspent funds)
- a liquidity ratio (current assets / liabilities).

As 9 of the 44 providers also provide residential aged care, a modified liquidity ratio was calculated for them, excluding Refundable Accommodation Deposits (RADs) and the Independent Living Units (ILUs) deposits.

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[6] Some providers have less than 20 care recipients in their care that meet the Review criteria, hence the total does not equate to 880 care recipients.

[7] A negative amount (-) indicates the provider reported less unspent funds to the Review than what was recorded by Services Australia, and a positive amount (+) indicates the provider reported more to the Review, than what was recorded by Services Australia.

[8] The remaining one provider's financial statement, while provided, was incomplete, therefore sufficient financial analysis was not able to be undertaken.

A score of less than one against any of these ratios would be a cause for concern for the Review team, as it could indicate that the amount owing is greater than amount available to the provider.

A higher ratio can indicate that a business is more likely to have the ability to meet debt obligations. However, a ratio is an indication only of a provider's ability to meet financial obligations. Ratios can vary, including due to providers' varying business models.

At the draft report stage, 4 providers had a low cash coverage ratio of less than 1.0. Upon engagement of the Review team, these 4 providers took remedial actions to satisfactorily address the concerns and improve their liquidity positions.

Out of scope observations[9]

The Review also identified incidental findings and observations. Although these were out of scope, the Review team noted them in the individual reports for providers in the interest of enhancing the integrity of the HCP Program and for continuous improvement purposes.

Examples of such observations included the purchase of potentially excluded items and care and/or package management charged where no services were delivered. Matters were individually raised with relevant providers to seek justification where required or for noting. Further details are in the body of the report.

Conclusion

The Review gained valuable insights into how selected providers reported their unspent funds, the accuracy of the reported amounts, and whether the providers can repay Commonwealth unspent funds if required (where care recipients exit the HCP Program) or make such funds available to care recipients to use for care and services.

The Review concludes that more than half (24) of the providers reviewed were able to report accurately, and almost all (43) demonstrated financial capacity to repay Commonwealth unspent funds. The Review also identified some potentially excluded items, noting that Review examined documentation that was historical, and, in some cases, providers have since stopped such practices.

Overall, the Review has been able to answer, based on evidence, the 2 questions it sought to assure.

[9] While out of scope of the Review, the Review team has a responsibility under the *Australian Public Service Act 1999* and the *Public Governance, Performance and Accountability Act 2013* to identify and report any issues it incidentally finds while examining providers' documentation, regarding the use of Commonwealth funds.

Other key outcomes from the Review include:

- improved provider business processes and products (such as improved clarity and readability of monthly statements)
- increased awareness of program requirements including HCP charging (for example no longer spending HCP funds on excluded items)
- increased program knowledge and management of unspent funds reporting
- assisted 2 providers in their effort to commence the process of voluntarily returning $241,831 of unspent funds to Services Australia.

Anecdotal feedback from most providers is that they found the Review team professional, the process procedurally fair and supportive of continuous improvement.

Taking an evidence-based approach, ultimately, the Review has helped support improved program integrity of the HCP Program and enhanced transparency and value for money for care recipients and the public.

The Review offers some optimism and confidence that the reviewed providers can cover their unspent funds liability and are now better equipped to manage their unspent funds. However, it is also likely that without the Review some of the selected providers may not have identified and addressed the variances in reported unspent funds.

All HCP providers (not just those reviewed) are reminded that unspent funds (the Commonwealth portion held by providers) are taxpayer and program funds and must be managed and reported accurately and in a timely manner.

In addition, care recipients and their support persons should carefully examine the declared unspent amounts from month to month in their monthly statements and ask questions of providers where required.

Why was this Review undertaken?

Key Points

- The HCP Program supports older people with complex needs to live independently in their own homes.
- As at 31 March 2023, there were 248,957 people receiving a home care package and 931 providers of home care. Demand is increasing with expected expenditure for 2023-24 to be approximately $7.7 billion.[10]
- As at May 2023, there is around $2.8 billion of HCP unspent funds, with approximately $700 million being held by providers and $2.1 billion held by Services Australia. The majority of the $700 million held by providers is the Commonwealth portion.
- The purpose of the Review was to assure the accuracy and amount of unspent funds (Commonwealth portion) self-reported by providers (and recorded by Services Australia) and the financial capacity of providers to return the funds if no longer required for care recipients.

To better manage HCP funds Improved Payment Arrangements (IPA) reforms were introduced to reduce the amount of funds held by providers and move the responsibility of managing these funds to the Government. From 1 September 2021, providers were required to report the total Commonwealth portion of unspent funds to Services Australia, no later than 31 December 2021. This change provides better protection of HCP funds and ensures they are available to purchase care and services when needed.

Since the introduction of IPA, the amount of unspent funds held by providers is decreasing proportionately, however, the total balance of unspent funds is still increasing. As at May 2023, $700 million is being held by providers (majority of which is the Commonwealth portion) and $2.1 billion is held by Services Australia.

[10] Home care packages program data report 1 January – 31 March 2023 - AIHW Gen (gen-agedcaredata.gov.au)

This Review was conducted under the auspices of the *Aged Care Act 1997* section 95BA.1. Assurance reviews aim to protect the integrity of HCP Program funding. This Review is the second[11] program assurance review of the HCP Program.

The Review sought to answer 2 critical questions:

1) Have selected providers accurately reported the amount of the Commonwealth portion of unspent funds to Services Australia – both the total aggregated amount reported for all care recipients in their care at the relevant point in time, and the individual amounts for up to 20 selected care recipients per provider?
2) Can selected providers return unspent funds to the Commonwealth (where care recipients no longer require these as they have exited the HCP Program) or make these funds available to relevant care recipients if required (for ongoing care and services)?

While focussing on these 2 questions, the Review team also considered other out of scope aspects that are relevant to the overall objective of program assurance reviews.

How did we conduct the Review?

Key Points

- Initially a sample of 50 providers was selected using a risk-based approach. However, 44 providers ultimately participated in the Review.
- A sample of care recipients per provider was selected, totalling 815 care recipients. 4,890 monthly statements (July to December 2021) for care recipients were examined.
- Financial ratios were developed to assess a provider's financial capacity to return the unspent funds.

