Australian Government
Department of Health and Aged Care

Home Care Packages Program Assurance Review No 1 – Indirect and Care Management Charges

Public Summary Report – August 2022

Executive summary

The Home Care Packages (HCP) Program provides support to older Australians with complex needs to help them stay at home. As at December 2021, there were 911 approved HCP providers. The Program's estimated expenditure for 2022–23 is around $6.5 billion, with nearly 275,600 people expected to receive a HCP by the end of 2022–23.

With growing demand for these HCPs, it is imperative that care recipients and the Government (on behalf of taxpayers) have confidence that funds are being spent for the purpose intended. There remains public concern that HCP 'administrative' charges are high. HCP Program Assurance commenced in 2021 to underpin the Government's plan to improve aged care and boost transparency and accountability in the sector. The inaugural Program Assurance Review (the Review), the subject of this report, focused on care management and indirect charges (together often referred to incorrectly as 'administrative charges' or 'indirect charges'[1]).

For the inaugural Review, the in-house Review team of accredited Review officers examined about 16,000 documents for around 1,000 care recipients and 100 providers. These providers together represent approximately 11% of the total HCP providers, covering around 60% of HCP care recipients. In undertaking this Review, the team tried to 'walk in the shoes' of providers and care recipients to understand what providers are charging, why, whether their approach is consistent with relevant HCP Program requirements, and whether providers are consistently applying their pricing methodology to variable charges across the sampled care recipients.

This public summary report contains general findings and observations and does not include commercial-in-confidence information.

Overall, the Review found that many providers are doing, or intend to do, the right thing by care recipients and taxpayers. Providers appreciated receiving clarity through the Review process on some important HCP Program requirements (for example, whether $0 can be charged for care management, or whether a percentage can be listed for third-party invoice processing surcharge). The Review team notes, with appreciation, that some providers proactively commenced improvements to their pricing transparency arrangements even before their individual report was finalised. Many updated their pricing schedules on My Aged Care.

[1] It is important to establish up front that care management is a specific support service type rather than an indirect charge.

The Review found considerable variation across providers in indirect and care management charges. While not part of the Review of providers, given the relevance to the topic, the Review team analysed the prices published on My Aged Care (as at 31 May 2022) of the 100 providers for about 1,400 services.

Based on My Aged Care published prices, for the 100 providers reviewed, on average:

- Fully managed care management charges represent 17% of the total HCP subsidy for Level 1 (ranging between 0% and 60%) and 16% of the total HCP subsidy for Level 4 (ranging between 0% and 35%)
- self-managed care management charges represent 12% of the total HCP subsidy for Level 1 (ranging between 0% and 35%) and 7% of the total HCP subsidy for Level 4 (ranging between 0% and 23%)
- package management charges represent 10% of the total HCP subsidy for Level 1 (ranging between 0.3%[2] and 30%) and 10% of the total HCP subsidy for Level 4 (ranging between 3% and 31%).

In undertaking the Review, it became apparent that the concept of 'value for money'[3] is subjectively interpreted by both providers and care recipients. For example, a low or no charge for care management might be considered optimal by a care recipient but can constrain the HCP provider from meeting their regulatory obligations. Full control over their HCP funds may be desired by self-managed care recipients, but providers remain accountable for the use of funds and hence still need to charge for care management. Some providers may consider simpler administrative processes to be more cost effective, but this may inadvertently compromise pricing transparency and/or consumer-choice.

[2] Unlike other percentages in this section, this percentage is deliberately not rounded to identify the relatively small percentage.

[3] The HCP Program Assurance Framework underpinning the Review uses the following three components for determining value for money:

- Efficient: the achievement of the maximum value for the resources used.
- Effective: the extent to which intended outcomes or results are achieved.
- Justified: providers are able to justify (through verifiable information provided to the Review team) their charges to care recipients.

When compared across the sampled 100 providers, the rationale for some care management and/or indirect charges was not always transparent, and value for money was at times unclear. Some examples include:

- a fixed percentage surcharge for third-party provider invoices even though the work effort in processing subsequent invoices is lower
- no cap on third-party invoice surcharge which adversely impacts care recipients
- no evident increase in package management work effort where package management charges increase with package level
- staff travel charges to a care recipient's address vary based on who is travelling the same distance. For example, a nurse's travel may cost more than a personal care worker (whereas in a per km flat rate scenario, this would not be different based on who is travelling). While both approaches may be valid, from a whole-of-program perspective, and from a care recipient's perspective, it was unclear why, in similar situations, some providers choose to charge per km while others charge by who is travelling to the care recipient's address
- limited care management support relative to other providers for similar charges, and
- in a limited number of cases, inclusion of business costs[4] into package management charges.

In contrast, the Review also found that some providers do not charge for package management, care management, third-party invoicing, or staff travel to the care recipient's address. Some providers offer unlimited care management hours and only face-to-face care management.

While out of scope, the Review report contains some incidental findings including the use of excluded items and charging contingency funds to cover future expenses (separate to unspent funds).

Lack of pricing transparency, or inaccurate pricing information on My Aged Care, was of particular concern. Pricing transparency requirements have been in place since 2019 and are clear. Yet, some providers are still not meeting their obligations. Pricing transparency is key to empowering care recipients to be fully informed and exercise choice.

[4]Business costs as defined in Section 4 of the User Rights Principles 2014 and refer to the costs of running a business that are not directly related to the provision of home care, such as rent, insurances and marketing. Business costs cannot be charged separately as per section 21K of User Rights Principles 2014 (legislation.gov.au).

The Review team found the following practices occurring:

- My Aged Care pricing schedules not being reviewed/updated every 12 months
- pricing schedules not covering all charges (missing care management charges, exit amounts)
- providers charging a single percentage charge for both care management and package management together, noting that care management is a specific support service, while package management is an indirect charge, and
- providers not following HCP Program pricing definitions.

A limited number of providers could not submit pricing schedules to the Review team that were meant to be attached to the sampled care recipients' HCP Home Care Agreements. This was concerning as these are essentially 'pricing contracts' between the care recipient and the provider and the inclusion of the pricing schedule is a legal requirement. Providers open themselves up to risk if they do not have in place a valid Home Care Agreement, as one of the conditions of subsidy being payable is that a Home Care Agreement is in force.

The Review team sought to understand providers' pricing methodology. Some providers had basic pricing methodologies or unsophisticated pricing models. Some providers' pricing approach was based on either market comparison or increasing charges annually to cover increasing costs. Some charged comparable prices as their competitors but could only provide limited explanation of the rationale. While it is not a program requirement to have a mature pricing model, efficient pricing in what is a competitive market can be impacted by providers' lack of understanding of their business model and HCP costs.

The Review sample also included some franchising models. These generally appeared to be competitively priced, but in some cases, it was unclear whether the franchisor (where franchisees fell under the franchisor's Approved Provider status) was actively assuring HCP Program funding integrity. The reason provided was that the franchisor could not dictate prices to franchisees. It was unclear to the Review team, however, why franchisors cannot still be accountable for assuring that program funds are spent for the purposes provided and prices set by franchisees deliver value for money. That said, the Review team was encouraged by some franchisors who appear to have HCP-relevant quality assurance processes and controls to meet program integrity obligations.

