Australian Government

Aged Care Financing Authority

Australian Government

Department of Health

Home Care Funding Analysis

December 2019

CONTENTS

1. Executive Summary

1.1 Introduction

Home care providers are currently paid a care recipient's full entitlement to Government subsidy for each month (i.e. their package level less any income-tested care fee), regardless of the services actually provided to the care recipient.

In response to the Government's announcement in *2019/20 Budget Paper 2* that payment arrangements in home care would be improved to address stakeholder concerns about unspent funds and to align home care arrangements with other Government programs, such as the National Disability Insurance Scheme, it has been proposed that payments to home care providers will be made in arrears based on the charges levied against a care recipient's budget.

The Aged Care Financing Authority (ACFA) has released a consultation paper "Improving home care payment arrangements" and ACFA is required to examine the potential financial impact on home care providers of the above Budget measure and provide advice. StewartBrown has been engaged to assist ACFA with this analysis.

1.2 Potential Financial Impact on Approved Providers

The potential financial impact to approved providers (APs) are likely to be amplified for those smaller APs who do not have other major sources of revenue other than that generated from the delivery of home care packages. The impacts to APs can be categorised as follows:

- Short-term cash flow shortfalls as payments transition from advance to arrears and normal payments to employees and suppliers will need to continue
- Operating with a negative margin so payments based on services provided will not sustain the business
- APs using unspent funds as working capital and, accordingly, this will be diminished as those unspent funds are drawn down
- Inability to withstand interruptions to cash flows that might occur with the introduction of a new funding remittance system

The other major impact on APs that may cause financial impacts would be additional costs associated with any additional administrative burden due to changes to the claiming and reconciliation process.

The analysis undertaken assesses the likely impact of each of these risks to APs to make conclusions as to the relative merit or unfavourable outcomes of the proposed changes to the current payment arrangements for home care providers. Recommendations for mitigating risks of any financial impacts identified as a result of the analysis have also been made in this report.

1.3 Conclusion

Financial Performance

The overall financial performance for APs, other than the potential additional interest expense and possible interest revenue earned on unspent funds, will not be materially impacted by the proposed changes to funding arrangements in our opinion. APs record revenue based on actual service delivery rather than subsidy received, and this treatment will remain under any amended funding amendments. Unspent funds (subsidy) is recorded as a liability and has no impact on the financial operating results.

Cash Flows (full subsidy paid in arrears)

On average, and across each cohort of APs, the results of this detailed impact analysis indicate that there are adequate liquid assets (cash and financial assets) held by at least 89% (being 477 in number) of APs (from the data set of 535) to have sufficient cash flows to meet normal operating expenses for one month while the payment arrangements for the full HCP subsidy transitions from being paid in advance to being paid in arrears.

We would anticipate that this percentage of APs (89%) will be even higher if the total liquid assets for the AP was included in the impact analysis for the remaining 11% considered to have marginal cash flow coverage. By way of explanation, the data was extracted from the Aged Care Financial Report (ACFR) for each AP, and where the AP does not also provide residential aged care services the consolidated balance sheet is not included, and the AP are only required to identify the liquid assets designated (allocated) to their respective home care segment. It was noted that in a number of instances, this allocation was significantly less than the likely liquid assets that the AP actually holds.

Cash Flows (repayment of current unspent funds)

The proposed amendments include provision that the unspent funds held by the AP at the time of the transition to subsidy payment in arrears based on actual service delivery, will then be progressively repaid by the AP back to the Department of Human Services (DHS) (who will then hold these unspent funds on behalf of the care recipient). This repayment will occur by the AP receiving a reduction in subsidy received each month until the unspent funds balance is fully acquitted.

On the basis of the analysis testing conducted, over 95% of APs could cater for a monthly reduction in subsidies equivalent to 20% of their monthly claim to DHS for services actually provided to care recipients (clients), to repay the unspent funds they currently hold. 23 APs out of the total of 525 appear to have insufficient liquid asset levels to meet these criteria.

At a subsidy reduction rate of 7.5% that percentage rises to 97.6% with only 13 of 535 APs having insufficient liquid asset levels as reported on the ACFR home care segment note.

Transition Cash Flow Requirements

On the basis of the impact analysis conducted, we are of the opinion that the proposed changes to the funding arrangements will not create a level of financial strain to APs of an amount that would require a significant short-term transitional funding requirement from the Government. Existing cash and financial assets reserves (including unspent funds held and unlikely to be utilised) would cover much of the additional cash flow requirements during the transition period.

We also note that the receipt of funding (or sales revenue) in arrears is consistent with the business practice in most industry sectors within the economy.

1.4 Considerations

There are a number of issues that should be considered by ACFA that could impact on APs as follows:

- The potential requirement to make significant adjustments to internal operating systems and software to facilitate the change in payment arrangements and the transmittal of required information to DHS or other agencies to instigate the payment transaction

- A prolonged disruption to payments to APs as a result of the payment system (through DHS or equivalent) in not making payments on time or facilitating a smooth reconciliation process between the DHS system and the AP internal systems

- Phases 2 and 3 of the proposed funding changes be implemented following a further analysis of the liquidity position of APs based on the FY20 ACFR which should include their respective consolidated (organisation level) liquid assets position. This financial analysis should not require a significant amount of time or cost and accordingly is not anticipated to delay the proposed timing

- Review of the proposed timing for implementation to occur from 1 July 2010 and 1 July 2021 (being after the fiscal year-end)

1.5 Significant Risk

If the Government, through DHS (Medicare) required APs to submit each claim at the individual care recipient level (similar to NDIS funding), this could result in considerable additional work, not only in making the claim but also reconciling the reimbursed funding receipt to the claim on a care recipient by care recipient basis.

While it reasonable to expect APs to extract from their respective home care subsidiary systems the aggregate amount for the monthly in arrears funding claim to DHS, a major concern that needs to be strongly considered is in relation to the additional workload.

If there was a valid reason for requiring APs to lodge claims at the care recipient level, we would suggest that this requirement be delayed until later stage once the initial transition to claiming in arrears had been completed.

We strongly recommend that subsidy claiming be conducted based on the aggregated data for the AP.

2. Background

2.1 Introduction

The Aged Care Financing Authority (ACFA) has released a consultation paper "Improving home care payment arrangements" which sets out the following:-

Background

The Government announced in 2019-20 Budget Paper 2 under its measure *More Choices for a Longer Life – improving the quality, safety and accessibility of aged care* services, that payment arrangements in home care would be improved to address stakeholder concerns about unspent funds and to align home care arrangements with other Government programs, such as the *National Disability Insurance Scheme*.

Proposed Payment Arrangements

The Budget measure involves home care providers being paid for the services provided to care recipients. The difference between the full Government subsidy that the care recipient is eligible to receive based on package level and days in care and the cost of the services actually provided to the care recipient will be held by the Department of Human Services (DHS) to be drawn upon by the care recipient in future, through the AP.

It is proposed that the available funds of care recipients held by providers will be drawn down as part of the implementation of the new payment arrangements.

ACFA is required to examine the potential financial impact on home care providers of the above Budget measure and provide advice. StewartBrown has been engaged to assist ACFA with this analysis.

Previous Analysis

In December 2018, StewartBrown undertook a high-level overview of the likely impact of the proposed changes to the payment arrangements for Home care packages.

For the purpose of that analysis, HCP providers were grouped by size based on revenue and the following analysis was undertaken to establish:

- The unspent funds coverage
- The cash flow coverage
- The net HCP result or net margin for the AP

These measures were used to assess the potential financial vulnerability of the home care providers individually and in aggregate to the proposed home care funding changes if they were implemented.

The analysis was performed on two different levels:

Method 1 used cash and liquid assets allocated to the Home Care Segment.
Method 2 used cash and liquid assets at the consolidated AP level.

It must be noted that the information at the consolidated AP level is only available for those APs that also operate a residential aged care home.

For the purpose of the 2018 analysis ***Liquid assets*** included operating cash balances and deposits with Authorised Deposit taking Institutions.

Based on the December 2018 analysis StewartBrown then concluded that:

- The majority of HCP providers (between 74% and 98%) will not be adversely affected by the proposed change from funding in advance to funding in arrears
- Most HCP providers analysed would have sufficient cash reserves (in the form of cash and cash equivalents and other current liquid assets) in order to continue operating over the implementation of such a change
- Depending on the methodology used, the number of those HCP providers vulnerable to the proposed funding changes ranges from 2% (16 providers) to 26% (220 providers)

2.2 Agreed Scope of Works

To provide a detailed and granular analysis of the likely financial impact of the proposed changes to the Home Care Package (HCP) payment arrangements from the current subsidy payment in advance to subsidy payment in arrears based on the services delivered to the care recipient (client).

The analysis would include:

- Note and make use of the previous StewartBrown financial analysis (December 2018) performed at a high level as appropriate
- Use the information available from the 2018-19 Aged Care Financial Report (ACFR)
- Use data obtained as part of the FY19 StewartBrown *Aged Care Financial Performance Survey (Survey)*
- Use information, where available from GPFS of a sample of home care APs
- Use any other financial data that is available to them to make a detailed financial assessment of the likely impact on APs should there be a change in the method of making payments to them
- Take into account AP characteristics such as size, location (State and region), capital (equity) base, working capital requirements and other related factors that may influence the impact of a change in payment arrangements

Consideration should be given to the information contained in the Aged Care Financing Authority consultation paper "Improving home care payment arrangements" when undertaking the analysis.

2.3 Methodology and Approach

StewartBrown conducted the detailed analysis based on the data provided by the Department of Health (the Department). This information was provided in the Excel workbook titled "Home Care Data 07112019 v2" and included:-

- Name of the Approved Provider (AP)
- Fees and Charges associated with the AP as recorded in the home care segment data sheet
- ACFR data for those home care APs with residential care operations

In addition, AP consolidated level data and HCP program level data was included and analysed as sourced from the StewartBrown *Aged Care Financial Performance Survey* for the year ended June 2019.

The approach to the analysis has been to determine the following:-

- The net HCP result and net margin % for the APs
- The likely impact of one month's subsidy payment in arrears
- The likely impact of drawing down on unspent funds over time
- The cash flow analysis for a 1 month delay in system payments

These measures are used to assess the potential financial impact on APs individually and in aggregate to the proposed home care funding changes if they were implemented.

2.4 Confidentiality

This report, and the information contained therein, including any recommendations made, is confidential and should only be used for the purpose for which the report was commissioned.

2.5 Report Disclaimer

This report has been prepared under instructions from and for the sole use and distribution by the Aged Care Financing Authority and Department as part the scope described in section 1.2. This report, including any analysis and opinions expressed therein is based on information provided to StewartBrown by the Department staff and management. For the purposes of this review, StewartBrown has not performed an audit on the financial data, accounts process flows or systems of internal control and accordingly has solely relied on the information provided by the Department. This report should not be relied upon by any party other than ACFA and the Department or for any purpose other than for which it has been written.

2.6 Independence Declaration

There are no other matters in relation to this assignment that StewartBrown are aware of that would constitute a real or perceived conflict of interest.

3. Home Care Funding

3.1 Background

The Australian Government provides a subsidy to an approved provider of home care to coordinate a package of care, services and case management to meet the individual needs of older Australians. The statutory authority is the *Aged Care Act 1997*.

There are four levels of home care packages:-

Level 1 - basic care needs;
Level 2 - low level care needs
Level 3 - intermediate care needs
Level 4 - high care needs

When care commences all APs must deliver home care package services on a consumer directed care basis.

3.2 Current Payment Arrangements

Government Subsidy

Home care providers are currently paid a care recipient's full entitlement to Government subsidy for each month (i.e. their package level less any income-tested care fee), regardless of the services actually provided to the care recipient.

The HCP subsidy is remitted to the AP on behalf of each eligible care recipient (client). The subsidy is calculated as follows:-

- Basic subsidy amount
- *plus* primary supplements (oxygen, enteral feeding, dementia and cognition, veterans)
- *less* any reductions in subsidy
- *plus* any other supplements (hardship, viability)

The subsidy is paid in two stages. Using the month of November as an example, the AP receives an advance payment at the beginning of November equivalent to the amount received for the month two months earlier, being September. Then, at the start of the subsequent month, December, the AP lodges a claim specifying the actual subsidy due for November, at which time a reconciliation takes place.

Any amount that is not spent providing care and services to a care recipient in a month is then held by the AP as available funds (unspent funds) to be drawn upon by the care recipient in future.