[11] The first program assurance review examined providers' indirect and care management charges. A Public Summary Report - Indirect and Care Management Charges was released in August 2022 outlining the findings.

Provider selection

Fifty providers were initially selected to participate[12] in the Review taking a risk-based approach. Providers were included in the Review where they met the following selection criteria:

- holding an average unspent funds amount equal to or higher than $15,000 per care recipient, or
- reported a $0.00 balance of the Commonwealth unspent funds for a high proportion of exited care recipients.

Provider participation

Under the current *Aged Care Act 1997*, providers that are corporations (non-government) are legally bound to participate in the assurance reviews while participation by government operated providers is voluntary.

Failure of corporations to participate may result in a provider being fined a civil penalty of 30 penalty units. Additionally, the Secretary of the department may choose to make publicly available the fact that organisations have either not complied with the Notice under section 95BA-5 or 95BA-6 or failed to comply with section 95BA-7.

All non-government providers complied with the requirements of the Review however, one provider did not submit sufficient information to enable completion of their Review. While the Review team has acted in good faith towards this provider, in future, non-cooperation with the Review Notice can see such a provider publicly named and/or fined.

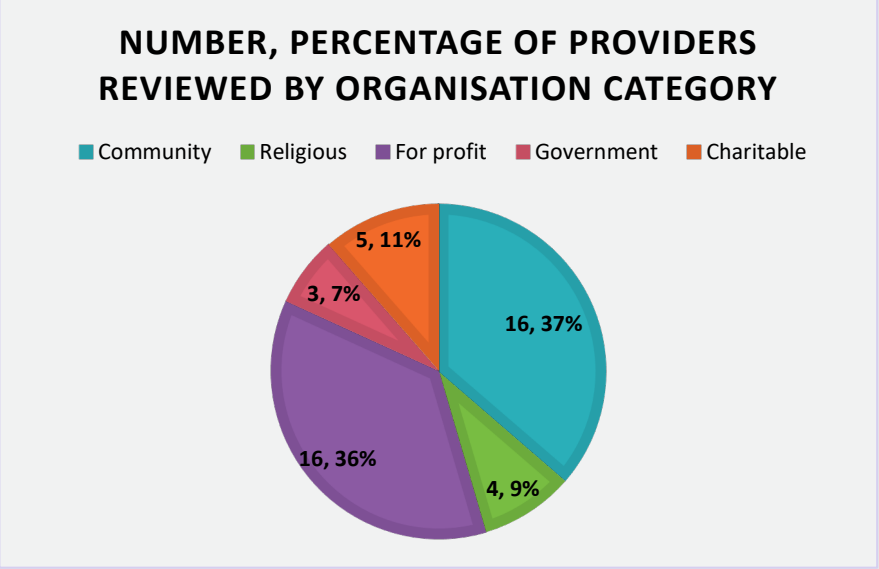
Of the 9 government operated providers, 6 elected not to participate or did not participate fully in the Review.

As a result, a total of 44 providers (41 corporations and 3 government providers) participated in the Review. A breakdown of providers by organisation-type is presented in Figure 1.

[12] An initial list of providers was shared with the Aged Care Safety and Quality Commission and as a result, providers that had existing and impending compliance actions were excluded from the Review.

Figure 1. Provider by organisation-type category

44 providers participated in the Review. Providers included a mix of government, community, religious, charitable, and for-profit organisations. The large majority of providers were community and for-profit providers.



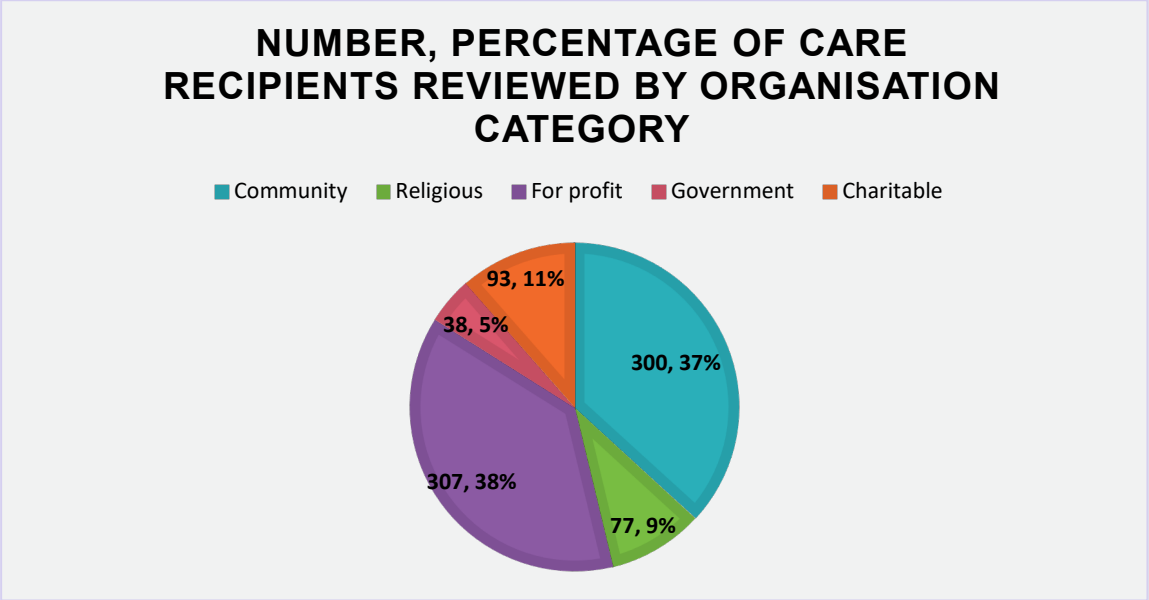
Care recipient selection

To assure the amount and accuracy of unspent funds, information for up to 20 selected care recipients[13] per provider was used, resulting in 815 care recipients across 44 providers.

Monthly statements from July 2021 to December 2021 for each of the 815 care recipients were also analysed for accuracy. A total of 4,890 monthly statements were examined.

[13] Providers were requested to select 20 out of a list of 25 care recipients provided by the Review team to ensure that only care recipients who were receiving care during July to December 2021, and those who continued to receive HCP services at the time of the Review, were included.