Regarding HCP Program management itself, the Review found that in some instances the HCP Program guidance (for example the HCP Program Operational Manual for providers, or other information on the Department of Health and Aged Care's (the Department's) website) was unclear, inconsistent, not updated or sometimes not found efficiently. While Approved Providers of HCPs are required to understand and fulfil their legal obligations, the Review team found that some time-poor

providers rely exclusively on the HCP Program Operational Manual as the source of truth. On a positive note, most relevant guidance was clear, long-standing and easily found on the Department's website.

The Review team takes this opportunity to thank the 100 providers, including five volunteers, who participated in this inaugural Program Assurance Review. Understandably, there was some concern given the nature of such reviews and the uncertainty associated with an inaugural Review, exacerbated by the challenges of COVID-19. Overall, providers positively engaged with the Review, made senior staff available, and cooperated by providing documentation and follow-up clarifications. Encouragingly, several providers embraced the Review process as an opportunity to improve their current practices. While structured feedback from participating providers will be sought through a provider survey, anecdotal feedback suggests that overall providers found the Review team to be respectful and the process procedurally fair.

Finally, in presenting this public summary report, the Review team acknowledges that this first Review has taken longer than anticipated. Most of the delay was attributable to the impact of COVID-19 on providers and the Review team. Some of the delay was due to inefficiencies expected from a first-time, labour-intensive Review process on a complex topic. The Review team is committed to continuously improving its operations and stakeholder engagement.

Contents

1. Background

The Home Care Packages (HCP) Program supports older Australians with complex needs to stay at home and access affordable and coordinated care services such as light gardening, bathing, nursing, health therapies and meal preparation. As at December 2021 (the relevant time period for the Review), there were 911 approved HCP providers. The Program's estimated expenditure for 2022–23 is approximately $6.5 billion, with nearly 275,600 people expected to receive a HCP by the end of 2022–23. With growing demand for these HCPs, it is imperative that care recipients and the Government (on behalf of taxpayers) have confidence that public funds are being spent for approved purposes.

HCP Program Assurance aims to protect the integrity of HCP Program funding. Underpinned by the *Aged Care Act 1997*, HCP assurance comprises evidence-based reviews and other activities that are generally risk-based. HCP Program Assurance Reviews underpin the Government's plan to improve aged care and boost transparency and accountability in the sector. These reviews focus on the HCP Program's design, delivery, and administration. Ultimately, assurance reviews and other activities seek to enhance value for money for HCP care recipients and Australian taxpayers, support HCP providers to enhance their program knowledge, and support the continuous improvement of HCP providers and the Program. Further rationale is available in the Framework document published on 7 October 2021.

This is the first public Summary Review Report (Report) issued under the remit of HCP Program Assurance. It provides themed findings from the inaugural HCP *Indirect and Care Management charges – October 2021 Assurance Review* (Review).

The purpose of the Review was to understand how selected providers calculate and charge for indirect and care management costs of the HCP Program.

Consistent with the notice issued to selected providers, the Review aimed to answer the following questions:

- what are HCP providers charging for indirect and care management charges and why

- whether HCP providers are charging consistently with relevant departmental policies and guidance[5]
- whether the methodology applied by HCP providers for determining indirect and care management charges can be verified[6], and
- whether indirect and care management charges have been applied to HCP care recipients on a consistent and accurate[7] basis by HCP providers and can be verified.

2. Methodology

The 95 Approved Providers selected for the Review covered a significant proportion of HCP care recipients and should be representative of issues identified regarding indirect and care management charges. In addition, six providers volunteered to participate, of which five were selected. The Review sample thus totalled 100 Approved Providers. Around 1,000 care recipients' documentation was sourced from the providers – a total of 16,000 documents were examined.

The documentation requested from participating providers included:

- HCP provider policy, procedure, guidance material, or, where unavailable, a narrative/description of the methodology, in relation to establishing charges
- an Excel file seeking HCP provider charges (revenue) for the period of 1 July 2020 to 30 June 2021
- HCP provider revenue for the sample of 10 care recipients selected for the Review for each charge
- audited financial statements for the HCP provider (or where unavailable unaudited financial statements or management accounts)

[5] Departmental policies and guidance on indirect and care management charges. These are referenced throughout this Review report. These included legislative requirements (User Rights Principles 2014, Quality of Care Principles 2014) and the Department's operational guidance to providers – for example, in the form of the HCP Program Operational Manual, and/or other published guidance including but not limited to pricing definitions, pricing transparency requirements etc.

[6] The Review team verified the calculations applied within the provider's methodology submitted to the Department as part of the Review, where relevant and possible.

[7] In line with the provider's methodology for these charges.

- signed Home Care Agreements, care plans, individualised budgets, relevant pricing schedules and monthly statements for the Review period for the sampled care recipients, and
- in relation to the March 2021 monthly statement (or the last monthly statement where a HCP care recipient ceased their package during the Review period), verifiable information for all variable indirect charges.

The Review process comprised:

- issuing a formal, legally binding Review notice to the selected HCP providers
- entry meetings (mandatory for providers)
- undertaking fieldwork/analysis of the submitted documentation (received via a secure portal)
- writing 100 draft reports and sharing these with providers for comment/clarifications
- exit meetings (optional for providers)
- finalising and issuing 100 detailed final individual provider reports, and
- publishing a public summary report (this report).

For the purposes of section 5.3, the pricing information was deliberately sourced from reviewed providers' published prices on My Aged Care, rather than using information collected during the Review.

Procedural fairness was important, as was making sure that the Review process yielded evidence-based findings. Given this was the first Review, the Review team refined its processes and approach as appropriate during the Review.

More details on the approach of the Review, including documentation collected, how information was used and how natural justice was supported for participating HCP providers, can be found in Attachment A.

3. Keeping individual providers accountable

All 100 providers have received a final detailed individual provider report as part of this Review. The final report includes actions in the context of the Program Assurance Review. For example, a provider may have been asked to advise the Review team in writing within 12 weeks of what action it has taken where the Review team identified an issue/concern. A Program Assurance Review compliance team has been established to monitor these actions.

The Department's HCP Program Assurance Reviews are separate to the Aged Care Quality and Safety Commission's (the Commission) role as the national regulator of aged care including the HCP Program. The Department is responsible for HCP Program funding and for assuring that these funds are spent for the purposes provided under the Aged Care legislation.

The Review team will share relevant information with the Commission. Where providers are found non-compliant with their provider responsibilities, the Commission will take proportionate regulatory action. Depending on the level of assessed risk, the Commission may issue a Direction, a Non-Compliance Notice or take other escalating enforceable regulatory action/s such as issuing a Sanction. In all circumstances, the Commission's response to non-compliance will be informed by the risk posed to the safety, health, wellbeing and quality of life of consumers.

4. Supporting continuous improvement of providers

Following the public release of this report, a public webinar and a Community of Practice (CoP) with the sector is planned.

The CoP will support providers' continuous improvement, using Review findings as an opportunity to:

- understand program requirements, and, thus, help improve provider performance in relevant aspects
- promote consistency of practice across the HCP provider sector, and
- where appropriate, help the sector to improve and/or innovate existing practices and approaches.