Consumer Contributions

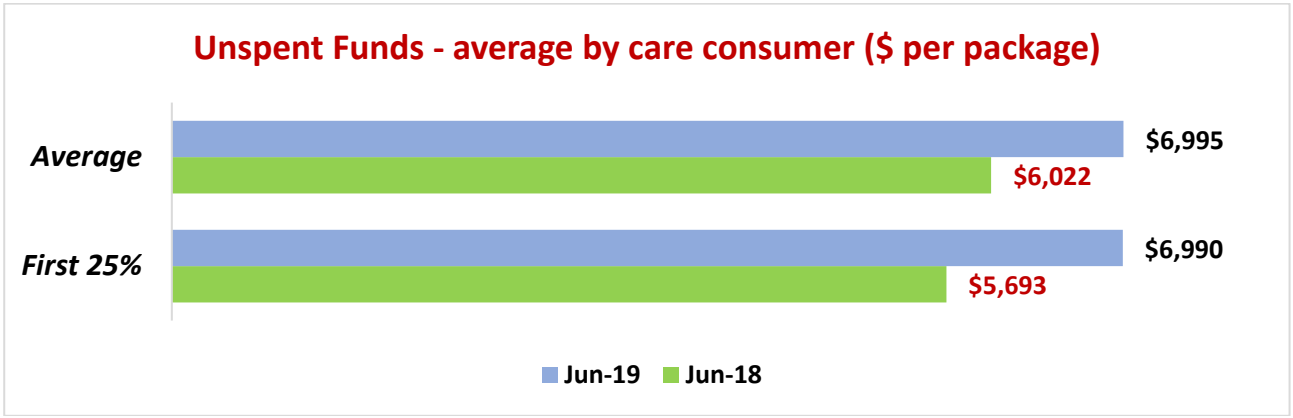
Based on the care recipient's personal financial circumstances, a consumer contribution may be levied by the AP to contribute to the cost of providing care. The amounts that can be charged are as included in the *Schedule of Fees and Charges for Residential and Home Care* issued by the Department. Care recipients will be financially assessed and an income tested fee component may be levied which is offset against the subsidy.

3.3 Unspent Funds

Unspent funds are the total amount of home care subsidy, supplements (if applicable) and care recipient contributions paid to an AP (on behalf of the care recipient) that have not been spent or committed on that care recipient's care. Unspent funds typically accumulate over time where the care recipient's package funds (subsidy plus contribution) have not been fully allocated within their individualised care budget.

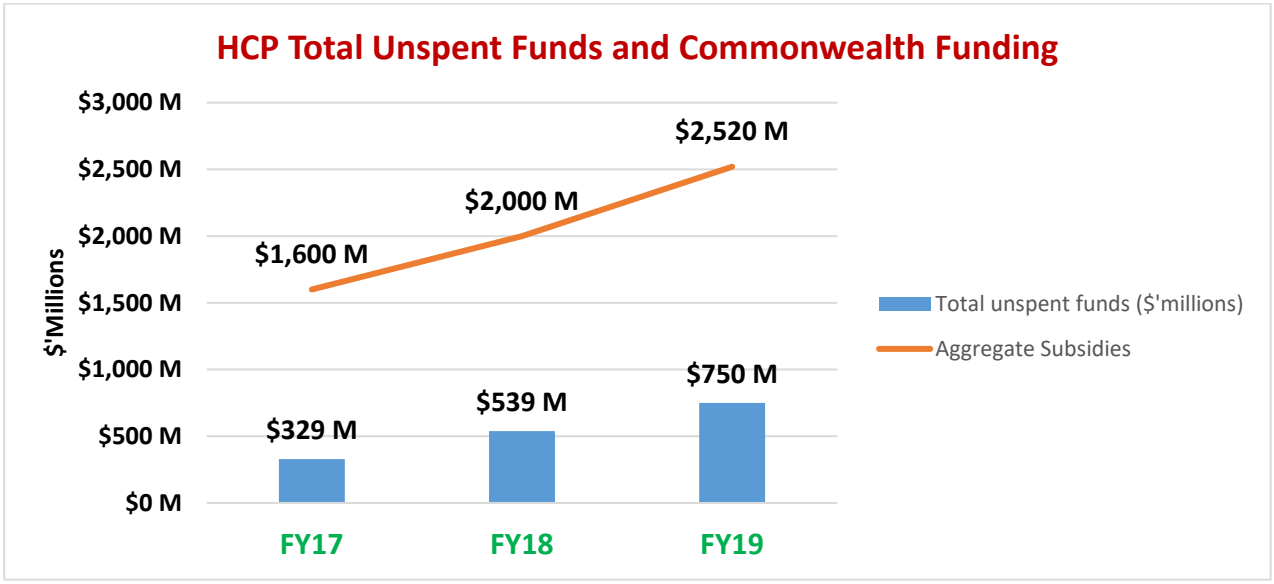
Despite the marginal improvement in *Average* revenue utilisation seen in the 2019 *Survey* there has been a continuation in the increase of unspent funds for each care consumer and as *Figure 1* shows, the unspent funds balance averaged $6,995 per package at the end of FY19, an increase of $973 from FY18.

Figure 1: Average Unspent Funds per care recipient as at Jun-19 and Jun-18 from StewartBrown 2019 Survey



As at 30 June 2018, APs reported holding a total of unspent funds of $539 million (FY17: $329m)[1]. Based on the data received to date (refer Table 1) unspent funds are likely to reach in excess of $750 Million at June 2019).

Figure 2: Trend for unspent funds and Commonwealth Government funding since FY17



Note that the FY17 unspent funds balance includes amounts calculated back to 1 July 2015 for those consumers that remain in a package at that date.

[1] As provided in the 2018 Aged Care Financial Report lodged by approved providers of home care packages

At the time of preparing this report, Aged Care Financial Reports (ACFR) for FY19 have been received from 804 (of a possible 928) HCP providers. The following analysis of unspent funds, and the movement during FY19, is based on the information contained in those ACFRs.

Table 1: Movement in unspent funds based on ACFR data received to date for FY19

Movement in Unspent Funds for FY19	$
Opening Balance of unspent funds	**533,197,464**
Inflows to package:	
Commonwealth subsidies and supplements	2,519,536,623
Care Recipient basic daily fee	64,994,047
Income tested care fees	40,970,734
Other	8,822,086
Funds transferred in from other providers	29,101,004
Total inflows:	**2,663,424,494**
Available package funds	***3,196,621,958***
Outflows:	
Transferred to another provider	30,847,484
Returned to care recipient / estate	7,045,928
Returned to the Commonwealth	121,259,487
Package funds spent	2,304,252,167
Total Outflows:	**2,463,405,066**
Closing Balance of unspent funds	**733,216.892**

Observations

The following observations can be made in relation to the data obtained from the 2019 ACFR's:-

- It is likely that, given the size of the data subset currently available, aggregated unspent funds will be greater than $750 million at end of FY19 once all ACFR data is available
- Total income from the Commonwealth and care recipients in FY19 was $2.63 billion. The gross subsidy amount (including ITCF) equated to 97.5% of the total. The care recipient basic daily fee (BDF) contributed the remaining 2.5%. The ITCF equated to 1.6% of the total
- The amount returned to the Commonwealth represents 94.5% of all funds returned which is in line with the revenue mix where Commonwealth subsidies and supplements contribute 95.6% of package funding
- The equivalent of 24.1% of the opening balance of unspent funds were returned to the Commonwealth or care recipient upon leaving the package
- The closing balance of unspent funds represents 27.5% of the total inflows into package funds for the FY19 year
- The following table outlines the outflows of funds for FY19 as a proportion of total available package funds and total inflows for the year

Table 2: Breakdown of inflows to package funds including proportion of total inflows and total package funds

	Amount $	Proportion of Total Available Package Funds	Proportion of Total Inflows
Total Funds		**$ 3,196,621,958**	**$2,663,424,494**
Transferred to another provider	30,847,484	3.8%	4.6%
Returned to care recipient / estate	7,045,928	0.2%	0.3%
Returned to the Commonwealth	121,259,487	1.0%	1.2%
Package funds spent	2,304,252,167	72.1%	86.5%
Retained in unspent funds	733,216,892	22.9%	
Change in unspent funds	200,019,428		7.5%
		100.0%	**100.0%**

The increasing amount of unspent funds continues to be a significant area of concern for several reasons:

- Care recipients may not be taking full advantage of their available package funding for use on services
- APs are not operating at optimal efficiency because the care recipients are not utilising the full value of their funding package
- There is an increasing level of prudential risk due to the build-up of unspent funds, bringing into question the ability for some APs to refund those monies if and when the time arises

3.4 Proposed Amendments to Funding Arrangements

The 2019-20 Federal Budget measure involves home care APs being reimbursed for the actual services provided to care recipients. The difference between the full Government subsidy that the care recipient is eligible to receive based on package level and days in care and the cost of the services actually provided to the care recipient will be held by the Department of Human Services (DHS) to be drawn upon by the care recipient in future, through the AP.

It is proposed that the available funds of care recipients held by APs will be drawn down as part of the implementation of the new payment arrangements.

3.5 Financial Risks to Approved Providers

The risks to APs are likely to be amplified for those smaller APs who do not have other major sources of revenue other than that generated from the delivery of home care packages. The risks to APs can be categorised as follows:

- Short-term cash flow shortfalls as payments transition from advance to arrears and normal payments to employees and suppliers will need to continue
- Operating with a negative margin so payments based on services provided will not sustain the business
- APs using unspent funds as working capital and, accordingly, this will be diminished as those unspent funds are drawn down
- Inability to withstand interruptions to cash flows that might occur with the introduction of a new funding remittance system

3.6 Risk of Other impacts on Approved Providers

There are risks that other issues could impact on APs as follows:

- Need to make significant adjustments to internal operating systems and software to facilitate the change in payment arrangements and transmittal of required information to Department of Human Services (DHS) or other agency to instigate the payment transaction
- That there is a prolonged disruption to payments to APs as a result of the payment system (through DHS or equivalent) not making payments on time or facilitating a smooth reconciliation process between the DHS system and the AP internal systems

3.7 Proposed Implementation Timeline

The following proposed implementation timetable is from ACFA's consultation paper "Improving home care payment arrangements".

Table 3: ACFA's Proposed Implementation Timetable

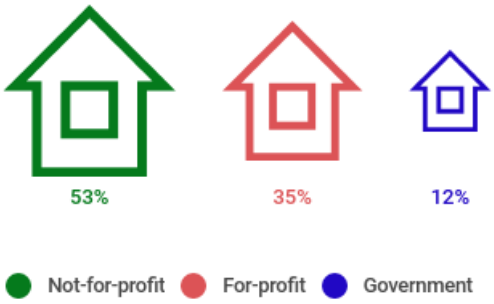
Phase 1 (to commence in June 2020)	**Phase 2 (to commence in April 2021)**	**Phase 3 (drawdown of unspent funds held by providers)**
• Subsidies and supplements will be paid in arrears at the full rate of subsidy based on package level and days in care, through the usual monthly claim.	• Payments will be based on services provided to care recipients and unspent funds will be held by the Government.	• Commencing with the March 2021 claim lodged in April, DHS will reduce a payment for a care recipient by a portion of the available funds held by the provider for that care recipient.
Practical application 1. The 'advance' payment made at the start of May 2020, for the month of May, will be the last 'advance' payment made. 2. Providers will then lodge their May claim in June as per normal. The usual reconciliation will occur for the month of May. 3. There will not be an 'advance' payment at the start of June (or any subsequent month). 4. In July, providers will lodge their claim for June and receive payment of the full subsidy for which each care recipient is eligible (i.e. based on their full entitlement and number of days in care).	*Practical application* 1. Providers lodge their March claim in April based on the amount of services provided for each care recipient in March. 2. DHS determines the amount to be paid for each care recipient considering: a. the amount of the claim; b. the full entitlement for which that care recipient is eligible for that month; c. any income-tested care fee payable by that care recipient; and d. [In future months] available funds held by DHS for that care recipient. 3. Any amount of subsidy, less any income-tested care fee, that is not paid to a provider for a particular care recipient accrues and is held by DHS to be drawn down in future.	*Practical application* 1. In February 2021 providers advise the amount of available funds held for each care recipient. 2. In addition to the matters taken into account when determining an amount of payment for a claim, DHS will reduce a payment in respect of a care recipient by a percentage amount (yet to be determined) in recognition of available funds held by the provider for that care recipient. 3. This will occur until the provider no longer holds available funds for that care recipient. 4. The portion of the care recipient's subsidy that is not paid to the provider during the drawdown will be accrued by DHS.

4. Home Care Sector

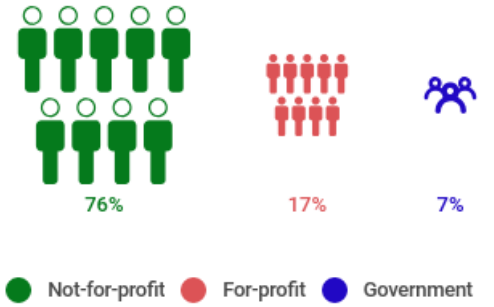
4.1 Overview

The Home Care sector is the fastest growing segment in the aged services sector as a result of policy shifts to cater for more older Australians receiving care in their home rather than in a residential aged care setting.