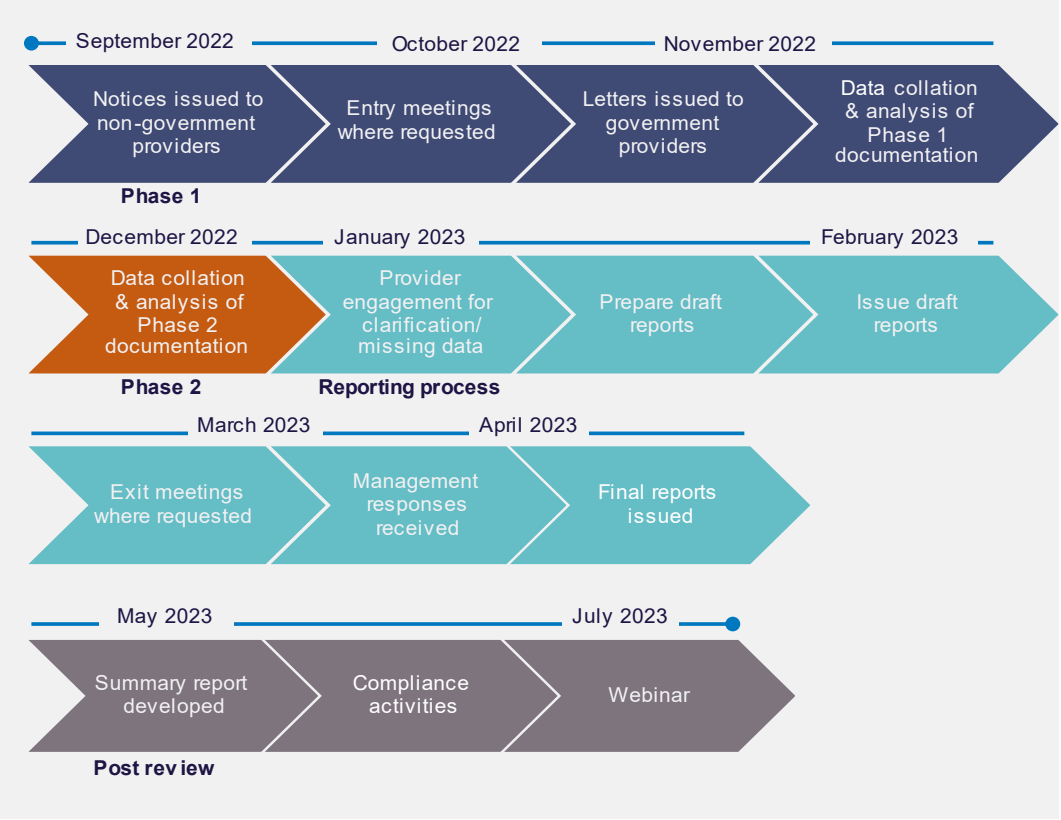
Figure 2. Care recipients by organisation-type category



815 care recipients across 44 providers were selected in the Review. While randomly selected, most care recipients were from for-profit and community providers.

To assure the amount and accuracy of the reported unspent funds, the Review team compared the Commonwealth unspent funds amounts for the selected care recipients against data recorded by Services Australia, for the same reporting period.

The Review process



Requested documentation

Providers received a legally binding notice (if a corporation) or letter (if a government provider) requiring/requesting them respectively to submit documentation in 2 phases to ease the administration burden on providers. Documentation requested comprised:

Phase 1

- The total balance (Commonwealth portion of the care recipient's unspent home care amount) formally reported to Services Australia no later than 31 December 2021
- A list of all care recipients which relates to the reported total balance and the individual Commonwealth portion amount for each of those care recipients
- A description of how the total balance (Commonwealth portion) was calculated
- Monthly statements for the period 1 July 2021 to 31 December 2021 for up to 20 selected care recipients

Phase 2

- Audited financial statements or financial records for the 2021-22 financial year – as providers are required to submit financial data to the department by October 2022, financial statements were requested by mid November 2022
- A cover letter or statement from the provider to identify the Commonwealth portion of unspent funds in the audited financial statements or financial records for the 2021-22 financial year
- Written assurance by an authorised person of the provider's financial capacity to return the Commonwealth portion of unspent funds where no longer required for the care recipient.

Analysis of submitted information

Phase 1

The Review team compared the total amounts of unspent funds reported to the Review against the amounts recorded by Services Australia and undertook detailed analysis of 4,890 care recipient monthly statements to assure the accuracy of the unspent funds amount. The Review team also considered descriptions of how the total balance was calculated.

Phase 2

The Review team analysed selected providers' financial capacity to repay Commonwealth unspent funds based on submitted financial documents. The Review team developed 3 ratios to understand a provider's financial capacity to return the Commonwealth unspent funds. Financial analysis is presented in the Review Findings section.

The Review team also considered providers' formal written confirmation that they can return the Commonwealth portion of unspent funds if required and if this claim was backed up with evidence.

Provider reports

Draft individual reports were issued in February 2023. Thirty voluntary exit meetings were held, and providers were afforded 3 weeks to respond to the draft report findings. Where provided and appropriate, providers' responses to the draft findings were analysed and incorporated into final individual reports. All 44 final reports were issued by 6 April 2023.

Procedural fairness

Procedural fairness was afforded to providers throughout the Review.

- Providers had an opportunity to attend an entry meeting.

- Providers were allowed 4 weeks to provide the required documentation. Where applicable, and reasonable, extensions were granted.
- Providers had the opportunity to clarify the required documentation with Review officers.
- The Review team followed up by phone and email with any providers who did not provide an email read receipt or acknowledgement of email to confirm contact details and receipt of information.
- A draft report was provided following analysis of providers' documentation and comparison against data held by the department.
- Exit meetings were offered to all providers, which gave providers opportunity to query the findings and recommendations in the draft report.
- Providers were given the opportunity to provide a management response to the draft report findings within 3 weeks of the date of the draft report.
- Review officers were available to provide clarification and correct any factual errors throughout the Review process.
- An internal dispute resolution process was available to address any complaints about the Review process, and/or any civil penalties that may have been applied for not participating in the Review.