This CoP will also support HCP providers to discuss sector implications from Review findings, share best practices, and provide feedback on the Review process and/or program settings. It will also serve as an opportunity for HCP providers to review information, develop and discuss new ideas, share resources, and build a sense of community with other providers.

A web-based platform will be used for this purpose and will go live in August 2022 post-release of the first Program Assurance Review summary report.

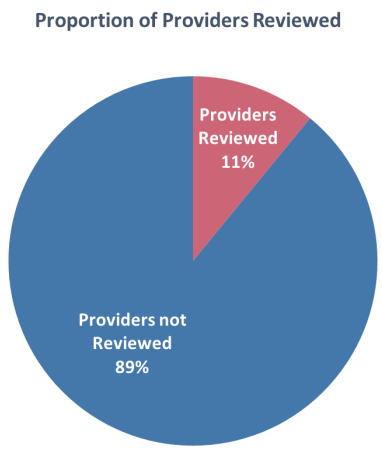
To successfully support continuous improvement of the sector, the CoP will require active and good-faith participation from HCP providers and departmental representatives.

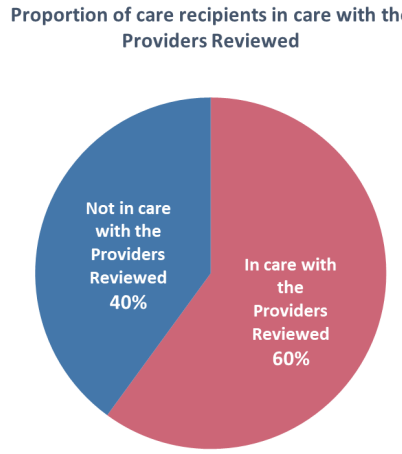
Where needed, webinars will complement the web-based CoP.

5. Findings and observations

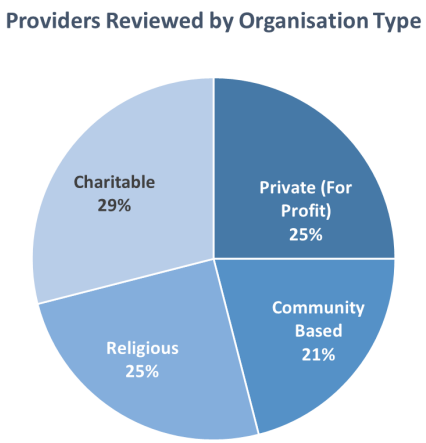
The findings and observations from the inaugural Program Assurance Review are summarised below.

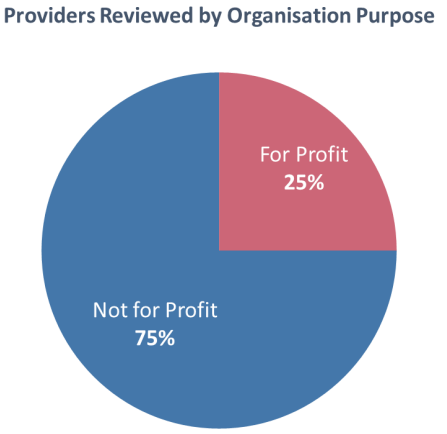
5.1. HCP providers' participation





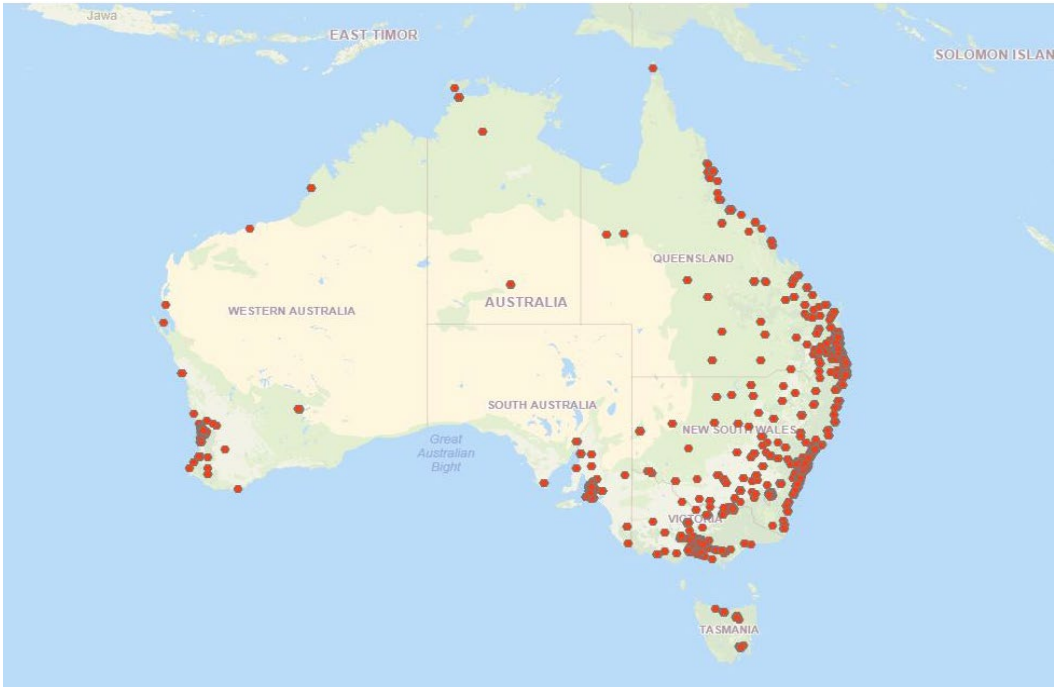
Note: As at 31 September 2021





Note: As at 31 May 2022

Geographical spread of 100 providers reviewed and their service delivery coverage



Note: as at 31 May 2022

Engagement of reviewed providers

of HCP Providers engaged with the review process and supplied the requested information

of HCP Providers requested an extension due to COVID-19 or similar reasons and were provided one

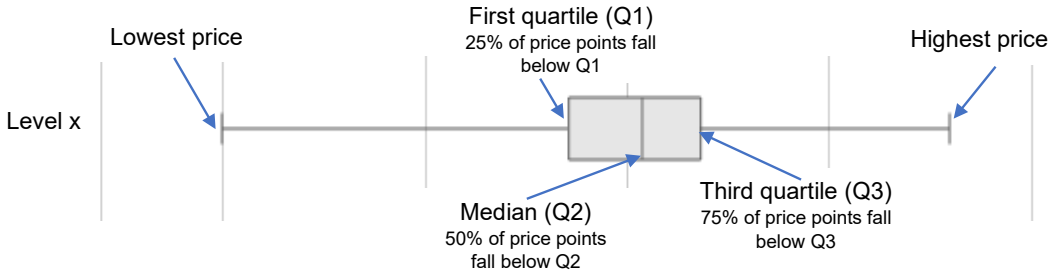
of HCP Providers participated in an exit interview

Note: participation in exit meetings was not mandatory

5.2. What are providers charging?

To support easy interpretation of the graphs below, readers may wish to note the following:

- The distribution of fortnightly fully managed care management, self-managed care management and package management prices covers all services (approx. 1,400 services or outlets) across the 100 providers reviewed.
- This information was published on My Aged Care as of 31 May 2022.
- Box and whisker plots are used to depict each of the distributions (fully managed care management Levels 1 to 4, self-managed care management Levels 1 to 4 and package management Levels 1 to 4). The middle 50% of the distribution is represented by the box with the first quartile[8] (Q1) and third quartile[9] (Q3) enclosing the median line (Q2). The whiskers extend to the lowest and highest prices in the distribution for each HCP level.