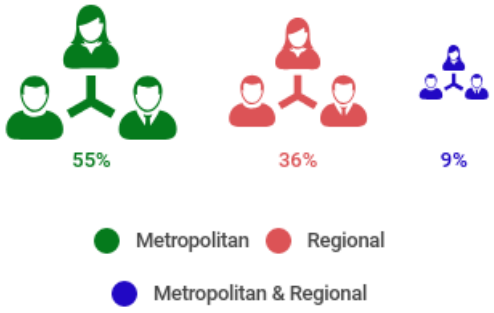
Providers



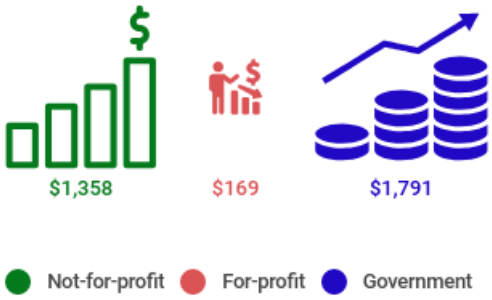
Number of Consumers at 30 June 2018



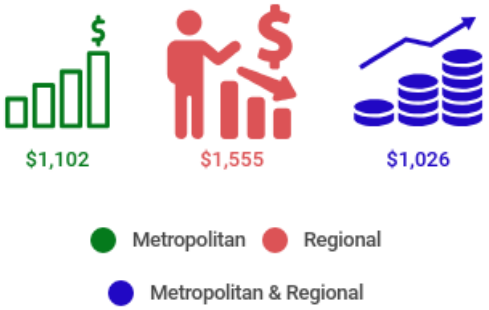
Provider Location



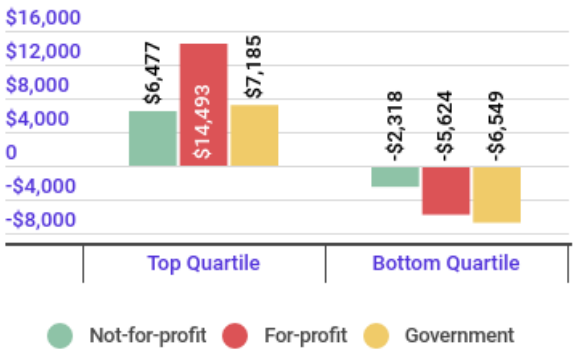
EBITDA FY18 by Ownership $ per consumer



EBITDA FY18 by Location $ per consumer



EBITDA FY18 by Ownership $ per consumer - Top and Bottom quartiles

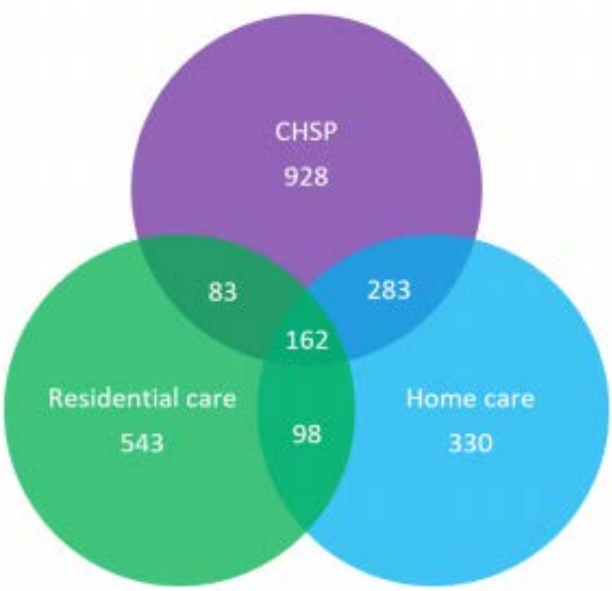


4.2 Overview of Home Care Approved Providers

Many home care APs do not operate in isolation, that is, they have other business streams within the aged care funding envelope, as well as interests outside the aged care sector including disability, affordable housing, retirement living, and children's services as examples.

The fact that APs do have other sources of revenue will ultimately have some bearing on the likely financial impact of any change to the payment arrangements for home care funding. A level of scale and cash reserves from other areas, particularly residential care and retirement living would help to soften any cash flow impacts of changing payment arrangements.

Figure 3: Proportion of aged care providers providing more than one type of aged care service, 2017-18



Source: 2019 ACFA Annual Report on Funding and Financing of the Aged Care Sector

Data for FY19 is still being processed, and we would expect that the proportion of APs who have diversified into more than one type of care continues to increase slightly. Applying the above ratios to the 2018-19 current analysis population of 804 home care APs the breakdown is as follows:

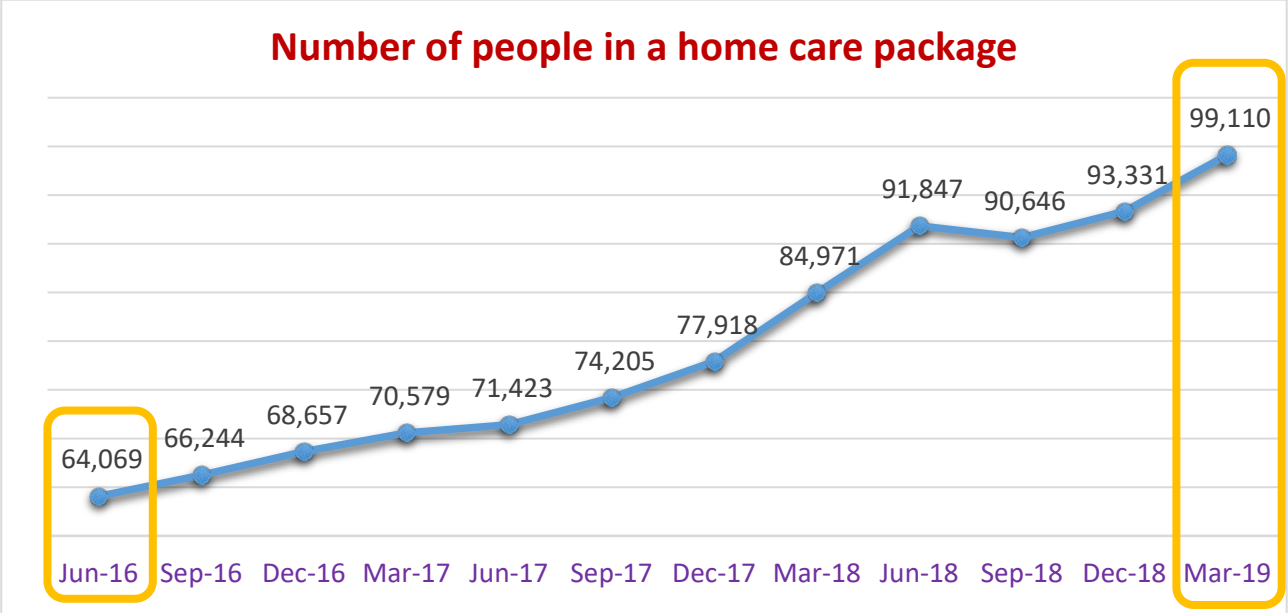
Table 4: Distribution of Home Care APs based on types of aged care segments it is operating in

Home Care Approved Providers	2017-18	*Ratio*	2018-19 Analysis*
With Residential Care	98	*11%*	90
With CSHP	283	*32%*	261
With Home Care Only	330	*38%*	304
With Residential Care and CSHP	162	*19%*	149
Total	873	*100%*	804

Notwithstanding the involvement of home care APs in other segments, most of the impact analysis will be confined to the home care segment of an AP. Most home care APs are either home care only or home care and CHSP providers. It is likely that these APs will be more exposed to the funding changes due to their inability to rely on cash and liquid assets provided by other business segments.

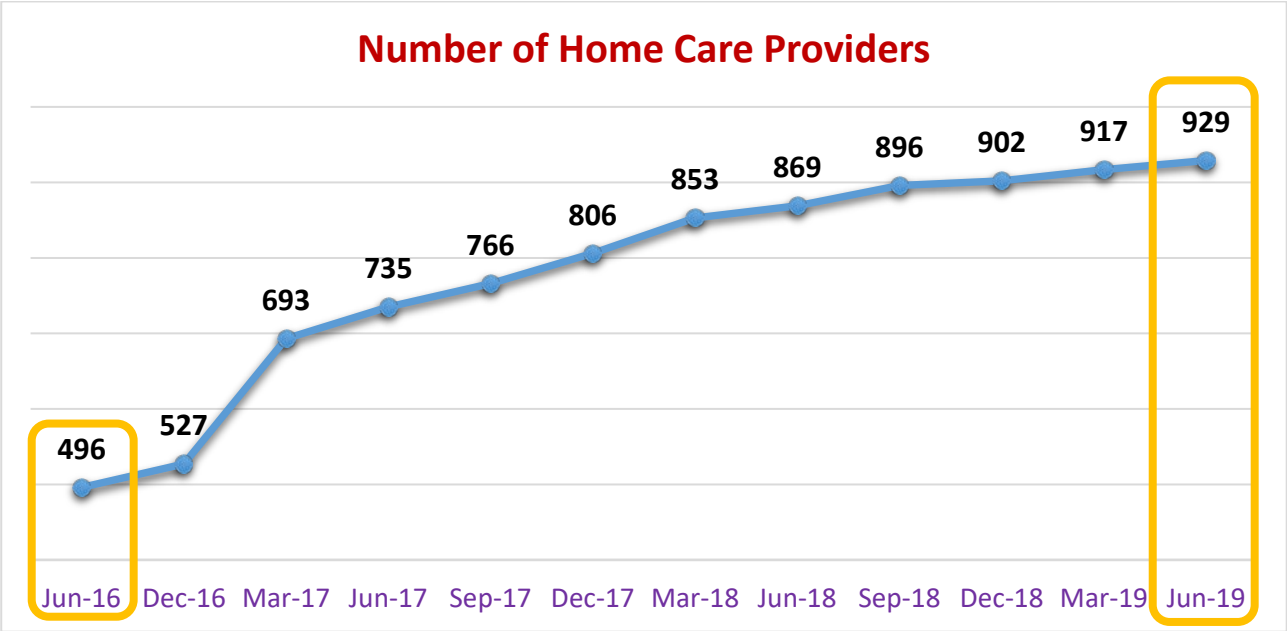
To provide context, some case studies and analysis at a consolidated AP level (incorporating all business segments) will be provided, however the level of information available at this level is limited to a subset of APs, that is those that also have residential aged care.

Figure 4: Number of persons in a Home Care package (Source: www.gen-agedcaredata.gov.au)



There has been a 40% increase in the number of persons in an home care package since the changes to the way packages were allocated in February 2017. It is estimated that by the end of FY20, there will be 144,912 packages allocated to care recipients[2]. During this same period, unspent funds have grown to at least $750 million.

Figure 5: Number of Home Care Providers (Source: www.gen-agedcaredata.gov.au)

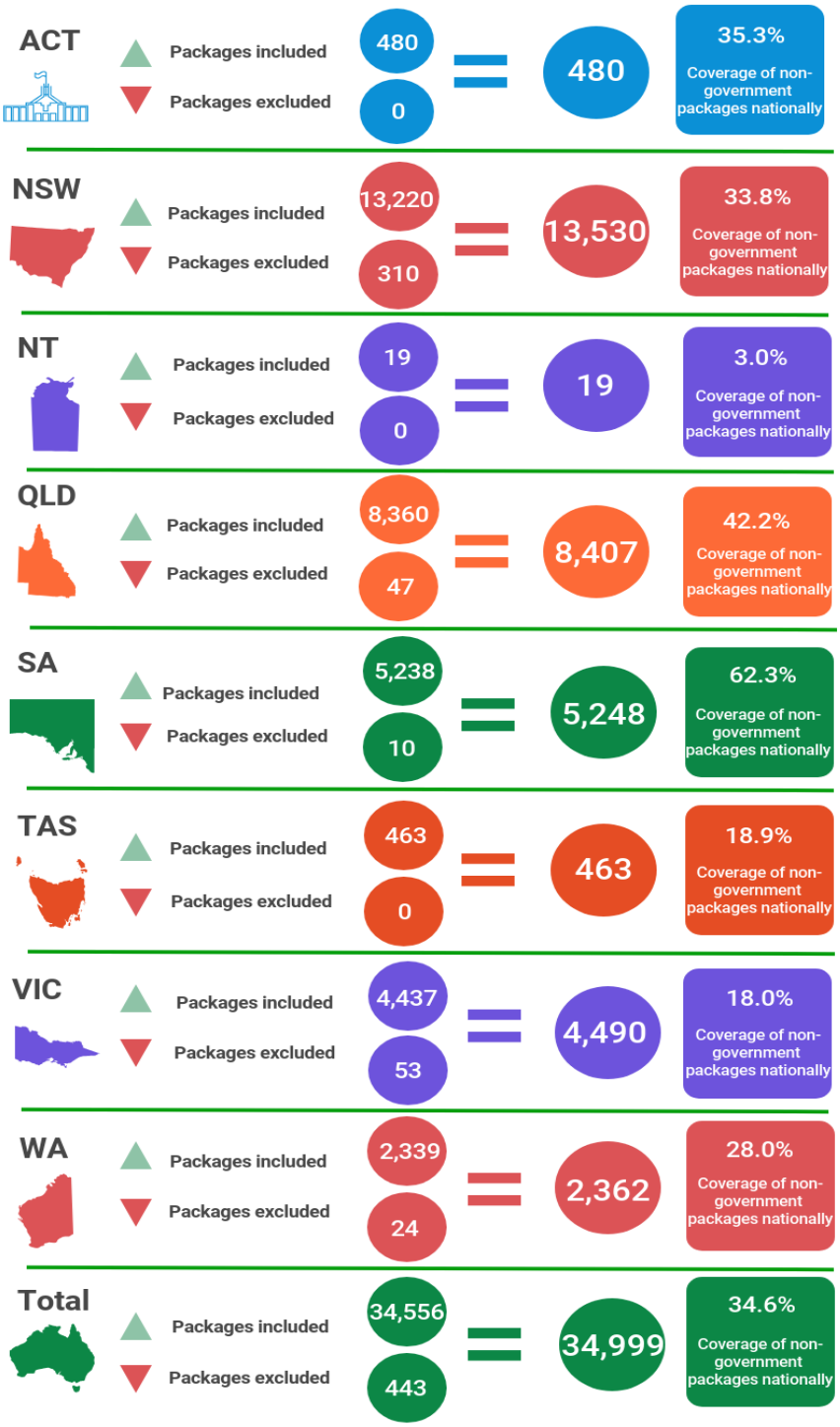


During the same period of growth in home care packages there has also been a large increase in APs of home care services. In the nine months leading up to, and the period since the reforms in February 2017 there has been an additional 433 APs enter the market representing a 87% increase on the number of APs at June 2016.