Review Findings

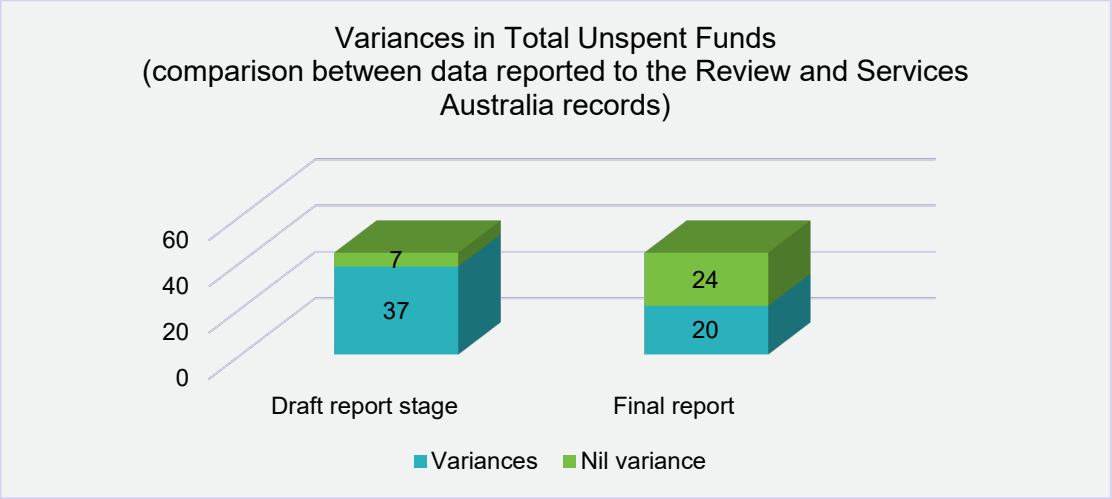
Key Points

- When the Review commenced, 7 out of 44 (16%) selected providers had no discrepancies between what they reported to the Review and what was recorded by Services Australia (that is, 37 providers had discrepancies).
- By the end of the Review, 24 out of 44 (55%) providers had no variances.
- Similarly, of the 815 care recipients reviewed, 618 (76%) had no variances between what was reported to the Review and recorded by Services Australia. This rose to 702 care recipients (86%) by the end of the Review.
- Providers who could not rectify variances during the Review were asked to actively work with Services Australia to do so and provide evidence to the Program Assurance Compliance team of having done so.
- Based on supplied financial information, most providers demonstrated an ability to return the Commonwealth portion of unspent funds for all care recipients, if required.
- The 4 providers who could not initially assure the Review team of their financial capacity, worked with the Review team to eventually provide satisfactory evidence of being able to cover their Commonwealth unspent funds liability.

Accuracy of reported Commonwealth Unspent Funds

Overall, the Review found variances in unspent funds amounts between what was reported to the Review and recorded by Services Australia. These variances were mostly addressed prior to the conclusion of the Review.

Figure 3. Variances in Total Unspent Funds



As evidenced from Figure 3 above, at the time of issuing the draft individual provider reports, the Review team identified 37 out of 44 (84%) providers with variances between what they reported to the Review compared with the amounts recorded by Services Australia.

Variances across all 44 providers ranged considerably at the beginning of the Review, from -$211,987 to +$409,350.

Following concerted efforts by the Review team through exit meetings, discussions, and data error resolutions[14], 17 of the 37 (45%) providers were able to rectify the variances. Some providers identified errors in their records and/or reporting processes and were able to rectify these to prevent recurrence.

Consequently, at the time of issuing the final individual reports, 24 out of 44 (55%) providers had no variances between what they reported to the Review compared to the total balance of unspent funds recorded by Services Australia.

Twenty providers still had variances at the time of issuing the final reports and were asked to continue to examine their records and engage with Services Australia, as applicable. However, the range of variance reduced significantly to -$17,885 and

[14] The Review further noted the data accessed by the Review team initially contained some errors, which were beyond the control of the providers and rectified as part of collaborations between the Review team and the Home Care and Assessments Branch of the department.

+$150,927 (from -$211,987 to $409,350).

Details regarding the reported variances

The variances for 37 out of 44 (84%) providers ranged from -$211,987 to +$409,350, with the negative amount indicating that the providers reported less to the Review than what was recorded by Services Australia. Table 1 below shows the average negative and positive variance at the commencement and completion stage:

Table 1. Average variance at Review commencement and completion

	Commencement	Completion
Average positive variance	+$64,199	$42,724
Average negative variance	-$39,426	-$8,052

- Twenty four providers reported more, and 13 reported less to the Review than what was recorded by Services Australia.

  Out of the 37 providers that initially had variances, 24 providers had less than 6% variance.

- The initial variances were in some cases due to an incorrect data source being used for the purposes of the Review. For example, claim data was provided to the Review rather than the balance of unspent funds. Once the issues were clarified and the correct data sources used, the percentage of providers with variances was reduced to 45%.

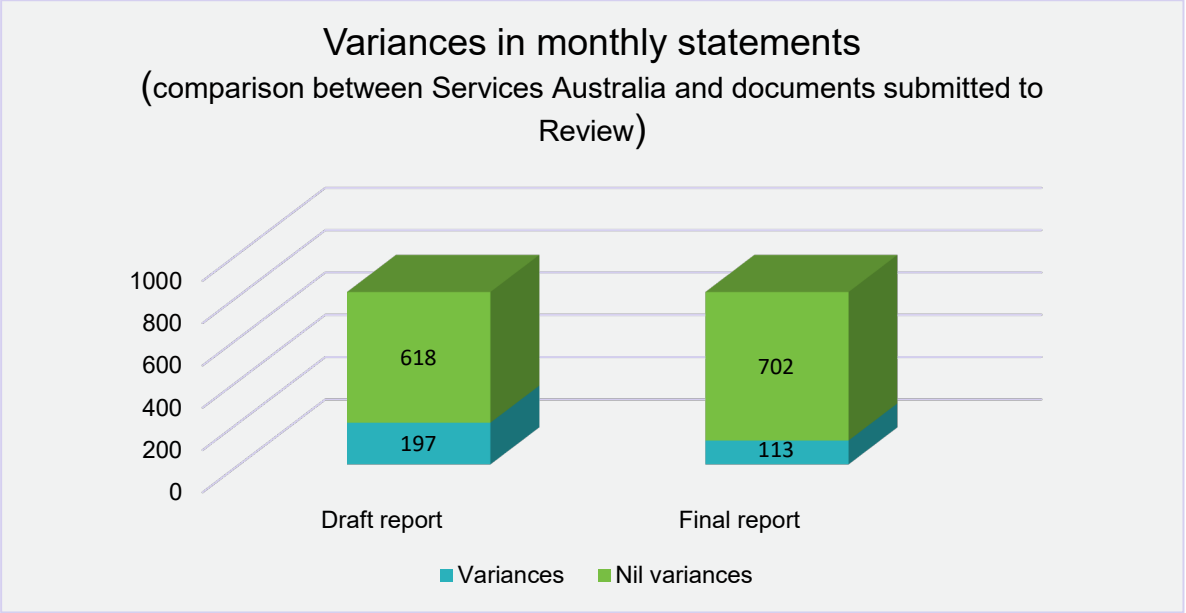
  By the end of the Review, the 20 providers who could not rectify variances during the Review were asked to engage with Services Australia within 4 weeks of receiving their final reports and provide the Review team with evidence of having done so.