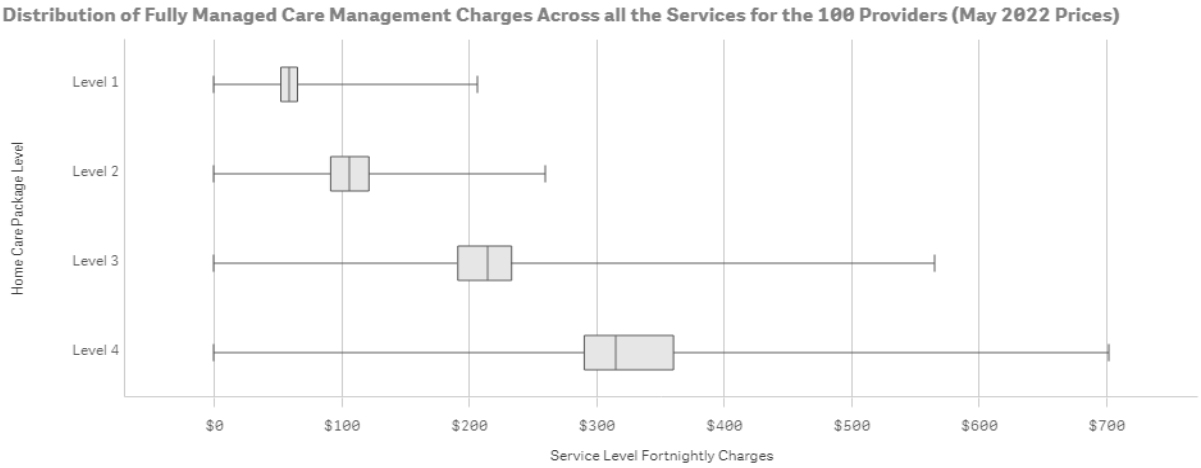


The information below is deliberately sourced from reviewed providers' published prices on My Aged Care, rather than using information collected during the Review. This approach was taken to support a fair comparison, using providers' published information and taking into account all their services on My Aged Care, rather than only those that were reviewed. Latest information was also used (31 May 2022) to be most beneficial publicly.

[8] 25% of data points fall below the lower quartile, or first quartile, Q1, when arranged in an increasing order.

[9] 75% of data points fall below the upper quartile, or third quartile, Q3, when arranged in an increasing order.

Fully managed care management charges per fortnight



Levels 1, 2 and 3 (n=1356)

Level 4 (n=1353)

Distribution of Fully Managed Care Management Charges Across all the Services for the 100 Providers (May 2022 Prices)

Pricing Type	HCP Level	Lowest Price	First Quartile (Q1)	Median (Q2)	Third Quartile (Q3)	Highest Price
Fully Managed By Provider Per Fortnight	Level 1	$0	$52	$59	$65	$206
Fully Managed By Provider Per Fortnight	Level 2	$0	$91	$107	$121	$260
Fully Managed By Provider Per Fortnight	Level 3	$0	$191	$215	$233	$566
Fully Managed By Provider Per Fortnight	Level 4	$0	$290	$315	$360	$702

As evidenced by the graph and table above, fully managed[10] fortnightly care management charges ranged from:

- $0 to $206 for HCP Level 1
- $0 to $260 for HCP Level 2
- $0 to $566 for HCP Level 3, and
- $0 to $702 for HCP Level 4.

The published price range for care management charges increased as the HCP levels increased. HCP Level 4 has the widest range with care recipients being charged between $0 and $702. Services charging $0 for care management and the higher costs associated with providing care management for Level 4 care recipients could contribute to this wide range of prices. Factors such as: type and duration of support and services; remoteness;

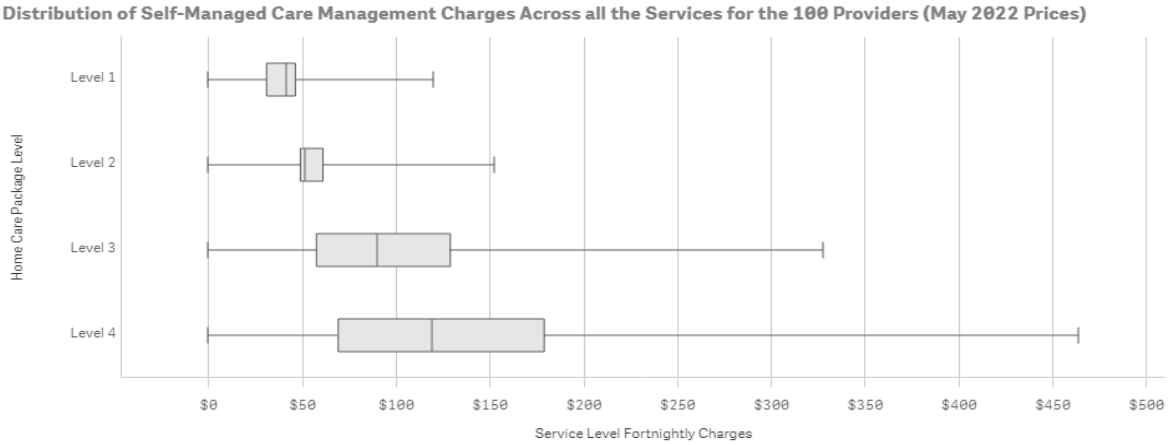
[10] This is where the provider manages all aspects of the HCP for the care recipient.

care recipient mix; provider profile; cultural differences; chronic conditions; and others that may also impact charges for service delivery on the ground. These are not considered in this analysis.

Based on published prices on My Aged Care (as at 31 May 2022), for the 100 providers reviewed, on average, fully managed care management charges represent:

- 17% of the total HCP subsidy for Level 1 (ranging between 0% and 60%)
- 17% of the total HCP subsidy for Level 2 (ranging between 0% and 43%)
- 16% of the total HCP subsidy for Level 3 (ranging between 0% and 43%)
- 16% of the total HCP subsidy for Level 4 (ranging between 0% and 35%)

Self-managed care management charges



Levels 1, 3 and 4 (n= 488)

Level 2 (n=489)

Distribution of Self-Managed Care Management Charges Across all the Services for the 100 Providers (May 2022 Prices)

Pricing Type	HCP Level	Lowest Price	First Quartile (Q1)	Median (Q2)	Third Quartile (Q3)	Highest Price
Self Managed By You Per Fortnight	Level 1	$0	$31	$41	$46	$120
Self Managed By You Per Fortnight	Level 2	$0	$49	$52	$61	$153
Self Managed By You Per Fortnight	Level 3	$0	$57	$90	$129	$328
Self Managed By You Per Fortnight	Level 4	$0	$69	$120	$179	$464

Self-managed[11] care management charges ranged from:

- $0 to $120 for HCP Level 1
- $0 to $153 for HCP Level 2
- $0 to $328 for HCP Level 3, and
- $0 to $464 for HCP Level 4.