[2] Home Care packages Program Data Report 4th Quarter 2018-19

4.3 StewartBrown *Survey*

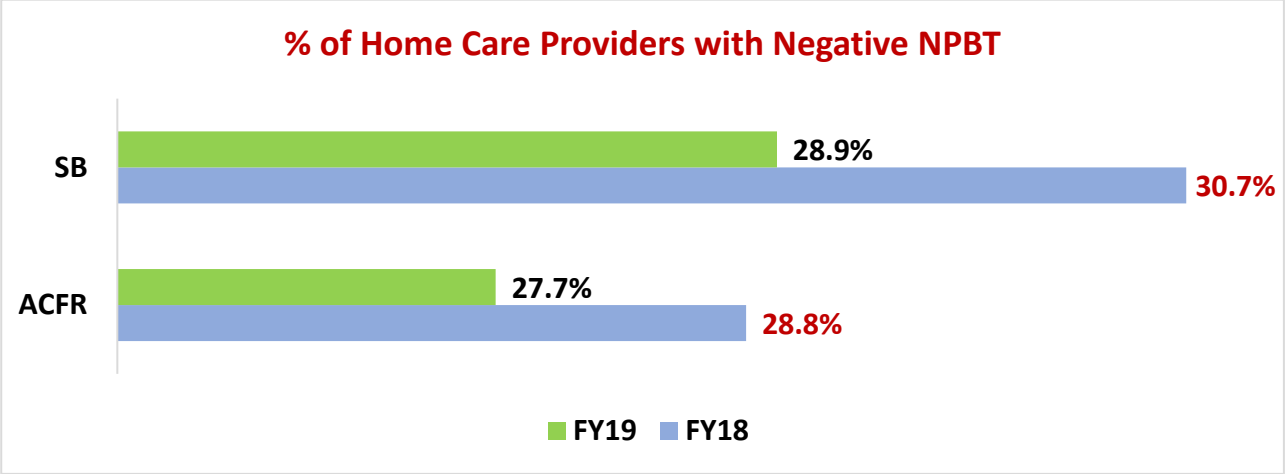
The following analysis is based on the StewartBrown *Aged Care Financial Performance Survey* which surveys home care APs on a quarterly basis with regard to their financial performance at a program level. Coverage of the *Survey* is extensive as shown below.



4.4 StewartBrown *Survey* FY19 Results

The total percentage of home care APs (92 in the *Survey*) making a negative Net Profit Before Tax (NPBT) (i.e. an operating loss) is 28.9%. This is a decrease of 1.8% compared to the FY18 figure of 30.7%.

Figure 6: Percentage of home care APs making negative NPBT

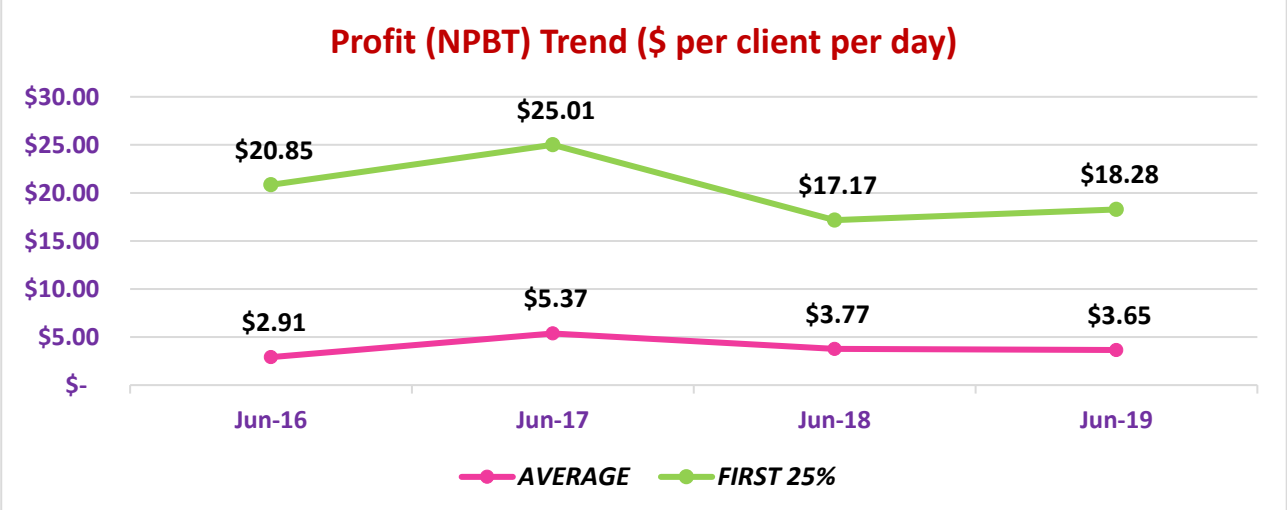


Please note that the above analysis for StewartBrown (SB) data is based on the financial operating performance at the consolidated home care programme level which is an approximation for the home care segment level. The ACFR data is based on the 535 providers in FY19 for which data has been received and excludes government providers and others for which data has not been submitted or there is obvious missing data. It should be noted that the ACFR data for FY19 has not been through a detailed cleansing process and is "as submitted". The StewartBrown data undergoes a comprehensive cleansing process to ensure it is an accurate reflection of the operating performance of the provider.

The home care segment has experienced a minor decline in the average operating surplus for FY19 of $0.12 per client per day (pcpd). The *Average* surplus was $3.65 pcpd. The HCP programmes in the *First 25%* fared much better with an increase in the surplus from $17.17 pcpd for FY18 to $18.28 pcpd in FY19, the increase being $1.11 pcpd.

These results for FY19 appear to have arrested the more dramatic declines in the results between FY17 and FY18 after the reforms in February 2017.

Figure 24: Trend of Net Profit Before Tax (NPBT) for Home Care Packages FY16 to FY19 - Survey Average and First 25%



There were various factors contributing to these results and some observations are as follows:

Package Revenue

- Increased by 4.6% for *Survey Average* and 2.5% for *Survey First 25%*
- Revenue utilisation increased by 2.5% for *Survey Average* and 1.6% for *Survey First 25%*
- Higher unspent funds across *Survey Average* and *Survey First 25%*

Package Expenses

- Increased by 5.0% for the *Survey Average* and 1.5% for the *Survey First 25%*
- Direct service costs increased by $0.88 pcpd (2.4%) for the *Survey Average* and by $2.49 pcpd (6.4%) for the *Survey First 25%*
- Cost of direct service and brokered/sub-contracted as a percentage of total income has increased to 62% from 61% (FY18) for the *Survey Average*
- There was an increase in the use of brokered services of $1.65 pcpd (29.5%) for the *Survey Average* compared to a reduction of $0.91 pcpd (15.3%) for the *Survey First 25%*
- Decrease in case management and advisory $0.04 pcpd (reduction in staff costs) for *Survey Average* and $0.56 pcpd for *Survey First 25%*
- Increase in administration costs of $0.82 pcpd for *Survey Average* and $0.21 pcpd for the *Survey First 25%*

Other

- According to the latest HCP Programme Data Report for the 4th Quarter 2018-19 there has been a 7.9% growth in the number of persons in a home care package in the nine months to March 2019 and a 16.6% increase in the year to March 2019. For APs, this type of growth has been rare
- In the year to March 2019 there has been an 8.9% growth in package numbers. There has also been an 8.9% increase in the number of APs of home care services, and this has absorbed some of the growth in packages
- We have seen, at an AP level, that the more consistent growth in packages has occurred for large APs with greater than 1,000 packages
- In the year to March 2019, the number of persons in home care packages has increased by 14,139
- The participants in the StewartBrown *Survey* have seen an increase of 3,078 packages in FY19, and an average increase of 9.8% across all the APs in the *Survey*
- Mix of packages - while there has been a significant increase in the number of high care packages in recent years, the latest June release of 47,700 packages contained 9,200 (19.3%) Level 1 packages and 13,900 (29.1%) Level 2 packages. This release of low care packages, combined with the effect of unspent funds at all package levels, is likely to see the number of programmes in the low-care categories in our *Survey* increase and average revenues decline, or at least stabilise somewhat

Regional Analysis

For the second consecutive year, the Survey asked participants to provide details of the geographical region (ABS Remoteness Category) for each of their home care programs.

In those instances where APs did not provide this information, we utilised the FY19 provider service list to determine the ABS Remoteness Category. We noted that in some cases there are differences between the geographic region provided and the ABS remoteness as per the service list. In these cases, we have designated the region as "mixed". The same approach was used in FY18.

Based on the information received and the supplemental research performed, the programs were grouped by geographic region into the following categories:

- Metro
- Mixed - metro & inner regional
- Inner regional
- Mixed - inner regional & outer regional
- Outer regional, remote & very remote

Of the 491 HCP programs (34,999 packages), the distribution of packages is displayed in the following graphic.

Figure 7: Distribution of Programs by Region in the FY19 and FY18 Survey

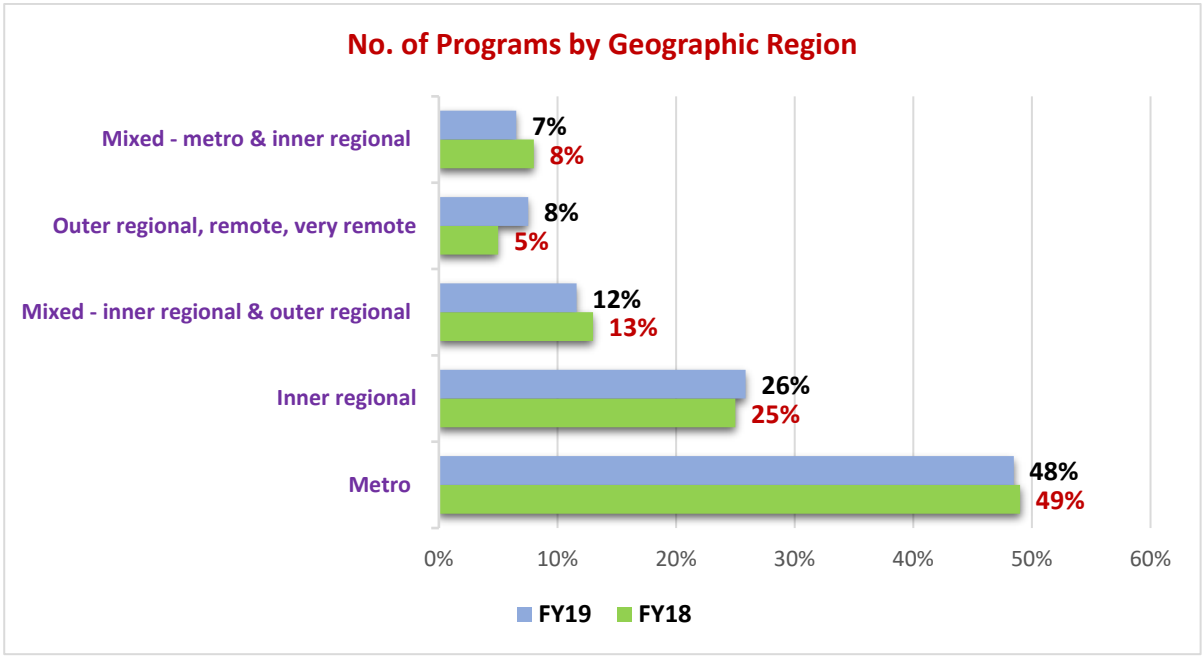
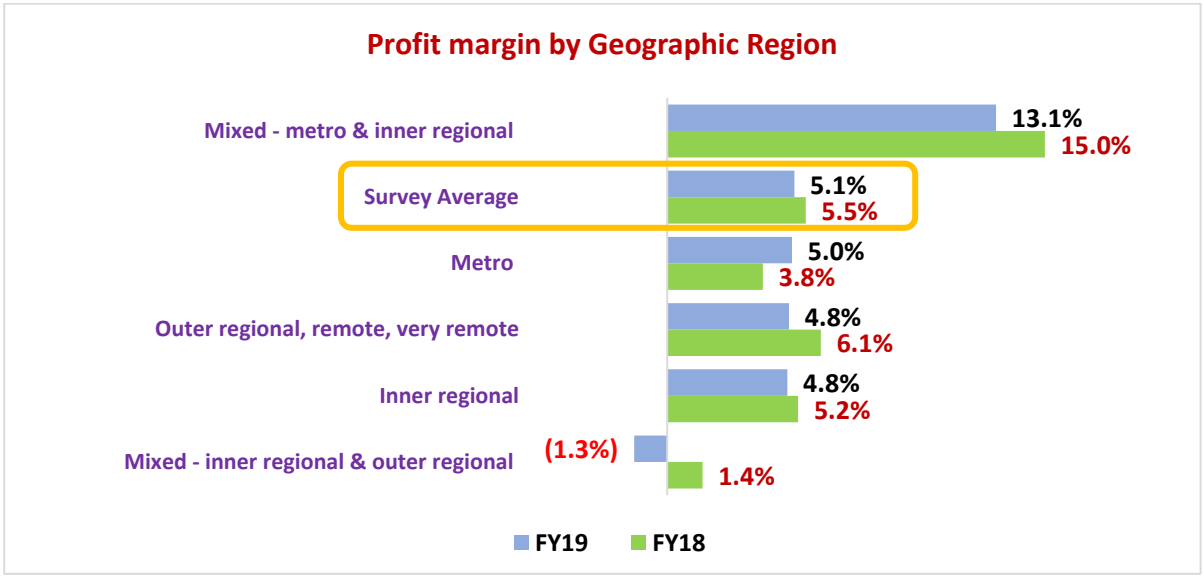


Figure 8: Average Profit Margin by Region FY19 vs FY18



Our analysis of the results by region shows that:

- Mixed - metro and inner regional are the most profitable with lower cost of direct care and administration and support services as % of total revenue
- Mixed - inner regional and outer regional are the least profitable having both a lower revenue $pcpd and higher cost of administration and support services as % of total revenue and are reported a net loss in FY19
- The profitability within larger APs who operate across regions varies due to different management and operational structures

5. Impact Analysis - Profitability of HCP Providers

In the data presented by StewartBrown regarding the financial state of the sector, the average margin for HCP providers was 5.1% for FY19, down slightly from an average of 5.5% in FY18. The APs in the StewartBrown Survey are predominantly Not-For-Profit and as the following analysis will show, they do have a higher average profit margin than the For-Profit providers.