Accuracy of reporting total unspent funds (Commonwealth portion) for selected care recipients

To assure the amount and accuracy of unspent funds, the Review team analysed data and monthly statements for up to 20 care recipients per provider. This totalled 4,890 monthly statements for July to December 2021 for 815 care recipients.

The Review team sought to assure whether the Commonwealth portion of individual care recipients' unspent funds amounts were verifiable through the itemised expenditure in monthly statements.

Figure 4. Accuracy of monthly statements



As shown in Figure 4, at the draft report stage, the Review team found that 618 out of 815 (76%) care recipients' monthly statements showed no variances between the unspent fund amounts reported to the Review compared to the amounts recorded by Services Australia.

Following mutual efforts by the Review team and providers in good faith, as well as data error resolution, the number of variances reduced by 84 instances.

At the conclusion of the Review, 702 out of 815 (86%) care recipients' reported amounts had no variances.

Calculation of unspent funds (Commonwealth portion)

All 44 providers described how they calculated the total balance (Commonwealth portion) of unspent funds for their care recipients.

Under IPA[15] providers must have the ability to separate the Commonwealth portion of unspent funds from the care recipient portion (from September 2021) and provide a breakdown of each component in their monthly statements (from September 2022).

[15] Under new IPA requirements commencing 1 September 2022, providers must show the split between the care recipient portion and the Commonwealth portion of unspent funds (held by the provider), as well as the Home Care Account balance (held by Services Australia) on all monthly statements. Further information is available at https://www.health.gov.au/resources/collections/monthly-statement-resources.

Financial capacity to return Unspent Funds (Commonwealth portion)

All 44 providers provided written assurance of their capacity to return unspent funds (Commonwealth portion), to the Commonwealth (for exiting care recipients) or make these available to relevant care recipients if required.

To further assure a provider's capacity to return unspent funds, the Review team conducted financial analysis based on a provider's submitted financial documents[16].

For this purpose, the Review team developed a cash coverage ratio and liquidity (current) ratio. Forty three of 44 providers submitted the relevant financial documents to enable a financial analysis to be conducted by the Review team.

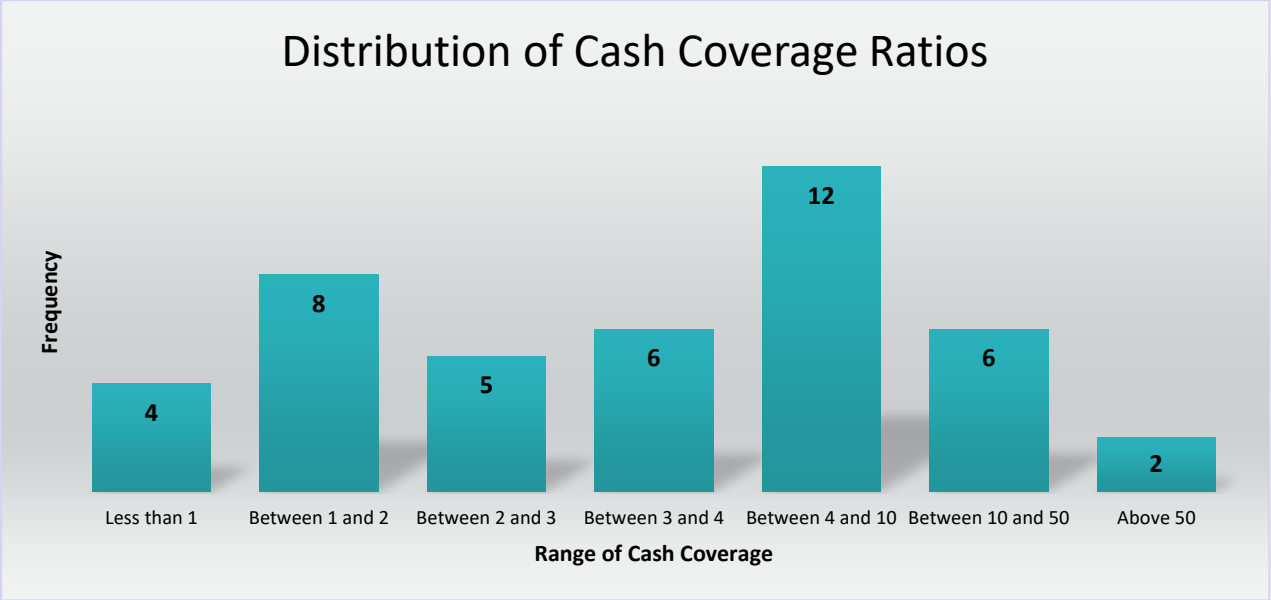
A ratio of more than 1.0 indicates that a provider is more likely to meet debt obligations.

Cash coverage ratio

The cash coverage ratio measures providers' 'cash and cash equivalents' compared to their unspent funds amount (Commonwealth and care recipient portion):

Cash coverage = Cash & Cash Equivalents / Unspent Funds.