The price range for self-managed care management charges also increased as the HCP levels increased. HCP Level 4 has the widest range with care recipients being charged between $0 and $464, across the 100 providers. Contributing factors discussed under fully managed care management also apply to self-managed care management charges. Overall, self-managed care management costs 42% less for HCP Levels 1 and 3, 41% less for HCP Level 2 and 34% less for HCP Level 4.

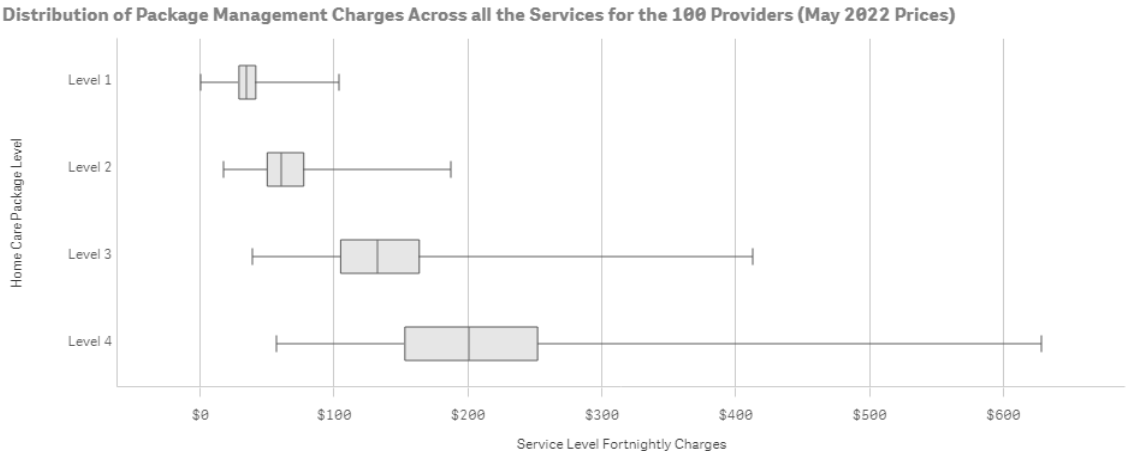
On average, self-managed care management charges (in May 2022) represented:

- 12% of the total HCP subsidy for Level 1 (ranging between 0% and 35%)
- 9% of the total HCP subsidy for Level 2 (ranging between 0% and 25%)
- 7% of the total HCP subsidy for Level 3 (ranging between 0% and 25%)
- 7% of the total HCP subsidy for Level 4 (ranging between 0% and 23%)

It is important to note that care management (full or self-managed) is a specific service and not an indirect charge.

[11] This is where the care recipient or their family takes a degree of control of their HCP management.

Package management charges



Level 1 (n= 1375)

Levels 2, 3 and 4 (n= 1393)

Distribution of Package Management Charges Across all the Services for the 100 Providers (May 2022 Prices)

Pricing Type	HCP Level	Lowest Price	First Quartile (Q1)	Median (Q2)	Third Quartile (Q3)	Highest Price
Package Management	Level 1	$1	$29	$35	$41	$104
Package Management	Level 2	$18	$50	$61	$77	$188
Package Management	Level 3	$39	$105	$133	$164	$413
Package Management	Level 4	$57	$153	$201	$252	$629

Package management charges ranged from:

- $1 to $104 for HCP Level 1
- $18 to $188 for HCP Level 2
- $39 to $413 for HCP Level 3, and
- $57 to $629 for HCP Level 4.

Price range for package management also increases as the HCP levels increased. HCP Level 4 has the widest range with care recipients being charged between $57 and $629, across the 100 providers reviewed. Contributing factors discussed under fully managed care management also apply to package management charges. Unlike fully managed and self-managed care management charges, minimum charges for package management increase from HCP Level 1 ($1) to HCP Level 4 ($57).

On average, package management charges (in May 2022) represented:

- 10% of the total HCP subsidy for Level 1 (ranging between 0.3%[12] and 30%)
- 11% of the total HCP subsidy for Level 2 (ranging between 3% and 31%)
- 10% of the total HCP subsidy for Level 3 (ranging between 3% and 31%), and
- 10% of the total HCP subsidy for Level 4 (ranging between 3% and 31%)

Package management is not the only indirect charge applicable. Based on the Review's findings, it is likely that most care recipients also pay other indirect charges such as staff travel to the HCP address and third-party invoice processing surcharges. As such, the total cost of indirect charges to a HCP package would be higher than just the package management charges listed here.

In addition to the above (service level) analysis, the distribution of median fortnightly charges for the 100 providers reviewed (provider level) is presented at Attachment B. This is to facilitate pricing comparison across the 100 providers (not individually identified in this Report) and understand the number of providers that sit in the different quartile ranges from lowest median price to highest median price. As there are approximately 1,400 services across the 100 providers on My Aged Care, median prices for each service type and level were derived for each of the 100 providers to form the distributions. Please refer to Attachment B for this comparison.

5.3. Pricing methodologies

The Review found that some HCP providers have basic pricing methodologies. Their approach is based on either market comparison or increasing charges annually to cover increasing costs. A few HCP providers were able to demonstrate more mature methodologies for determining charges, such as considering both components of cost to deliver as well as market pricing. Only a small number of providers determined charges through the use of financial modelling incorporating projected revenue.

Some of the reviewed providers included their indirect charges in their charge for common services. They calculated this by including staff costs (such as carer wages,

[12] Unlike other percentages in this Section, this percentage is deliberately not rounded to identify the relatively small percentage.

superannuation, payroll tax, and workers compensation), overheads (business costs such as business insurance) and regulatory costs.

While the Review team acknowledges that a pricing methodology is not a program requirement, it was important to review this aspect to understand how providers determine charges in what is a competitive market.

5.4. Pricing transparency is sub-optimal

Review findings

The Review team noted with concern the sub-optimal pricing transparency[13] of many providers. Pricing transparency is integral to supporting care recipients to exercise effective choice and control over the level of care that they receive. Care recipients should have complete and correct information, which is easily understandable and comparable across all providers for the same types of charges. This was not always the case as evidenced from the following findings:

- *Pricing schedules not reviewed every 12 months* – as required under section 19D of the User Rights Principles 2014 [Note some providers have reviewed/updated their pricing schedules since engaging with the Review team].
- *Applicable pricing schedules not attached* to some sampled Home Care Agreements.
- *Providers claim N/A or $0 for some charges* – noting this could be because such costs are covered through other charges or the hourly rate for direct services.
- *Charges not listed clearly* – such as the full cost of care or package management.
- *Not listing all charges* – some information was only available to the Review team and was not on the published My Aged Care pricing schedules/providers website or was not easily located on the provider's website. For example, exit amounts were not in some providers' pricing schedules but were charged. Providers are reminded they cannot charge this if not listed in the pricing schedule.
- *Waiving of some charges appeared discretionary* – some charges were applied/waived at the discretion of a staff member, but it was not evident to the Review team whether there were standard operating procedures or governance to ensure fair and equitable decision-making.