The profitability of APs is an important factor in the risk analysis for several reasons:

- Policy for the payment arrangements for APs should not, in our view, be predicated on providing support for poorly performing APs
- APs should be pricing their services to include a margin to be able to recover the costs of supplying that service
- A profit margin helps to provide the necessary working capital to promote growth within the sector and within individual APs

5.1 FY19 HCP Sector Financial Performance

Aged Care Financial Report (ACFR)

All APs who supply residential aged care, short term restorative care and/or home care packages are required to submit an unaudited ACFR to the Department by 31 October each year.

The format of the ACFR is prescriptive and specific data definitions are provided to ensure that APs accurately complete the ACFR via the Department portal.

With respect to residential aged care APs, they must complete a number of additional data spreadsheets, including a summary Financial Position (balance sheet), Income and Expenses Statement and Cash Flow Statement at the Approved Provider (consolidated) level (meaning inclusion of all activities of the AP).

With respect to HCP providers they must complete the tab "Statement of Inc & Exp (Home)" (extract below) which also includes additional with respect to unspent funds, utilisation of funds (subsidy and care recipient contributions), movement of funds, and the total "Cash and Liquid Assets (Current)".

APs who do not supply residential aged care services are not required to submit any AP (consolidated at whole organisation level) financial data.

A detailed review of the ACFR's submitted as at the date of this report analysis (11 November 2019) indicated significant variances in the accuracy of the HCP data in relation to cash and liquid assets, in addition to other insufficient data.

A summary of the 804 submitted ACFR's received is as follows:-

- Income and Expenses fields not completed or missing information *(67 APs)*
- HCP segment liquid assets not completed or incorrectly completed *(114 additional APs)*
- Government providers – not applicable in relation to this analysis *(88 APs)*

Accordingly, the respective data sets used for this analysis are:-

- Financial performance (net profit before tax) is **737** APs *(804 less 67)*
- Liquid assets coverage and cash flow analysis is **535** APs *(737 less 114 less 88)*

ACFR Extract for HCP Approved Providers

An extract of the ACFR data spreadsheet that home care APs must complete and submit is as follows:-

Home Care Income Statement 2018-19

	Total Home Care	Program (Service level)	Program (Service level)
Income			
◦ Fees Charged to Clients:			
- Provision of Care/Services Fees	$0.00	$0.00	$0.00
- Client/Case Management Fees	$0.00	$0.00	$0.00
- Administration Fees	$0.00	$0.00	$0.00
◦ Exit Amounts Deducted	$0.00	$0.00	$0.00
◦ Other Revenue	$0.00	$0.00	$0.00
Total Income:	$0.00	$0.00	$0.00
Expenses			
◦ Wages and Salaries - Care Staff	$0.00	$0.00	$0.00
◦ Wages and Salaries - Administration & Non-Care Staff	$0.00	$0.00	$0.00
◦ Administration Costs and Management Fees	$0.00	$0.00	$0.00
◦ Care Related Expenses	$0.00	$0.00	$0.00
◦ Sub-contracted or Brokered Client Services	$0.00	$0.00	$0.00
◦ Depreciation Expenses	$0.00	$0.00	$0.00
◦ Interest Expenses	$0.00	$0.00	$0.00
◦ Other Expenses	$0.00	$0.00	$0.00
Total Expenses:	$0.00	$0.00	$0.00
Net Profit/(Loss) Before Tax:	**$0.00**	**$0.00**	**$0.00**
From Consolidated Client Statement:			
◦ Unspent Package Funds Opening Balance.	$0.00	$0.00	$0.00
◦ Commonwealth Subsidies and Supplements	$0.00	$0.00	$0.00
◦ Client Fees - Basic Daily Fee	$0.00	$0.00	$0.00
◦ Client Fees - Income Tested Care Fees	$0.00	$0.00	$0.00
◦ Client Fees - Other	$0.00	$0.00	$0.00
◦ Funds Transferred in With New Clients	$0.00	$0.00	$0.00
◦ Funds Transferred Out With Existing Clients			
- Transferred to Another Provider	$0.00	$0.00	$0.00
- Returned to the Client/Estate	$0.00	$0.00	$0.00
- Returned to the Commonwealth	$0.00	$0.00	$0.00
◦ Package Funds Spent	$0.00	$0.00	$0.00
◦ Unspent Package Funds Closing Balance.	$0.00	$0.00	$0.00
From Home Care Segment Balance Sheet:			
◦ Cash and Liquid Assets (Current)	$0.00	$0.00	$0.00

ACFR - Sector Financial Results

For the 804 APs that had submitted ACFR data at the time of preparing this report[3], 67 APs submitted insufficient information. These constituted small to medium sized APs only. Accordingly, the FY19 financial performance of the remaining 737 APs is follows:

Table 5: FY19 ACFR financial data (based on 737 APs that provided complete data)

ACFR Profit and Loss Summary - FY19[4]	$	% of Revenue
Revenue:		
Provision of care / services	1,675,795,331	*67.5%*
Case management fees	344,999,025	*13.9%*
Administration fees	385,108,260	*15.5%*
Exit fees	5,226,073	*0.2%*
Other revenue	70,054,043	*2.8%*
Total revenue	2,481,182,732	*100.0%*
Expenses:		
Staff costs - direct care	973,534,797	*39.2%*
Staff costs - other	343,508,029	*13.8%*
Care related expenses	267,347,976	*10.8%*
Sub-contracted or brokered client services	387,566,058	*15.6%*
Administration costs and management fees	322,318,988	*13.0%*
Depreciation expense	16,500,027	*0.7%*
Interest expense	6,947,132	*0.3%*
Other expenses	70,068,008	*2.8%*
Total expenses	***2,387,791,015***	***96.2%***
Net Profit Before Tax	**$ 93,391,717**	***3.8%***
NPBT $ per care recipient pa *(based on estimate of 79,000 packages)*	**$ 1,182**	

The sector overall made a profit before tax of $93.4 million which represents an average margin of 3.8% on revenue. Note that this is the services revenue, not the inflow of funds into the package for the year.

The largest single expense is staff costs which represent 53% of revenue earned. A further 13% of revenue is expended on administrative costs. A total of 15.6% of revenue is expended on sub-contracted or brokered services. This will include the purchases of goods and capital items.

HCP Results by Ownership

Table 6: Aggregate result by ownership based on FY19 ACFR HCP segment data

ACFR Profit and Loss Summary - FY19	Not-For-Profit (401 providers) $	For-Profit (248 providers) $	Government (88 providers) $	Total (737 providers) $
Revenue	1,804,945,606	527,333,817	148,903,309	2,481,182,732
Expenses	1,727,287,869	522,437,429	138,065,717	2,387,791,015
Net Profit Before Tax	**$ 77,657,737**	**$ 4,896,388**	**$ 10,837,592**	**$ 93,391,717**
Profit Margin	*4.3%*	*0.9%*	*7.3%*	***3.8%***
Average result by provider	**$ 193,660**	**$ 19,744**	**$ 123,154**	**$ 126,719**

[3] It is apparent from an examination of the data, and the timing of it, that the ACFR data is still to undergo a data cleansing process to increase its level of accuracy

[4] Aggregate of all information for the 737 providers that submitted complete data in the HCP segment note in the ACFR

Overall the average profit per AP based on the FY19 ACFR segment data is higher for the Not-For-Profit providers than for the For-Profit providers. This confirms the EBITDA per package data extracted from the 2019 ACFA Annual Report *(based on the FY18 financial results)* where the Not-For-Profit providers achieved an average EBTDA per consumer of $1,358 and the For-Profit providers averaged $169 EBITDA per consumer.

It is noteworthy that of the total interest expense of $6,947,132 (refer *Table 10*) incurred by APs, 89% is incurred by the For-Profit providers. This would strongly indicate that the For-Profit sector is more likely to use external sources of finance to fund working capital requirements and may not maintain the same level of liquid assets as the Not-For-Profit providers.

Revenue and Expenses for Providers based on Positive or Negative Net Profit Before Tax

Of those 737 APs that have submitted an completed ACFR at 30 June 2019, 221 had a negative result and 516 had a positive net profit before tax or a break even result as summarised below.

Table 7: ACFR data for 2019 (as submitted at 11 November 2019) broken down by positive and negative NPBT

ACFR Profit and Loss Summary - FY19	Providers with Positive NPBT (516 providers) $	% of Revenue	Providers with Negative NPBT (221 providers) $	% of Revenue
Revenue:				
Provision of care / services	1,184,987,289	*67.4%*	490,808,042	*67.8%*
Client / case management fees	233,789,974	*13.3%*	111,209,051	*15.4%*
Administration fees	286,444,890	*16.3%*	98,663,370	*13.6%*
Exit fees	3,460,709	*0.2%*	1,765,364	*0.2%*
Other revenue	48,703,300	*2.8%*	21,350,743	*2.9%*
Total revenue	1,757,386,162	*100.0%*	723,796,570	*100.0%*
Expenses:				
Staff costs - direct care	669,605,156	*38.1%*	303,929,641	*42.0%*
Staff costs - other	214,821,156	*12.2%*	128,686,873	*17.8%*
Care related expenses	172,274,291	*9.8%*	95,073,685	*13.1%*
Sub-contracted or brokered client services	272,868,833	15.5%	114,697,225	15.8%
Administration costs and management fees	209,665,356	*11.9%*	112,653,632	*15.6%*
Depreciation expense	9,943,112	*0.6%*	6,556,915	*0.9%*
Interest expense	1,879,389	*0.1%*	5,067,743	*0.7%*
Other expenses	42,184,062	*2.4%*	27,883,946	*3.9%*
Total expenses	1,593,241,355	*90.7%*	794,549,660	*109.8%*
Net Profit Before Tax	**$ 164,144,807**	***9.3%***	**$ (70,753,090)**	***(9.8%)***

The APs that made a profit or break-even result (as reported in the ACFR), the average profit margin on revenue was 9.3%. This represents the difference between the cost of providing the services to care recipients and the actual price charged to those care recipients.

This would indicate that, for those APs, the cash flow effect as a result of the discount of 7.5% on the subsidy amount received (representing the actual services delivered - refer *Table 2*), once the drawdown of unspent funds commenced in Phase 3 of the implementation process, will still provide sufficient working capital cash flows for the AP to be able to cover the costs of providing services, in the circumstance that they currently do not have all unspent funds balances represented by liquid assets.

Total unspent funds for those loss-making APs was $245.6 million at 30 June 2019 and the total cash and liquid assets at that date was $495.8 million, a ratio of 2:1 on average. A deeper analysis of the cash and subsidy coverage is included in the following *Section 6* of this report.

Approved Providers with Positive Net Profit Before Tax by Ownership

For those APs who declared a profit for FY19 the stratification by ownership is as follows:

Table 8: Aggregate result by ownership for those APs with positive NPBT based on FY19 ACFR HCP segment data

ACFR Profit and Loss Summary - FY19	Not-For-Profit (281 providers) $	For-Profit (177 providers) $	Government (58 providers) $	Total (516 providers) $
Revenue	1,271,708,905	371,404,606	114,272,651	1,757,386,162
Expenses	1,160,323,730	333,144,713	99,772,912	1,593,241,355
Net Profit Before Tax	**$ 111,385,175**	**$ 38,259,893**	**$ 14,499,739**	**$ 164,144,807**
Profit Margin	*8.8%*	*10.3%*	*12.7%*	*9.3%*

In this instance the For-Profit providers achieved a slightly higher margin than the Not-For-Profit providers, however they made a significantly higher negative margin than the Not-For-Profit providers when they achieved a deficit result as shown in *Table 9*.

Approved Providers with Negative Net Profit Before Tax by Ownership

Table 9: Aggregate result by ownership for those APs with negative NPBT based on FY19 ACFR HCP segment data

ACFR Profit and Loss Summary - FY19	Not-For-Profit (120 providers) $	For-Profit (71 providers) $	Government (30 providers) $	Total (221 providers) $
Revenue	533,236,701	155,929,211	34,630,658	723,796,570
Expenses	566,964,139	189,292,716	38,292,805	794,549,660
Net Profit (Loss) Before Tax	**$ (33,727,438)**	**$ (33,363,505)**	**$ (3,662,147)**	**$ (70,753,090)**
Profit Margin	*(6.3%)*	*(21.1%)*	*(10.6%)*	*(9.8%)*

It is these APs with a negative profit margin that may be considered to be at greater risk of not being able to sustain the transition to payments being made in arrears or the eventual drawdown of unspent funds over time.