Figure 5. Cash Coverage Ratios



[16] Analysis was conducted based on audited financial statements for the 2021-22 financial year. Where audited financial statements were not available, relevant HCP part of financial records were accepted.

As shown in Figure 5, only 4 providers had a cash coverage ratio of less than 1.0. These providers took remedial actions to address the low cash coverage ratio to improve their liquidity.

Current ratios (liquidity ratios)

The current ratio measures an organisation's ability to pay short-term obligations or those due within one year.

Current ratio

> *Current ratio = Current Assets / Current Liabilities (including RAD and ILU Resident Loans)*

The current ratio ranged from 0.02 to 8.89 across 43 providers.

Modified current ratio

The Review team calculated 2 current ratios based on a provider's current assets and liabilities. One included and the other excluded Refundable Accommodation Deposits (RAD) and Independent Living Units (ILU) Resident Loans liabilities where applicable. The removal of the RAD and ILU Resident Loans, where applicable, ensures that the modified current ratio is not skewed by these liabilities and therefore comparable across all reviewed providers.

> *Liquidity ratio = Current Assets / Current Liabilities (excluding RAD and ILU Resident Loans)*

The modified ratio ranged from 0.14 to 25.49 across relevant providers.

The Review team found a few instances of poor disclosure of financial information affecting the Review team's capacity to analyse the presented information and then to accurately present its findings. **Providers are reminded that review notices are legally binding (unless a government provider) and the department can issue civil penalties and/or name providers publicly for non-participation in reviews.**

Incidental findings

Key Points

- While out of scope of the Review, the Review team noted anything of concern and made observations in individual providers' reports, in the spirit of supporting providers' continuous improvement.
- Observations included the purchase of potentially excluded items, care and/or package management charges while no services were delivered in the same month, accumulation of contingency funds and possible errors or misrepresentations in monthly statements.

While not directly related to the scope of this Review, the matters identified below are within the scope and matters that may be the subject of a review as outlined in 95BA-2(2)(a-f) of the *Aged Care Act 1997*. As such, the Review team has documented these incidental observations in the table below.

Where some purchases, charges or other matters were observed in monthly statements or documentation submitted to the Review, and the reasons were unclear, the Review team recorded these instances. Matters were individually raised with relevant providers to seek justification where required.

Regarding excluded items, the Review team notes the reports and data reviewed are historical and the previous HCP Program Operational Manual contained some ambiguities. An updated HCP Program Operational Manual released in January 2023 may have resulted in the cessation of some of these purchasing practices.

Potential excluded items noted in monthly statements

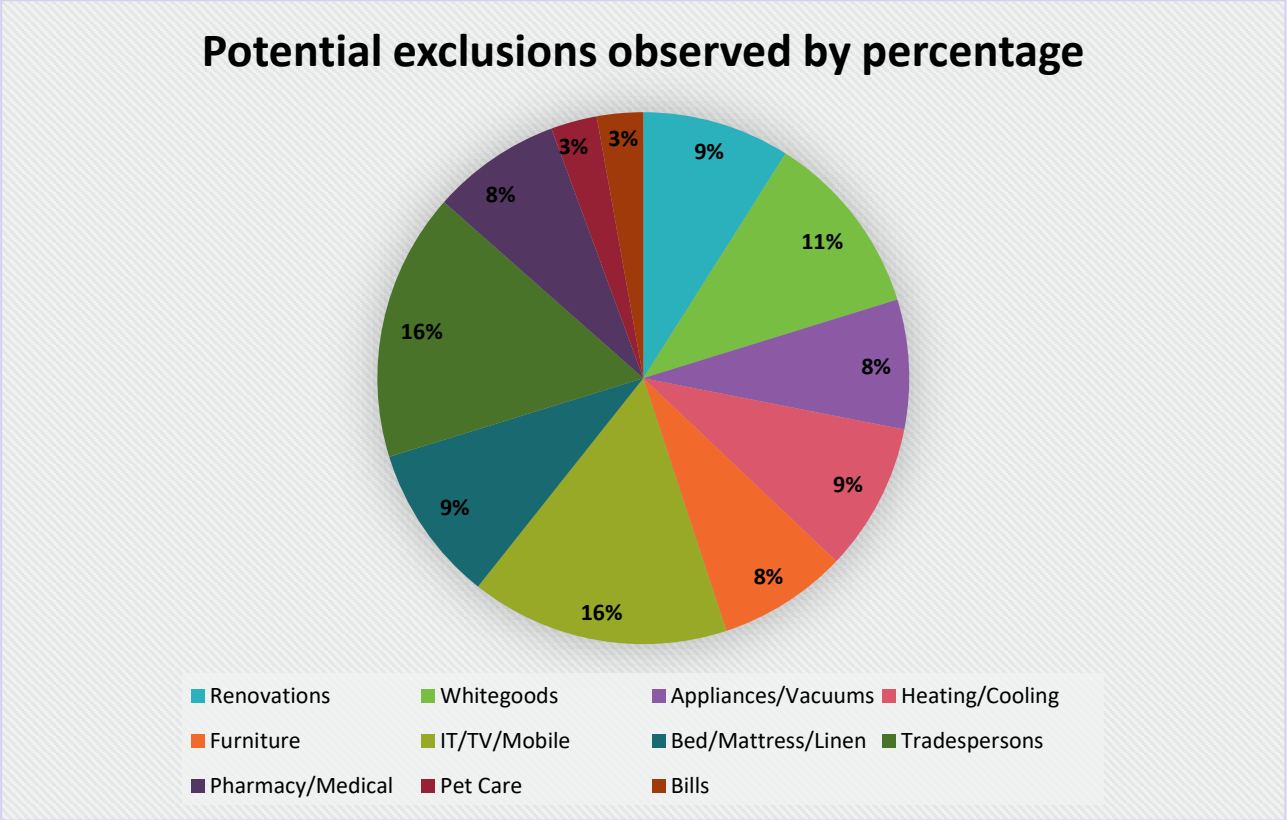
Program funds must be used for the purposes provided for under the Aged Care legislation (*Aged Care Act 1997)* and relevant subordinate legislation) and be in line with the HCP Program Operational Manual. Taxpayers need to have confidence that funds are being effectively administered and used by providers for approved program purposes.