[13] Price transparency for Home Care Packages | Australian Government Department of Health and Aged Care

- *Annual increases and agreement of care recipients* – some Home Care Agreements had an annual increase mentioned, but the actual amount of increase was only advised by letter each year to care recipients. In such cases it was unclear how overt agreement was sought from the care recipients for this. [Note this was an incidental finding and not within scope of the Review.]

Review observations

Some providers commented on the challenges with My Aged Care, claiming that it did not support provision of details to enhance pricing transparency/justification. However, it was evident to the Review team that some providers are able to provide the requisite pricing transparency to their care recipients via My Aged Care and their own websites.

Some providers stated that their own systems were such that they could not meet the HCP Program's transparency requirements (such as producing an itemised monthly financial information statement for care recipients).

Notwithstanding these challenges, providers must adhere to pricing transparency requirements. For example, the requirement to issue itemised monthly financial information statements has been in place for some time and Approved Providers must issue these.

Providers also open themselves up to risk if they do not have in place a valid Home Care Agreement, as one of the conditions of subsidy being payable is that a Home Care Agreement is in force.

Pricing transparency is a central tenet of Consumer Directed Care. Given the lack of comparable negotiation power between providers and care recipients in what is a home care 'market', pricing transparency is key to care recipients exercising choice and control. The Australian Competition and Consumer Commission (ACCC) also has pricing requirements[14] in this context, including price display obligations. Most pricing transparency requirements (under Aged Care Law or Australian Consumer Law) are long-standing and clear and therefore there is no satisfactory reason for providers not to adhere to these.

[14] Pricing & surcharging | ACCC

Given the insufficient pricing transparency found by the Review team, there is benefit in prioritising pricing transparency on My Aged Care related program assurance activity across HCP providers. This will be for the purposes of assuring program integrity (and not for regulatory purposes which is the Commission's purview).

Program guidance improvement

Nil – however, please note that for individual topics discussed below, improvement suggestions are included where relevant.

The quarterly publication of the national median prices for common home care services, care management and package management is helping to enhance pricing transparency for consumers. In this context, it is important that Approved Providers familiarise themselves with the definitions of and guidance on common home care services, care management and package management, plus make use of the free text fields on the My Aged Care pricing schedule to accurately describe their approach to delivering common home care services, care management and package management.

Further, new tools are also available on the My Aged Care Website, including:

- an improved layout to display Provider Costs
- a new Quick Costs Checker tool, and
- Cost Comparison indicators.

These tools are dependent on providers following My Aged Care pricing transparency requirements. The changes will better inform older Australians about the breakdown of HCP funding, by package level, and enable them to compare the prices of like services between providers.

5.5. Value for money is not always evident/justified

Review findings

The Review found that value for money is not always evident or justified. For example:

- Some providers have a surcharge for third-party invoice processing (services and goods), some only have a surcharge for goods acquisition, and some do not have a surcharge.
- Some have a cap for such charges noting that section 21L of the User Rights Principles 2014 requires that Approved Providers not charge more than a reasonable amount. (The cap appeared relatively high to the Review team in some cases when

compared with other providers among the 100, although justification was not overtly sought from providers as 'reasonableness' of charges was not within scope of this Review).

- Some providers do not consider it practicable to charge a dollar figure and thus charge a percentage. However, others have a flat dollar rate which in some cases is charged for the full hour whereas others charge in 15-minute increments.
- Some of the charging methods include:
    - charge per kilometre for staff travel
    - charge per kilometre but have a higher charge for nurses and less for personal care staff[15]
    - charge with a cap to be fairer to care recipients
    - charge to the care recipient's place of residence and back
    - charge one way and not a round trip charge, and
    - some have a fairer method for calculating this charge (for example, beyond a certain distance from the city centre, or measuring the kilometres from the city centre to the residence rather than from the provider's office to the residence).
- Some charge relatively low prices for self-management, which may appeal to some care recipients looking for more control over their HCP package management in return for reduced charges. However, in some such cases, it was unclear to the Review team whether providers were fully meeting their mandatory care management obligations. [Note: reviewing care management obligations being delivered was out of scope.]
- Franchising business models seem to have lower charges relative to other business models. Generally, HCP franchisors do not appear to mandate charges and franchisees can determine their own pricing to ensure that franchisee and care recipient circumstances are considered in the actual charge. Franchisees can also set their own charge rates for the services which they provide directly. These charges are based on the local market competitiveness, industrial awards, inflation and profitability.
    - However, it is unclear in some cases how franchisors, who have many franchisees delivering HCP services under the franchisor's Approved Provider

[15] Such charges can be different based on who is travelling; i.e. to cover the staff member's travel time (vs a flat per km charge), and assuming this is transparent to the care recipient and consistent with the provider's pricing methodology. However, program-wide, and walking in a care recipient's shoes, why some providers must charge this way while others charge a flat rate per km was unclear to the Review team.

status, are successfully balancing their franchising regulatory requirements against their HCP Program requirements. Some appear to have a relatively hands-off approach, stating that as franchisors they cannot dictate pricing approaches to their franchisees under the ACCC's franchising regulations. However, it was unclear why they cannot have in place processes that assure value for money towards care recipients and program integrity of funds across their franchisees.

    - Reassuringly, in some cases, franchisors, as HCP Approved Providers, claimed to have strong quality assurance and system-based controls and appeared to effectively balance their franchisor and HCP Approved Provider obligations.

- While out of scope for the Review, incidental findings around the use of HCP funds for purchasing excluded items suggest that program funds are being used for purchases that should be funded by general income (noting general income purchases are a legislated exclusion), thus undermining value for money for Australian taxpayers.

Review observations

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

The majority of funds must be used by providers for the direct care and services support for HCP care recipients, and business costs and other costs should be covered through the common/direct services hourly rate. However, there are legitimate care management and indirect charges that providers must charge, if they are to fulfil their regulatory obligations as Approved Providers of the HCP Program and to run viable businesses.

Value for money considerations can be subjective to provider and care recipient needs/contexts. Accurate pricing transparency is thus essential to support value for money considerations for both care recipients and providers. If care recipients and their loved ones can make confident, like for like comparisons between providers, they can move to a different provider (where they have choice of providers – this may not always be possible, for example in remote and very remote areas) to secure better value for money in line with their expectations and care needs.

The Review team's observation is that not all providers are currently supporting this outcome – this could be due to lack of clarity about program requirements in some instances, but mostly it appears to be lack of awareness or due to business need or preferences (administrative ease, old practices, systems-based constraints, misunderstanding that if the care recipient agrees to it or does not complain then it must be acceptable).

Program guidance improvement

Nothing specific noting there may be relevant findings in the following sections.

The Review team found that overall there is sufficient program guidance available to providers. While this guidance would benefit from consolidation and further clarity, Approved Providers are aware, by virtue of being Approved Providers, that they are obliged legislatively to understand and deliver to the HCP requirements as articulated in the *Aged Care Act 1997* and relevant Aged Care Principles.