Having a negative profit margin within the HCP segment, does not categorically mean that the AP will be at risk financially as a result of changes to the payment arrangements. Rather it is likely to be a combination of ongoing negative profits, insufficient liquidity and lack of working capital or equity underpinning the business that will cause the provider to be vulnerable to any impacts of a change in payment arrangements.

While the margin overall for APs with an operating loss is negative 9.8%, the For-Profit providers have a higher negative margin (minus 21.1%) than the Not-For-Profit or Government providers. One reason for this is the significant interest burden carried by the For-profit providers compared to the other AP cohorts.

The total interest burden across the 71 For-Profit providers who made a loss is $4,978,654 which is considerably greater on average than the $1,197,142 in interest costs accumulated by the 203 For-Profit providers who made a profit (refer *Table 10*).

Of the total of 248 For-Profit providers, 91 or 36.7% of those APs disclosed an interest cost which averaged $67,866 per AP of the FY19 year. The average interest burden for those For-Profit providers that made a negative NPBT was $237,079 per AP. The average for the 70 APs that made a profit was $17,102 per AP.

Table 10: Analysis of interest costs comparing For-Profit providers and Not-For-Profit providers

	Total number of Providers	Number of Providers with interest expense	Proportion of total %	Total interest cost $	Average interest cost per applicable Provider $
For-Profit providers					
NPBT > $0	177	70	*39.5%*	1,197,142	17,102
NPBT < $0	71	21	*29.6%*	4,978,654	237,079
Total	**248**	**91**	***36.7%***	**$ 6,175,796**	**$ 67,866**
Not-For-Profit providers					
NPBT > $0	281	14	*5.0%*	656,868	46,919
NPBT < $0	120	5	*4.2%*	89,089	17,818
Total	**401**	**19**	***4.7%***	**$ 745,957**	**$ 39,261**

This data indicates that those For-profit providers that are making a negative NPBT are utilising a greater level of external financing compared to those APs making a profit.

In contrast, only 4.7% of the Not-For-Profit providers have incurred an interest cost and the greater proportion of these are APs who are achieving a positive NPBT. There is certainly a lesser reliance on debt financing in the Not-For-Profit sector than there is in the For-Profit sector.

5.2 Financial Sustainability - Conclusion

The financial performance of the HCP sector has slightly deteriorated in FY19 where the average return is $1,182 per care consumer per annum based on the ACFR data provided at the time of this analysis. Of the 649 APs reviewed (government providers were excluded) some 458 (70.6%) recorded a net profit before tax, and, conversely, 191 (29.4%) recorded a loss before income tax.

The impact of requiring additional borrowings and resultant interest expense to support the additional cash flow requirements will effect 110 of the APs reviewed, however 91 APs of this cohort recorded a profit which could be used to reduce their level of borrowings over time.

Ongoing financial performance will continue to be directly linked to each APs respective business model, service revenue achieved, pricing policies, appropriate cost management, scale of operation and capital and equity structure.

The overall financial performance for APs, other than the potential additional interest expense and possible interest revenue earned on unspent funds, will not be materially impacted by the proposed changes to funding arrangements in our opinion. APs record revenue based on actual service delivery rather than subsidy received, and this treatment will remain under any amended funding amendments. Unspent funds (subsidy) is recorded as a liability and has no impact on the financial operating results.

6. Detailed Impact Analysis

6.1 Methodology Used for Detailed Analysis of FY19 ACFR data

For the remainder of the analysis where the financial data is examined on a far more granular level, a number of APs have been removed from the analysis as follows:

(a) Government Home Care providers *(88 APs)*
(b) APs that did not provide important data items for the purpose of this analysis such as cash balances, unspent funds balances *(114 APs)*
(c) APs that did not receive, or report having received any home care funding for FY19 *(67 APs previously excluded from the 804 APs lodging an ACFR)*

For the purpose of performing analysis based on the size of an AP, they have been grouped in revenue bands based on subsidies received as follows:

Table 11: Category by funding size

Category	FY19 Home Care Package (HCP) Funding	Number of Providers in 2018-19	%
Very small	Less than or equal to $550,000	206	38.5%
Small	Between $550,000 and $2,000,000	168	31.4%
Medium	Between $2,000,000 and $5,000,000	90	16.8%
Large	More than $5,000,000	71	13.3%
Sub-total	**Used for Detailed Analysis**	**535**	**100.0%**
Government	Excluded (a)	88	
Excluded	Key data not provided (b)	114	
Total		**737**	

Liquid assets include operating cash balances, deposits with Authorised Deposit taking Institutions; financial assets (managed funds, equity investments or similar publicly traded securities) and excludes any related party receivables as these are not considered to be liquid or readily redeemable.

It should be noted that the analysis for the HCP segment data is based on the liquid financial assets allocated to the Home Care segment. In many cases it is clear that the amount that has been allocated to the segment is equal to the unspent funds balance. It is likely that most of these APs will have additional sources of cash and liquid assets at the provider (consolidated) level.

StewartBrown data has been used to supplement the FY19 ACFR data where appropriate to provide a further level of analysis and to support, or contradict as may be the case, the information provided in the ACFR. StewartBrown data has undergone a comprehensive data cleansing process to ensure its accuracy. At the time of receiving the ACFR data, this would not have been able to take place for all data received.

6.2 Impact of Phase 1 - Deferring Payment of the Normal Subsidy for One Month

In Phase One of the implementation process it is proposed that in June 2020 DHS (Medicare) will pay the normal HCP subsidy due to APs at the end of the month instead of at the beginning of the month. In effect this is the transition to an arrears payment system and the effect will be to defer the cash flow from the Government subsidy, less any ITCF for one month

Impact on Approved Providers

While the deferral of the payment will affect the timing of cash flows for all APs, a vulnerable AP will be one that will not have sufficient working capital to sustain that cash flow effect.

The normal cash flows of APs on a monthly basis, as they currently stand are typified as follows:

Table 12: Illustration of the typical timing of cash flows for a Home Care Provider

Cash flow	Beginning of the Month	During the Month	End of the Month
Bill clients Basic Daily Fee	✓		
Bill clients for ITCF	✓		
Receipt of subsidy in advance	✓		
Pay suppliers		✓	✓
Pay employees		✓	✓
Refunds to client on exit		✓	✓

At present the majority of the cash flow is derived at the beginning of the month and that in effect provides the working capital for the business for the remainder of the month. The subsidy in advance (which includes unspent funds) are utilised to provide the working capital for the business.

The purpose of unspent funds should be to provide sufficient funds that if a care recipient requires additional services, or needs to make a capital purchase under their package, there are sufficient funds available to the care recipient to do so. Prudentially, those funds should be available for use by the care recipient, or to be refunded to government and care recipient should they leave HCP or transfer to another AP.

The typical business model requires the owners to have sufficient working capital to sustain the business. Most businesses are built on the premise of either being paid at the time of supplying the service (retail) or within trade terms if the service is supplied on account. Very few business models would exist where funding is extended by the taxpayer in advance to fund the business owner for the provision of services over a period of time.

Should payments be changed over to an arrears system, the initial impact will be on the ability of the AP to continue to pay their operating costs such as wages, third party suppliers, rent etc for one month until the subsidy payment (which initially will be the gross subsidy amount as is currently the case) is paid.

The monthly operating costs equal to the difference between the revenue charged to the care recipient budget less the profit margin on that revenue.

The following analysis looks at various groupings of APs and assesses whether there are sufficient liquid assets held by the AP (as recorded in the Home Care Segment note in the ACFR) to cover the average monthly operating costs.

Sector Operating Cost Cover Based on Size of Approved Provider

The first level of analysis examines the liquid assets coverage of operating costs of APs based on the level of subsidy they currently receive.

Table 13: Analysis of liquid asset coverage for one month's cost of operations

Category	Number of Providers	Average Monthly Revenue $	Average Monthly Margin $	Average monthly cost to fund operations $	HCP Segment Liquid Assets	Segment Liquid Assets / 1 month's operational cost
Very small	206	27,694	179	27,515	707,154	*25.7*
Small	168	117,876	8,146	109,730	1,059,635	*9.66*
Medium	90	270,899	22,334	248,566	2,992,682	*12.04*
Large	71	1,292,623	21,879	1,270,743	11,076,027	*8.72*
Total	**535**	**$ 264,795**	**$ 9,287**	**$ 255,508**	**$ 2,578,377**	***10.09***

Based on this analysis, on average there should be sufficient liquid assets held by providers to transition from payments in advance to payments in arrears.

Table 14: Analysis of liquid asset coverage of one month's operational costs where negative margins

Category	Number of Providers	Average Monthly Revenue $	Average Monthly Margin $	Average monthly cost to fund operations $	HCP Segment Liquid Assets	Segment Liquid Assets / 1 month's Operational cost
Very small	82	16,181	(7,090)	23,271	1,217,418	*52.32*
Small	32	101,884	(19,226)	121,110	1,447,845	*11.95*
Medium	15	237,396	(14,200)	251,596	5,894,037	*23.43*
Large	19	1,694,238	(164,574)	1,658,812	12,423,361	*6.68*
Total	**148**	**$ 272,558**	**$ (30,652)**	**$ 303,210**	**$ 3,179,823**	***10.49***

For those APs with a negative profit margin, there is on average sufficient liquid assets to transition from payment in advance to payment in arrears in that those liquid assets will cover at least one month's operating costs to provide services to care recipients.

Of the 535 APs in the sample analysed, there are a total of 58 (11%) of APs that have a liquid asset to operating cost ratio of less than 1. This is stratified by size of AP as follows:

Table 15: Number of APs with liquid assets to operating cost ratio of less than 1

Category	Number of Providers	Number of Providers with liquid assets to operating cost ratio < 1	% of Total
Very small	206	27	*13%*
Small	168	21	*13%*
Medium	90	3	*3%*
Large	71	7	*10%*
Total	**535**	**58**	***11%***

These APs are also likely to have negative liquid assets to unspent funds balances which means that they may have a prudential risk of not being able to refund unspent funds when the time comes, or they have other financing arrangements. It should also be noted that once again, this analysis is using the cash and financial assets at the *home care segment level*.

In order to form an overall conclusion, further analysis would be required based on the liquid assets held at AP level for all home care APs.

This information is likely to be available if recommended changes to the information to be collected in ACFRs in the future are adopted. As part of recommendations before the Department included in the review of the current Prudential Regulations, it has been proposed that all providers of funded aged care services will be required to provide data at an Approved Provider (consolidated) level, not just residential aged care providers as currently required.

This additional information will enable an additional layer of analysis of the total assets and liabilities of each AP that is not currently available for home care APs (nor CHSP providers). While this data would not be available prior to the changeover to providing the full subsidy in arrears in June 2020, it should be available (subject to the ACFR recommendations being adopted) prior to the phasing in of the full changes to the subsidy arrangements in April 2021.

While the changes to the DHS payment system should be minimal in Phase 1 of the implementation process as the changes only relate to the timing of the payment rather than how the payment is calculated, the changes to the system for Phases 2 and 3 will be significant.

It will be critical to the sector that these proposed changes to the funding arrangements do not cause long delays in processing claims by DHS from APs to be paid. There are far more smaller APs in the sector since June 2017 and these smaller APs will be more vulnerable to long delays in processing claims and making payments.

Analysis by Region

A regional analysis is less conclusive with home care data as a result of the different ways in which APs report. Many APs are also operating in regions where they may not be physically based and using brokered services to deliver services. We have adopted the same categories for grouping by region as that used by ACFA as follows:-

- City
- Regional
- City and regional

Table 16: AP Category by Region

Region	Number of Providers in 2018-19	%
City	349	*47%*
Regional	168	*23%*
City & Regional	18	*2%*
Sub-total	**535**	***73%***
Government and excluded	202	*27%*
Total	**737**	***100%***

Within each regional designation there is, on average, sufficient liquidity to cover operating costs for one month while payment systems are transferred. It should be noted of the 18 APs that operate across City and Regional areas, 13 of them are large APs.

Table 17: Regional analysis of APs ability to continue to pay operating costs while subsidy payments are deferred

Category	Number of Providers	Average Monthly Revenue $	Average Monthly Margin $	Average monthly cost to fund operations $	HCP Segment Liquid Assets	Segment Liquid Assets / 1 month's Operational cost
City	349	247,578	9,160	238,419	2,173,244	*9.12*
Regional	168	155,261	1,322	153,939	1,614,329	*10.49*
City & Regional	18	1,620,920	86,102	1,534,818	19,431,242	*12.66*
Total	**535**	**$ 264,795**	**$ 9,287**	**$ 255,508**	**$ 2,578,377**	***10.09***

The majority of APs that have a liquid asset to operating cost ratio less than one are situated in the City regions. Four of the 18 APs that operate across the City and Regional areas have ratios less than 1. Of these one is very small and the other three are large APs. The three large APs all operated residential care as well as home care and each of them have a liquid asset to operating cost ratio significantly greater than one when assessed using their overall liquid assets.