Changes to the HCP Program Operational Manual in January 2023 helped to make inclusions and exclusions requirements under the HCP Program clearer[17]. It is important to note that there was no change in policy, and the updates make

[17] Feedback from providers during the Review supported the updated HCP Program Operational Manual and the clarity it has provided in relation to inclusions and exclusions. Many providers stated that they had changed their practices due to the updated guidance.

inclusions and exclusions requirements more transparent and easier for everyone to understand.

Figure 6. Potential exclusions



Thirty six providers were observed to have purchased potentially excluded items. Figure 6 shows the potential[18] exclusions observed by the Review team across 4,890 monthly statements included examples such as IT, TV and mobile phone purchases (16%), provision of tradesperson services (16%), purchase of whitegoods (11%) and evidence of payment of bills (3%).

Providers are reminded that any purchases must be:

- **directly linked to the care recipient's care needs and goals**
- **providing support for daily living that is important for the care recipient's health and wellbeing**
- **necessary for them to support functional safety in their home**
- **agreed within the care recipient's care plan**

[18] These are noted as "potential" as the Review team observed these based on the monthly statements reviewed. However, a thorough review/analysis was not conducted as this aspect was out of scope for this Review.

- **within the available budget for the package level, with any fees mutually agreed with the care recipient through the Home Care Agreement before purchase.**

Given the ongoing evidence regarding use of HCP Program funds for excluded items, a review of excluded items is planned over coming months, once the sector and care recipients have had time to engage with the revised Manual.

Large purchases

The Review team observed the purchase of large items in care recipients' monthly statements across 28 providers. **While the purchase of large items is allowable under the Program, providers are reminded that their processes and procedures in place for large purchases must be in line with requirements and must be:**

- **related to the care recipient's care needs**
- **agreed within the care recipient's care plan**
- **within the available budget for the package level, with any charges mutually agreed with the care recipient through the Home Care Agreement before purchase.**

Using HCP subsidy for meals

The use of HCP subsidy to purchase meals was observed in some care recipients' monthly statements across 23 providers. The HCP subsidy can only be used for the preparation and delivery of meals. The raw food component cannot be included, except in the case of enteral feeding.

The providers generally addressed the concerns raised. Some explained that while abiding by the rules, their monthly statements lacked sufficient detail. They committed to actions to improve clarity of monthly statements to include details on whether the expenditure relates to the preparation, delivery, or enteral feeding component.

Care and/or package management charged where no services delivered

Fourteen providers were observed in some care recipients' monthly statements to charge for care and/or package management, yet no services appeared to have been delivered in the month. **Providers are reminded to ensure that package management is not charged for calendar months where no services (other than care management) are delivered, except for the first month of care. In the instance that a care recipient takes leave from their HCP, providers cannot deliver or charge for any services, including care and package management.**

Legislation changes were implemented on 1 January 2023 to address the way providers could charge for care and/or package management where no services are

delivered in that month. Further information on the changes can be found in the Home Care Packages Program Pricing Update – FAQs and the HCP Program update – November 2022.

Contingency Funds

The Review team observed 5 providers were accumulating contingency funds on behalf of care recipients. Contingency funds may have been accrued to address a care recipient's future needs however, this is inconsistent with the policy intent of the HCP Program.

Providers are reminded that under the IPA, from 1 September 2021, any additional charges should only be used for current identified and delivered care and service needs, and providers should no longer be accruing unspent funds (for example as "contingency" funds or similar). The revised Home Care Packages Program Operational Manual (published in January 2023) made it clear that providers cannot charge contingency amounts to care recipients.

Possible errors or misrepresentations in monthly statements

The Review team noted 12 instances of providers with possible errors or misrepresentations in monthly statements.

These matters were raised in the individual reports and discussed with providers at exit meetings. Some providers could justify these issues, and many committed to improving their processes.

Providers were/are also reminded of new requirements (regarding unspent funds) that came into effect in September 2022[19] to improve monthly statements and support care recipients and their families to understand them. To support providers, the department has developed a Better Practice Home Care Package Statement Guide and a Monthly Financial Statement Template. Monthly Statement resources can be found at https://www.health.gov.au/resources/collections/monthly-statement-resources.

In light of these and the above-mentioned legislation changes to HCP charging requirements implemented in January 2023, some providers advised the Review team they were considering introducing new software to address these changes.

[19] Aged Care Alert – Home Care Package monthly statements are changing | Australian Government Department of Health and Aged Care

Provider Engagement

Key Points

- Providers viewed the Review as a positive learning opportunity to improve organisational practices and procedures.
- Feedback on the Review and processes was encouraged through a structured and anonymous survey following the conclusion of the Review.

Most providers were responsive and engaged well with the Review team and process. Many providers sought to rectify issues prior to the finalisation of the Review. Some providers were able to identify reporting data errors and rectified the issues, through either one-off or systematic adjustments.

Overall, the Review process demonstrates the benefits of closely working with providers to support improved understanding of program requirements and continuous improvement. The significant level of positive engagement by providers demonstrates that they valued the opportunities offered by the Review to closely examine and improve their organisational and/or HCP-relevant procedures and understanding.

The Review team will continue its practice of obtaining structured feedback from participating providers through an anonymous survey following the conclusion of the Review. Feedback from providers is used to improve the way the department conducts program assurance reviews.

Provider Feedback

Provider feedback to the Review team

- The Review process reinforced/informed providers of key changes/reforms ensuring improved outcomes for care recipients.
- Providers used the Review process as a learning experience and an opportunity to review internal practices and procedures including improved clarity of monthly statements.

Some examples:

- A provider welcomed the opportunity to be involved, stating that they were a small organisation, curious to know they were “doing the right things”; and keen to stay in front of changes in the aged care sector. The provider regarded the Review as useful for this purpose. The provider embraced the Review “with an open mind” and was “very happy to help”. At the end of the Review process this

provider complimented the Review team on a good process that did not feel like an audit.

- Working with the Review team, a non-government provider was able to identify and rectify errors with their data submitted to the Review. This provider thanked the team, noting the Review was a positive experience and a learning opportunity.