5.6. Care management and package management charges

Review findings

The majority of providers are charging for package management and care management, and generally as a percentage of the total HCP. This means that where a person moves from a lower package to a higher-level package, their package and care management charges in actual dollar terms increase. A common rationale for charging a percentage appears to be that this is simpler for the provider to calculate and the care recipient to understand.

An alternative approach observed by the Review was percentage rates *decreasing* for fully managed care management charges, self-managed care management charges and package management charges as the HCP level increases. This approach was deliberate to leave higher level care recipients with more funds available for other direct care and support services.

Some providers charge for both care[16] and package management together, even though these are distinctly different types of activities.

Some providers do not clearly list the total charges for care management, making it difficult to compare like with like. For example, the care management charge is listed for a minimum number of hours on My Aged Care, and beyond these hours, there is an additional hourly rate. In contrast, some providers offer unlimited care management despite having a minimum number of hours listed on My Aged Care as a guide.

Some providers were of the view that care management charged at an hourly rate results in care recipients with complex care needs choosing a lower level of care management in favour of retaining funds for direct services.

Review observations

Charging a percentage for care management/package management is not aligned with legislative requirements and impinges on care recipients' ability to easily compare and contrast prices.

In addition, charging for care management and package management together is also not consistent with legislative requirements.

Value for money for care recipients requires that actual effort/support from the provider increases to justify increased package and care management charges. This was not always evident to the Review team.

Regarding care management (a direct support service), the majority of providers, when queried, advised that this arrangement (of charging a percentage against the package level) was justified as care management activities increase proportionately in both frequency and complexity of the higher the level of HCP received. This may be justified in

[16] Unlike package management, care management is a defined support service under the *Quality of Care Principles 2014* Schedule 3, Part 1(2) that an approved provider of home care service may provide (https://www.legislation.gov.au/Details/F2020C00096). It is a provider's responsibility to comply with the Aged Care Quality Standards (the Quality Standards) pursuant to section 54–1(d) of the *Aged Care Act 1997. Standard 2: Ongoing assessment and planning with consumers* has a number of requirements which are clear about the obligations of Approved Providers with respect to undertaking assessment and planning of consumer care needs (Requirements 3(a) and (b)), liaising with others involved in the care of the consumer (Requirement 3(c)) and that care and services are regularly reviewed (Requirement 3(e)).

cases where care recipients on higher levels of packages require more complex support, and there is evidence that there is a care plan in place, individualised budget and frequent delivery of care and services.

Regarding package management (an indirect charge), some providers, when queried, advised that package management resourcing requirements to administer the HCP increase depending on the subsidy level of the care recipient. Accordingly, to them this justifies the increased amount that higher level care recipients are charged. However, as many providers do charge the care recipient for additional effort involved in sourcing third-party providers/goods/services, the justification for also charging a higher package management charge with a higher-level package was not always evident.

Package management charges should be 'reasonable' as per the *User Rights Principles 2014*[17]. The Review team did not examine 'reasonableness' of such charges.

Program guidance improvement

While what is considered a 'reasonable' charge will vary depending on the specific circumstances, further program guidance on assessing what is 'reasonable' would assist providers in setting prices.

5.7. Providers charging $0 for care management

Review findings

The Review found that a few providers do not charge separately for care and/or package management. In some cases, providers are transparent about this, by listing $0 on My Aged Care. In some cases, providers indicated that they had incorporated the cost of care management into an all-inclusive service price.

Care management is a mandatory requirement and must be delivered to all care recipients, irrespective of whether they are fully managed or self-managed.

[17] Section 21L of the User Rights Principles 2014 (Prices and Business costs to be kept to reasonable amounts) refers to 'reasonable' in a very specific manner: An approved provider of home care must not charge a care recipient to whom the approved provider provides home care a price that is more than a reasonable amount for a matter mentioned in paragraph 19B(1)(b), (c) or (d) (certain travel, subcontracting arrangements and Package Management).

While some providers did not separately charge for care management, it raises the question as to whether mandatory care management was being delivered, noting that this was out of scope for the Review.

Review observations

From a provider's perspective, Aged Care legislation does not explicitly require a price to be greater than $0. The HCP Program Operational Manual is also not explicit on whether the price for care management needs to be more than $0.

To provide clarity for providers, the current HCP Program position on care management is:

- Care management is a defined support service that must be provided to both self-managed and fully managed care recipients.
- If there is no charge for care management (the price is $0), the Department would be concerned if it is not being provided, as required under relevant legislative responsibilities:
    - Quality of Care Principles 2014 Schedule 3, Part 1(2)18 as a specific support service.
    - Aged Care Quality Standards*:* Standard 2 – Ongoing assessment and planning.
    - *User Rights Principles 2014*: 19B Notice of common care and services and prices and fees, s(1)(a)(vi) care management; 19C Notice of all care and services and prices and fees – for 'each kind of care and each service'[19].

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[18] The section states – 'Care Management – Includes reviewing the care recipient's home care agreement and care plan, coordinating and scheduling care and services, ensuring care and services are aligned with other supports, liaising with the care recipient and the care recipient's representatives, ensuring that care and services are culturally appropriate, and identifying and addressing risks to the care recipient's safety.' Whilst this is a defined support service that approved providers may provide, it is a provider's responsibility to comply with the Aged Care Quality Standards (the Quality Standards) pursuant to section 54–1(d) of the Aged Care Act 1997. A number of requirements in this standard are clear about the obligations of Approved Provider with respect to undertaking assessment and planning of consumer care needs. (Requirements 3(a) and (b)), liaising with others involved in the care of the consumer (Requirement 3(c)) and that care and services are regularly reviewed (Requirement 3(e)).

[19] Appendix D, part B.2 How do the pricing changes affect care management?) – 'Care management, often called case management or care coordination, is a key component of every home care package. … Providers need to indicate the cost

- It is in line with the policy intent of the User Rights Principles 2014 that providers charge separately for care management to provide transparency for consumers.
- For any charge (package management, care management or any other charge) listing a $0 for a service that a provider intends to charge for may be inconsistent with Australian consumer law.

Consistent with the policy intent of the User Rights Principles 2014, care recipients and the public should be able to compare the costs for care management across providers easily and to understand what service they will receive for this charge. Bundling of care management, for example with package management charges or in an all-inclusive service cost, does not support this outcome and may be an indicator that required care management services are not being provided.

For package management, which is an administrative charge, listing $0 (and not N/A[20]) is appropriate where this is not charged separately[21]. However, administrative activities are required to support delivery of home care packages and care recipients need to understand how they may be charged for this. Where providers have incorporated package management into the service cost then this should be transparent[22] to care recipients.

Program guidance improvement

The HCP Program guidance should be reviewed to make the distinction between care management and package management clear (specific support service vs administrative activity respectively) and if or when it is appropriate for providers to list N/A or $0. Further, all relevant public-facing program guidance materials should be reviewed to ensure

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for care management services and outline their approach to care management in the Schedule. Care management may include: …'Appendix D, part B.1 What is the pricing Schedule and what do providers need to do with it?). 'All home care providers are required to publish their pricing information in a new standardised pricing comparability Schedule (the Schedule) on the My Aged Care Service Finder'.