Table 18: Number of providers by region with a liquid asset to operating cost ratio less than 1

Category	Number of Providers	Number of providers with liquid assets to operating cost ratio < 1	% of Total
City	349	40	*11%*
Regional	168	14	*8%*
City & Regional	18	4	*22%*
Total	**535**	**58**	***11%***

Analysis by Number of Services

ACFA uses the following split which we have also adopted as follows:-

- Single service
- Two to six services
- Seven or more services

Table 19: AP Category by number of services (separate programs)

Category	Number of Providers in 2018-19	%
Single service	392	*53%*
Two to six services	92	*12%*
Seven or more services	51	*7%*
Sub-total	**535**	***73%***
Government and excluded	202	*27%*
Total	**737**	***100%***

The results of this analysis also follows the same pattern as when APs were grouped in bands by subsidy received where the smaller APs have a slightly higher cash coverage than some of the larger APs. This is reversed however, if the analysis is done at the AP consolidated level as shown in the past where many of the larger APs also operate residential aged care services.

Table 20: Analysis of APs ability to pay operating costs while subsidy payments are deferred (based on services)

Category	Number of Providers	Average Monthly Revenue $	Average Monthly Margin $	Average monthly cost to fund operations $	HCP Segment Liquid Assets	Segment Liquid Assets / 1 month's Operational cost
Single service	392	93,875	6,145	87,730	955,493	*10.89*
Two to six services	92	320,308	18,532	301,777	3,380,314	*11.20*
Seven or more services	51	1,478,386	16,762	1,461,624	13,605,680	*9.31*
Total	**535**	**$ 264,795**	**$ 9,287**	**$ 255,508**	**$ 2,578,377**	***10.09***

The smaller and larger APs have a slightly higher proportion of their groups with a ratio less than 1. As commented upon above, this is mitigated in respect to the larger APs as most of these have other business streams and hold sufficient liquid assets at their consolidated level. This may not be the case with the smaller APs, however this can't be ascertained without access to their consolidated financial statements.

Table 21: Number of APs by region with a liquid asset to operating cost ratio less than 1

Category	Number of Providers	Number of providers with liquid assets to operating cost ratio < 1	% of Total
Single service	392	47	*12%*
Two to six services	92	5	*5%*
Seven or more services	51	6	*12%*
Total	**535**	**58**	***11%***

Analysis by Ownership Structure

ACFA reporting defines ownership categories which we have also adopted as follows:-

- Not for profit
- For profit
- Government

  Government providers have been excluded from our analysis

Table 22: AP Category by ownership

Category	Number of providers in 2018-19	%
Not for Profit	307	*42%*
For Profit	228	*31%*
Sub-total	**535**	***73%***
Government and excluded	202	*27%*
Total	**737**	***100%***

Table 23: Analysis of APs ability to pay operating costs while subsidy payments are deferred (based on ownership)

Category	Number of Providers	Average Monthly Revenue $	Average Monthly Margin $	Average monthly cost to fund operations $	HCP Segment Liquid Assets	Segment Liquid Assets / 1 month's Operational cost
Not for Profit	307	325,569	15,478	310,091	3,570,331	*11.51*
For Profit	228	182,962	952	182,011	1,242,720	*6.83*
Total	**535**	**$ 264,795**	**$ 9,287**	**$ 255,508**	**$ 2,578,377**	***10.09***

The Not-For-Profit providers have a more favourable level of coverage than the For-Profit providers and this is expected. It was observed in earlier analysis that the For-Profit sector relied more heavily on debt than the Not-For-Profit sector based on the level of interest paid by the For-Profit providers. They are more likely to use debt for working capital purposes whereas the Not-For-Profit sector is more likely to use internally generated liquidity to provide working capital.

Table 24: Number of APs by ownership with a liquid asset to operating cost ratio less than 1

Category	Number of Providers	Number of Providers with liquid assets to operating cost ratio < 1	% of total
Not for Profit	307	27	*9%*
For Profit	228	31	*14%*
Total	**535**	**58**	***11%***

Other Factors

In previous analysis, there has been some comparison between liquid assets at the AP consolidated level where that information is available, which at present, is only for those APs that also operate residential aged care services. The following analysis breaks down the data by APs who do have residential aged care services and those that don't.

Table 25: Category by AP type

Category	Number of providers in 2018-19	%
Operate residential aged care homes	143	*19%*
Don't operate residential aged care homes	392	*54%*
Sub-total	**535**	***73%***
Government and excluded	202	*27%*
Total	**737**	***100%***

Table 26: Regional analysis of APs ability to continue to pay operating costs while subsidy payments are deferred

Category	Number of Providers	Average Monthly Revenue $	Average Monthly Margin $	Average monthly cost to fund operations $	HCP Segment Liquid Assets	Segment Liquid Assets / 1 month's Operational cost
Operate residential aged care homes	143	444,560	19,941	424,618	5,491,427	*12.93*
Don't operate residential aged care homes	392	199,217	5,401	193,817	1,515,709	*7.82*
Total	**535**	**$ 264,795**	**$ 9,287**	**$ 255,508**	**$ 2,578,377**	***10.09***

Those APs that operate both residential aged care and home care services have significantly more coverage of the operating costs by liquid assets than those APs that do not operate residential aged care homes. In any event, on average there are still sufficient liquidity held by both cohorts to support a months transition to payment in arrears.

The proportion of APs that have less than one months operating costs held in liquid assets is spread evenly across the two types of APs (based on their overall numbers).

Table 27: Number of APs by region with a liquid asset to operating cost ratio less than 1

Category	Number of Providers	Number of providers with liquid assets to operating cost ratio < 1	% of Total
Operate residential aged care homes	143	16	*11%*
Don't operate residential aged care homes	392	42	*11%*
Total	**535**	**58**	***11%***

For those APs that also operate aged care homes, consolidated AP level financial data is available. At that level, the number of APs that have a liquid asset to operating cost ratio of less than one falls to 2 APs. These are both Religious entities that have cash and financial assets in a separate vehicle to the property trust that holds the AP licence.

Supplementary Analysis - Using StewartBrown *Survey* data set

The StewartBrown *Survey* data for FY18 for 6 home care APs who do not operate residential aged care homes the average liquid assets to the average monthly HCP operating costs was 36.34 times. The minimum was 6.41 times and the maximum was 72.68 times.

In contrast, the ACFR data extracted from the Home Care segment note provided the following results:

- Average liquid assets to monthly expense ratio = 1.53 times
- Minimum liquid assets to monthly expense ratio = 0.65 times
- Maximum liquid assets to monthly expense ratio = 4.93 times

This further demonstrates that the cash and liquid assets declared as part of the ACFR Home Care segment note is likely to be considerably less than the total holdings of liquid assets at an AP (consolidated) level.

This also reinforces the future requirement for all APs, including HCP and CHSP providers, to submit within the ACFR financial information at both the segment level and the AP (consolidated) level as is currently required of all residential aged care providers.

Conclusion

On average, and across each cohort of APs, the results of this detailed impact analysis indicate that there are sufficient liquid assets held by at least 89% (477) of APs (from the data set of 535) to have sufficient cash flows to meet normal operating expenses for one month while the payment arrangements of the full subsidy transitions from being paid in advance to being paid in arrears.

The risk to APs is further mitigated by the fact that they will still be collecting care recipient contributions and income tested care fees at the beginning of each month in the majority of instances. This will provide a further cash flow buffer for APs.

The remaining 58 APs who may not have sufficient funds at the segment level also indicates that they are also unlikely to have sufficient funds to fully cover the balance of unspent funds currently held. This indicates that they are using unspent funds for working capital purposes, which was not the intention of HCP funding arrangements in our opinion. These APs will need to review their business model and equity structure to adapt to the new payment arrangements.

The other mitigating factors are that:

- For many of the APs, the liquid assets at AP (consolidated) level will be greater than that disclosed in the ACFR Home Care segment and the number of vulnerable APs should decrease significantly as a result
- There should be sufficient time under the proposed transition timetable for APs to consider their future working capital requirements as a result of the funding payments reform

Based on the detailed impact analysis performed, the HCP sector, and individual APs, should, with few exceptions, be able to sustain their business while the payment arrangements transition to the subsidy reimbursement in arrears from June 2020.

6.3 Impact of Phases 2 and 3

Phase two of the implementation process involves changing the way subsidies are paid to APs so that instead of the gross subsidy amount, less any income tested care fee, the payment to APs will be based on the amount of services supplied (charged) to care recipients in the previous month. In effect DHS will hold any unspent funds balance.

At the same time, DHS will start "recouping" the unspent funds currently being held by APs. At 30 June 2019 this is likely to total above $750 million. It is anticipated that DHS, through the payment process, will reduce the amount of subsidy paid to the AP in any given month by an as yet undetermined amount until the unspent funds balance held by the AP is exhausted. After that point DHS will pay the full amount claimed by the AP based on services supplied to the care recipients less any income tested fee, and any basic daily care fee charged to the care recipients.

Based on the information recorded on the ACFR home care segment note, there were 117 (22%) of the 535 APs that did not have liquid assets in excess of the balance of unspent funds held at 30 June 2019. While this appears to a significant number, as has been demonstrated throughout this report, these numbers will reduce significantly when liquid assets are measured at the AP (consolidated) level.

In this regard, of the 143 home care APs that also submitted AP (consolidated) level financial data in their ACFR (due to them also supplying residential aged care services) the following outcomes in relation to liquid asset coverage of the total unspent funds were:

Table 28: Analysis of liquid assets coverage of unspent funds for APs of both HCP and residential aged care (source: ACFR)

At the ACFR Home Care Segment Level	
Number of Providers	143
Total Unspent Funds at June 2019	$ 235,571,519
Total liquid assets declared in HCP segment note	$ 785,274,066
Average coverage (times)	3.33
Number of Providers with ratio less than 1	29
Proportion of total	*20.3%*
At the Approved Provider (consolidated) level	
Number of Providers	143
Total Unspent Funds at June 2019	$ 235,571,519
Total liquid assets declared in segment note	$ 7,071,413,248
Average coverage (times)	30.02
Number of Providers with ratio less than 1	8
Proportion of total	*5.6%*

Similar outcomes resulted from an analysis of the AP level data and ACFR data for 6 home care providers in the StewartBrown *Survey* for FY19. These APs did not have residential aged care, although they did have other business streams other than the delivery of services under home care packages.

Table 29: Analysis of liquid assets coverage of unspent funds for APs of both HCP and residential aged care (source StewartBrown Survey)

	$
At the ACFR Home Care Segment Level	
Number of Providers	6
Total Unspent Funds at June 2019	$ 18,685,866
Total liquid assets declared in HCP segment note	$ 8,517,561
Average coverage (times)	0.46
Number of Providers with ratio less than 1	6
Proportion of total	*100%*
At the Approved Provider (consolidated) level	
Number of Providers	6
Total Unspent Funds at June 2019	$ 18,685,856
Total liquid assets declared in segment note	$ 202,925,542
Average coverage (times)	10.86
Number of Providers with ratio less than 1	0
Proportion of total	*0%*

It is clear that the information declared on the ACFR in the Home Care segment note is likely to overstate the vulnerability of APs in holding sufficient cash to cover the total amount of unspent funds.

It is also very important to note that the proposal is not to request that APs refund the whole of the unspent funds balance to DHS. Instead it is proposed to draw down the unspent funds balance over time. This would be done by applying a "discount" to the revenue claimed each month.

Based on the outcomes in from the analysis, there are very few APs that should not be able to manage the drawdown in unspent funds given the existing liquid assets maintained by the APs. Even at a revenue reduction rate of 20%, there would only be 20 APs (4.3%) of the total of 535 APs analysed that would have insufficient cash balances to cover that loss in cash flow.

Given that this change will not occur until March 2021, there should be sufficient time for all APs to put their financial and capital requirements in order so that they can address any current shortfalls in liquid assets.

Conclusion

On the basis of the analysis testing conducted (refer *Table 30*), over 95% of APs could cater for a monthly reduction in subsidies equivalent to 20% of their monthly claim to DHS for services provided to care recipients, in order to repay the unspent funds they currently hold. 23 APs out of the total of 525 appear to have insufficient liquid asset levels to meet this criteria.

At a subsidy reduction rate of 7.5% that percentage rises to 97.6% with only 13 of 535 APs having insufficient liquid asset levels as reported on the ACFR home care segment note.

Using this basis for the analysis has the following outcomes for a variety of discount rates:

Table 30: Analysis of liquid asset coverage for reductions in revenue claims (due to draw down on unspent funds) by DHS

Sector in aggregate	Providers	Unspent Funds $'Millions	Segment Liquid Assets $'Millions	Average Monthly Revenue $'Millions	Ratio of unspent funds to Monthly Revenue	Ratio of Liquid Assets to Average Monthly Revenue	Ratio of Segment Liquid Assets to Average Monthly Revenue Reduction				
							Reduction of 7.5% of average Revenue	Reduction of 8.3% of average Revenue	Reduction of 10% of average Revenue	Reduction of 15% of average Revenue	Reduction of 20% of average Revenue
NFP	307	376.3	1,096.1	99.9	3.76	10.97	146.22	132.13	109.66	73.11	54.83
FP	228	125.4	283.3	41.8	3.01	6.79	90.56	81.83	67.92	45.28	33.96
Total	**535**	**$ 501.7**	**$ 1,379.4**	**$ 141.7**	**3.54**	**9.74**	**129.83**	**117.32**	**97.37**	**64.92**	**48.69**

Sector in aggregate	Providers	Months to Exhaust Unspent Funds Balance (assuming no exits)					Number of Providers with Liquid Asset to Average Monthly Revenue Reduction of Less than 1				
		Reduction of 7.5% of average Revenue	Reduction of 8.3% of average Revenue	Reduction of 10% of average Revenue	Reduction of 15% of average Revenue	Reduction of 20% of average Revenue	Reduction of 7.5% of average Revenue	Reduction of 8.3% of average Revenue	Reduction of 10% of average Revenue	Reduction of 15% of average Revenue	Reduction of 20% of average Revenue
NFP	307	50	45	38	25	19	9	9	9	12	13
FP	228	40	36	30	20	15	4	4	5	8	10
Total	**535**	**47**	**43**	**35**	**24**	**18**	**13**	**13**	**14**	**20**	**23**

7. Other Issues to Consider

7.1 Current Subsidy Claiming Process

In the current funding arrangements, subsidy funding is received in advanced based on the care recipient's assessed home care package (refer sections 2.1 and 2.2). In this respect, the subsidy funding received is at the gross amount less any income tested care fee. APs lodge a claim for these subsidies which is on an exception basis, that is they only need to enter any changes that have occurred since the previous claim such as exits, persons on hospital leave and new care recipients.