Next steps

Key Points

- Providers will continue their effort in examining their records and engage with Services Australia to address outstanding issues regarding unspent funds (Commonwealth portion) reporting, where applicable.
- The Program Assurance Compliance team will follow up with reviewed providers where required.

A webinar will be held after the summary report is published outlining the findings and outcomes of the Review.

A live online program assurance Community of Practice (CoP) session is planned after the summary report is published. Providers are encouraged to engage with each other and the department through the CoP.

Keeping individual providers accountable

Each of the 44 providers received a report at the end of the Review. Providers with outstanding actions were asked to address them and confirm in writing with the Program Assurance Compliance team within 4 weeks of receiving the final reports. This may involve further reconciliation of their own records and continuing engagement with Services Australia where applicable. The Program Assurance Compliance team will follow up with relevant providers.

All HCP providers (not just those reviewed) are reminded that unspent funds (the Commonwealth portion held by providers) are taxpayer and program funds and must be managed and reported accurately and in a timely manner.

Supporting continuous improvement of providers

Where applicable, providers have been asked to advise the Review team what action has been taken where the Review team identified an issue/concern in the final report. Relevant providers have been requested to contact Services Australia to address

identified issues regarding unspent funds (Commonwealth portion) reporting where applicable. A Program Assurance Compliance team will monitor actions and follow-up with providers as appropriate.

The Review team will share relevant information with the Aged Care Quality and Safety Commission, the national regulator of aged care, including home care packages. Where non-compliance with approved provider responsibilities is identified, the Commission's response will be proportionate to the assessed level of risk and the potential consequences for consumers.

Webinar

Following the public release of this report, a public webinar about the Review, findings and implications for consumers is planned. Further detail, including the webinar recording, will be available at Webinars for the aged care sector | Australian Government Department of Health and Aged Care.

HCP Community of Practice

A HCP Community of Practice was launched in August 2022 following the conclusion of the first assurance review.

The Community of Practice is an online platform supporting providers to engage with each other and the department, share program knowledge and better practice.

The department uses the platform to share post-program assurance review findings, discuss sector implications from review findings, share best practices, and provide feedback on the review process and/or program settings.

All HCP providers are encouraged to join the Community of Practice. Providers that are yet to sign up can do so at HCP Program Assurance Community of Practice.

An online live session is planned after this report is published to engage with the broader HCP Provider sector to discuss review findings and respond to any questions. At this session departmental staff will be online to respond in real time to questions about the Review.

HCP Program Assurance Reviews

The Review team will continue to undertake program assurance reviews and activities to support continuous improvement of providers and to help manage the risks identified in the Program Assurance Framework.

Conclusion

This Review has successfully gained insights into the accuracy of reported unspent funds (Commonwealth portion) of the reviewed providers and has been able to assure these providers' capacity to return these funds if required.

Initially only 7 of the 44 providers had no discrepancies in their reported unspent funds amounts, with the remaining 37 providers having discrepancies at the commencement of the Review. At the end of the Review, 24 providers were able to achieve no discrepancies, after addressing the issues identified and working closely with the Review team and Services Australia in some instances.

For the remaining 20 providers, the range of the reported variance reduced significantly to -$17,885 and +$150,927 (from -$211,987 to $409,350) by the time the Review concluded. These providers were asked to continue assessing their records and engaging with Services Australia to rectify the reported Commonwealth portion of unspent funds and provide the Review team with evidence of having done so within 4 weeks of receiving their final reports.

Initially the Review team found that 618 of 815 (76%) showed no variances between the unspent fund amounts reported to the Review compared to the amounts recorded by Services Australia. At the conclusion of the Review, 702 of 815 (86%) care recipients' reported amounts had no variances. The Review team was encouraged by the overall level of cooperation from reviewed providers. Providers worked with the Review team to respond to queries, provide the assurance required and improved their HCP Program understanding and associated processes.

Importantly, the Review team was satisfied, based on financial documentation, and associated analysis, that 43 participating providers had the financial capacity to return the Commonwealth portion of unspent funds, where a care recipient exits the HCP Program. While the Review team had initial concerns for 4 providers that had low cash coverage at the commencement of the Review, these providers took action to address their cash flow issues and improved their financial position.

Where some providers voluntarily identified that they had a portion of Commonwealth unspent funds to be returned, the Review team assisted them to do so. The Review assisted 2 providers in their effort to commence the process of voluntarily returning $241,831 of unspent funds to Services Australia. This amount may increase with other providers actively engaging with Services Australia to return amounts of unspent funds.

The Review team also identified out of scope incidental findings and observations, which were raised with relevant providers. The Review team took the opportunity to help improve providers' knowledge of out-of-scope issues such as new program changes to HCP charging, monthly statement requirements, and potentially excluded items and services under the HCP Program. Noting that the Review examined

documentation that was historical, in some cases providers have since stopped such practices.

While a sense of optimism is justified, the Review team notes that without this Review effort some providers may not have identified the variances or confirmed their ability to cover this liability. Unspent funds (the Commonwealth portion were held by providers) are taxpayer and program funds, and HCP providers in the sector must ensure they have a clear understanding of what they owe in unspent funds to the Commonwealth and/or the care recipients, report this accurately to Services Australia, and ensure that they continue to maintain ongoing financial capacity to return these funds where required. Additionally, they must work with Services Australia to identify and return any unspent funds that they should not be holding anymore.

Care recipients and their support persons should carefully examine the declared unspent amounts from month to month in their monthly statements. Asking questions of providers where the variation in the unspent amount from one month to the next does not add up will help care recipients, as well as providers, manage unspent funds effectively. People should also ask questions if any expenses show up that a care recipient is unclear about, including any excluded items. Given the ongoing evidence regarding use of HCP Program funds for excluded items, an excluded items review is planned in the coming months, once the sector and care recipients have had time to engage with the revised Manual.

While the Review team has sought formal feedback (as it does after each review) from participating providers results of which is pending, anecdotal feedback suggests that generally providers found the Review process useful and Review officers professional, transparent and procedurally fair.

By assuring the reported amount and availability of unspent funds, using a risk-based sample of providers, and by examining 4,890 monthly statements for 815 care recipients for a six-month period, ultimately, the Review has supported improved program integrity of the HCP Program and enhanced transparency and value for money for care recipients and the public.