The gross amounts for each package level, current as at 20 September 2019 is as follows:

Package Level	Daily Rate	Annual Amount
Home Care - Level 1 package	$24.07	$8,785.55
Home Care - Level 2 package	$42.35	$15,457.75
Home Care - Level 3 package	$92.16	$33,638.40
Home Care - Level 4 package	$139.70	$50,990.50

APs are entitled to charge a co-contribution to the care recipient, and this amount is included in the overall home care package budget. The full amount of the co-contribution is not levied in many instances for a variety of reasons. Currently the maximum basic daily fee that can be charged for each package level is as follows:

Package Level	Daily Rate	Annual Amount
Home Care - Level 1 package	$9.52	$3,474.80
Home Care - Level 2 package	$10.07	$3,675.55
Home Care - Level 3 package	$10.35	$3,777.75
Home Care - Level 4 package	$10.63	$3,879.95

Based on the current subsidy levels and maximum daily fee chargeable the full package value for each package level is as follows:

Package Level	Annual Subsidy	Annual Basic Daily Fee	Total Package Value	Subsidy as % of Total	BDF as % of Total
Home Care - Level 1 package	$8,785.55	$3,474.80	$12,260.35	71.7%	28.3$
Home Care - Level 2 package	$15,457.75	$3,675.55	$19,133.30	80.8%	19.2%
Home Care - Level 3 package	$33,638.40	$3,777.75	$37,416.15	89.9%	10.1%
Home Care - Level 4 package	$50,990.50	$3,879.95	$54,870.45	92.9%	7.1%

In addition to the basic subsidy and basic daily fee there are a variety of supplements available as follows:

Home Care Supplements

1. Dementia and Cognition and Veterans' Supplement

Home Care Package Level	Amount of Supplement
Level 1	$2.77
Level 2	$4.87
Level 3	$10.60
Level 4	$16.07

2. EACHD Top Up Supplement

Eligibility	Amount of Supplement
For consumers who were in receipt of an EACHD package on 31 July 2013	$2.77

3. Oxygen and Enteral Feeding Supplements

Supplement	Amount of Supplement
Oxygen Supplement	$11.72
Enteral Feeding Supplement – Bolus	$18.57
Enteral Feeding Supplement – Non–bolus	$20.86

4. Home Care Viability Supplement

Modified Monash Model rates

These rates are applicable from 1 July 2019 to 30 June 2020

MMM Classification	Amount of Supplement
MMM 1,2,3	$0.00
MMM 4	$1.06
MMM 5	$2.35
MMM 6	$15.59
MMM 7	$18.71

ARIA rates

These rates are applicable from 1 July 2019 to 30 June 2020

ARIA Score	Amount of Supplement
ARIA Score 0 to 3.51 inclusive	$0.00
ARIA Score 3.52 to 4.66 inclusive	$5.53
ARIA Score 4.67 to 5.80 inclusive	$6.63
ARIA Score 5.81 to 7.44 inclusive	$9.28
ARIA Score 7.45 to 9.08 inclusive	$11.14
ARIA Score 9.09 to 10.54 inclusive	$15.59
ARIA Score 10.55 to 12.00 inclusive	$18.71

These rates apply to care recipients who entered a Home Care Package on or before 31 December 2016, who would otherwise qualify for a lower rate of payment under the Modified Monash Model rates (subject to receiving care in the same location).

7.2 Transaction Flows and Revenue Recognition

Currently, the receipt of subsidy and the billing of care recipients does not precipitate (or should not precipitate) the recognition of revenue for the AP. Rather this is in effect a billing exercise where a claim is made on DHS through the Medicare portal and care recipients are billed separately.

In the case of the DHS, the subsidy payment is remitted in advance based on the number of packages lodged by each AP via the portal and adjusted by the means tested fees and any movements processed for the AP in the previous month.

In the case of the care recipient, they are either billed in advance or arrears (dependent upon the particular AP software and internal processes) and calculated on the agreed amount basic daily fee levied as well as any income tested care fee (noting that depending on the level of unspent funds held for a care recipient an AP may decide to stop charging the care recipient the income tested fee amount as well).

At this point all funds received by the AP should be recorded as being an unspent funds liability. No revenue should be recognised by the AP until they satisfactorily supply the agreed services to the care recipient. This is when revenue recognition occurs in the books of the AP (being the amount charged against the care recipient budget or package funds) for those services including any goods purchased, or capital expenditure made on the care recipient's behalf.

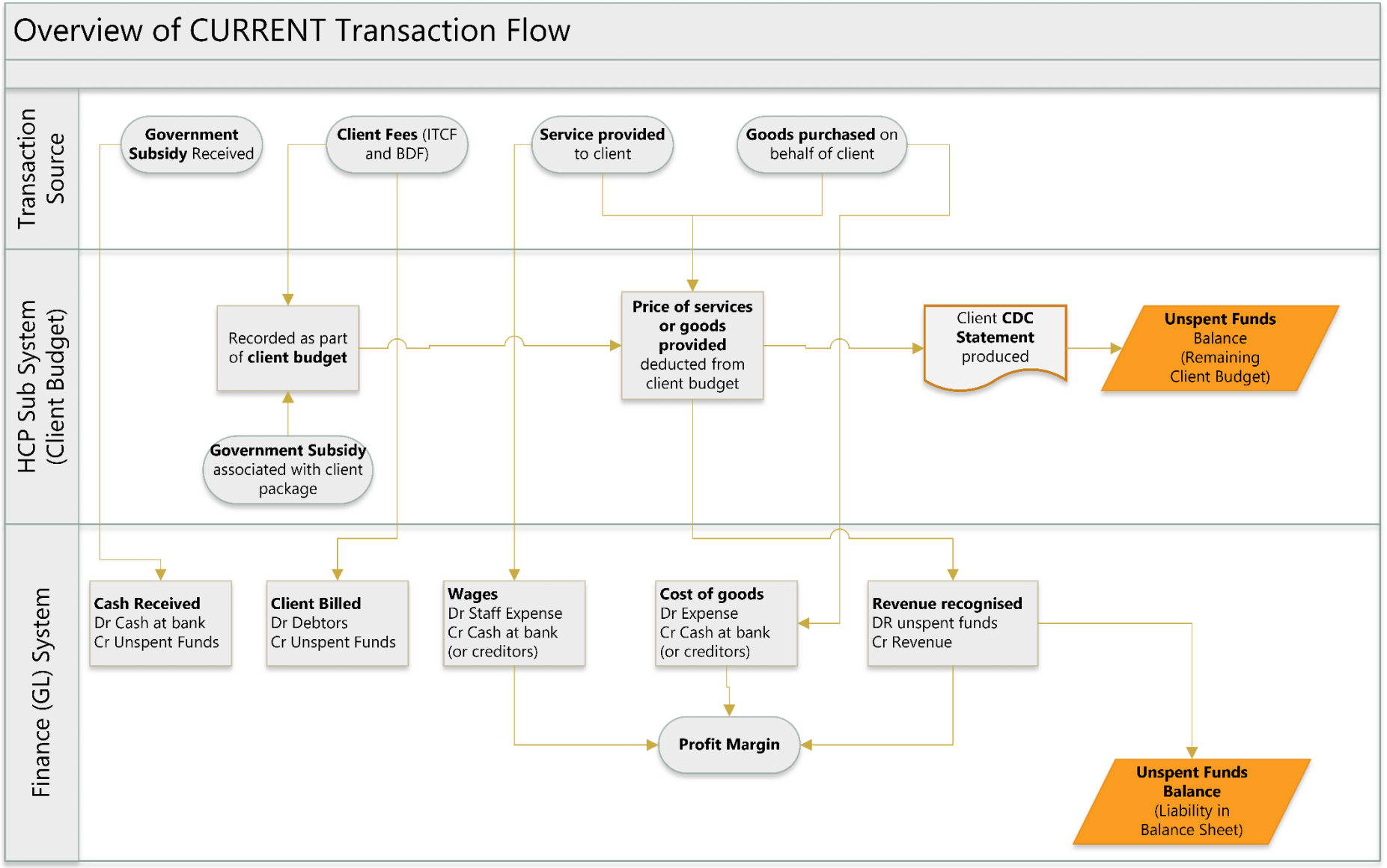
The monthly CDC statement to care recipients should itemise the following at a minimum:-

- Opening balance of unspent funds
- Subsidy received
- Income tested care fee contributed by the care recipient
- Basic daily fee contributed to the package by the care recipient
- Itemised list of services provided at the "sale price" including care management and package management (administration) fees
- Itemised list of any third party goods or services provided
- Closing balance of unspent funds

Currently this information is used to recognise revenue internally and to reconcile unspent funds between the HCP subsidiary software and the finance system.

When a care recipient leaves a HCP (transition to residential care or death), the AP must remit to DHS the subsidy portion of the unspent funds and remit to the care recipient (or estate) the co-contribution portion of the unspent funds. This requires a calculation of the total subsidy amount received as a percentage of the total package amount (subsidy plus co-contribution) to ensure that the refunds are calculated correctly.

Figure 9: Flowchart of current transaction flows for subsidies, care recipient fees and services provided



7.3 Proposed Funding Arrangements

The proposed system countenances that subsidies will be paid in arrears to the AP based on the actual services provided to the home care recipient.

Other than the short term cash flow impact of the subsidy payment change which is considered in this report, the proposed funding arrangements should have little or no impact on the systems and transaction processes of APs *unless they are required to transmit the amounts being claimed for services provided individually for each care recipient.*

The reimbursement funding calculation will be required to exclude the care recipient co-contribution portion, and accordingly, the APs may be required to amend their processes to allow this to be calculated. As noted above, this calculation is already made at the point of a care recipient departing the service, but would now have to be calculated each month.

If the Government, through DHS (Medicare) required APs to submit each claim at the individual care recipient level (similar to NDIS funding), this could result in considerable additional work, not only in making the claim but also reconciling the reimbursed funding receipt to the claim on a care recipient by care recipient basis.

While it reasonable to expect APs to extract from their respective home care subsidiary systems the aggregate amount for the monthly in arrears funding claim to DHS, a major concern that needs to be strongly considered is in relation to the potential additional workload. The considerations include:-

- Currently there is no B2B functionality in relation to the HCP subsidy claiming system, and many smaller APs currently do not use software conducive to making B2B transactions in any event. Many smaller APs are still using off-the-shelf software complimented by Excel spreadsheets to manage care recipient transactions
- Currently the subsidy claiming system is operated on an exception basis. The transition to a system where transactions have to be transmitted every month for all individual care recipients would be a major shift in policy and a significant additional burden on APs
- The reconciliation process between the claim to DHS and the subsidy reimbursement from DHS would be far easier in aggregate than it would on a care recipient by care recipient basis, particularly if there was no B2B capability and limited automated ability to reconcile payment advices within the HCP software module

If there was a valid reason for requiring APs to lodge claims at the care recipient level, we would suggest that this requirement be delayed until later stage once the initial transition to claiming in arrears had been completed.

We <u>strongly recommend</u> that subsidy claiming be conducted based on the aggregated data for the APr.

Care Recipient Basic Daily Fee and Income Tested Fees

Currently the monthly CDC Statement does not separately identify the subsidy and co-contribution portion in relation to care services delivered (including case management, package management, sub-contract brokerage etc).

Under the proposed new funding arrangements being considered, the AP will have to advise DHS of the subsidy portion of the service delivery, aggregated by care recipient (client) for the month.

Consideration will be required as to the process to calculate how the claims to the DHS are to be made based on the actual services supplied to each care recipient, including whether the ITCF and BDF are to be separately accounted for in the claiming process.

We recommend that, irrespective of whether a claim is made in aggregate or at the care recipient level, the following methodology be used:

- Funding reimbursement claim is made by the AP based on the services delivered
- DHS deducts the gross amount of ITCF relevant to that AP (irrespective of whether the care recipient has been charged the ICCF by the AP)
- DHS deducts the maximum amount of the BDF chargeable to the care recipient (irrespective of whether the care recipient has been charged the BDF by the AP)

This methodology has a number of advantages:

- Encourages all APs to fully charge the ITCF and BDF to all care recipients (unless they chose to forego this as a business decision)
- The total contribution to the overall HCP funding pool by the consumer (care recipient) will increase, making that pool of funds larger overall
- The claiming and reconciliation process by both the AP and DHS should be more streamlined as a result

Figure 10: Flowchart of future transaction flows for subsidies, care recipient fees and services provided