[20] N/A in the context of the HCP Program means a service is not offered therefore is not applicable. $0 means the service is offered but there is no charge for it.

[21] Package management is required for all HCPs even if an Approved Provider chooses not to explicitly charge for it.

[22] So that they are clear that they will receive package management and the charge for that is covered under an all-inclusive service price.

consistency. Ideally these should be consolidated for ease of reference of providers, care recipients and the public.

5.8. Self-management charges

Review findings

Some[23] providers offer self-management as part of their suite of care management options. Some providers do not offer a self-management option for business reasons, such as self-management not being consistent with the provider's care management philosophy. Some do not overtly advertise it but can offer it where a care recipient requests it. A very small number of providers exclusively offered only self-management.

Self-management charges were found to be generally lower than fully managed charges. The Review found that there was variation in the level of support offered for self-management purposes.

Review observations

The Review team is concerned that some providers, in offering self-management, inadvertently may not be fulfilling their care management obligations towards self-managed care recipients. Providers are reminded that care management is a service that must[24] be provided to both self-managed and fully managed care recipients. Care management is a specified support service under legislation. As such, while self-managed care recipients may wish to 'trade in' support from the Approved Provider in return for low administration charges, Approved Providers must still comply with their legislative responsibilities:

[23] Based on published information on MAC, only 38 of the 100 providers reviewed offer self-management. More providers may be offering this but not stating this on My Aged Care.

[24] *Aged Care Quality Standards*: Standard 2 – Ongoing assessment and planning; *User Rights Principles 2014*: 19AC Responsibility to provide information to assist care recipients to choose best care and services and 19AD Responsibility to provide written plan of care and services.

- Quality of Care Principles 2014 Schedule 3, Part 1(2)[25] as a specific support service.
- Aged Care Quality Standards: Standard 2 – Ongoing assessment and planning.
- User Rights Principles 2014: 19B Notice of common care and services and prices and fees, s(1)(a)(vi) care management; 19C Notice of all care and services and prices and fees – for 'each kind of care and each service'[26].

Program guidance improvement

Program guidance could be improved to clearly articulate the minimum requirements for providers in relation to self-managed options.

In this context, and this is relevant to various other findings, the Review team observes that a challenge for the Program area is how to keep published guidance regularly updated, particularly where advice to individual providers (provided 1:1 but may be on the same issue) indicates a theme over time that needs to be conveyed more broadly to the sector.

5.9. Brokerage and sub-contracting charges – third party invoice processing surcharge

Review findings

According to the pricing definitions[27] for the HCP Program, subcontracted/brokered

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[25] The section states – *'Care Management – Includes reviewing the care recipient's home care agreement and care plan, coordinating and scheduling care and services, ensuring care and services are aligned with other supports, liaising with the care recipient and the care recipient's representatives, ensuring that care and services are culturally appropriate, and identifying and addressing risks to the care recipient's safety.'* Whilst this is a defined support service that Approved Providers may provide, it is a provider responsibility to comply with the Aged Care Quality Standards (the Quality Standards) pursuant to section 54–1(d) of the *Aged Care Act 1997.* A number of requirements in this standard are clear about the obligations of Approved Provider with respect to undertaking assessment and planning of consumer care needs (Requirements 3(a) and (b)), liaising with others involved in the care of the consumer (Requirement 3(c)) and that care and services are regularly reviewed (Requirement 3(e)).

[26] Appendix D, part B.2 How do the pricing changes affect care management?) – '*Care management, often called case management or care coordination, is a key component of every home care package. … Providers need to indicate the cost for care management services and outline their approach to care management in the Schedule. Care management may include: …*'Appendix D, part B.1 What is the pricing Schedule and what do providers need to do with it?) – '*All home care providers are required to publish their pricing information in a new standardised pricing comparability Schedule (the Schedule) on the My Aged Care Service Finder*'.

[27] Home Care Pricing Schedule Definitions | Australian Government Department of Health and Aged Care

services are defined as:

> The amount the provider charges for any services they coordinate for the care recipient but which another provider delivers, and how it is charged. For example, whether it is charged as a separate cost; or included in the service price.

As a general principle, where a provider chooses to use a subcontractor, providers must not charge care recipients more than a reasonable amount for sub-contracting arrangements. If subcontracting is 1) the provider's decision, the provider must include the extra cost in the service price (a provider cannot charge for it separately) as this would be considered a business cost and therefore cannot be charged separately, and 2) the care recipient's choice, the provider must explain how they will charge the extra cost in the pricing schedule.

The Review found that many providers had a surcharge for third-party service provision if the care recipient requested to use their preferred provider. Many providers also imposed a surcharge on the provisioning of goods.

The approach to charging a surcharge for third party providers was also variable across providers and the rationale for this was not always evident to the Review team. For example:

- Many providers listed such charges as a percentage rather than in whole dollars or a range, claiming that it would not be practicable to list whole dollars for such charges.
    - Some providers stated that charging a modest percentage surcharge overcomes the challenge of a fixed dollar charge which may be disproportionate to consumers when purchasing small items.
- Some providers did not have a cap on the amount charged, thereby leaving care recipients exposed to charges that could be fairly high.
- Some providers did cap such charges, but the cap did not seem 'reasonable'[28] based on a comparison by the Review team among the relevant providers it reviewed.

[28] Section 21L of the User Rights Principles 2014 (Prices and Business costs to be kept to reasonable amounts) refers to 'reasonable' in a very specific manner: An approved provider of home care must not charge a care recipient to whom the approved provider provides home care a price that is more than a reasonable amount for a matter mentioned in paragraph 19B(1)(b), (c) or (d) (certain travel, subcontracting arrangements and Package Management). The Review team notes that 'reasonableness' of charges was not within scope for this Review.

- Only a few providers had a fixed dollar amount. Occasionally, the Review team observed that the care recipient paid the difference if the charge was above this fixed dollar amount. On the other hand, if the actual amount was lower than this fixed dollar amount, then the provider 'pocketed' the difference. This was considered a simpler way to administer such charges but is of concern to the Review team.
- A few providers had a fixed hourly rate and charged based on work effort involved. The first time they process an invoice from a new third-party provider, they might charge for the full hour. However, in future, they might only need 15 minutes of effort, so they only charge for those 15 minutes.
- Some providers only had a surcharge for third-party invoices where a care recipient did not pick a provider from their preferred provider list.
- Very few providers had a one-off administration charge, or no charge at all, for third-party arrangements.

Review observations

It was evident to the Review team that several providers did not understand why listing a percentage charge was unacceptable. The Review team found the Program guidance unclear on this. The Review team has worked with the Department's Program Area to confirm the following requirements:

> Subcontracting and brokering costs should be incorporated into care management (e.g. coordinating and scheduling services) and/or package management (e.g. managing package funds such as invoicing) charges.
>
> Additional costs that may arise, for example to provide care or services through a subcontracting arrangement that gives effect to a care recipient's request, can be charged separately. Additional charges must be justifiable and reasonable. The provider must explain within the Pricing Schedule why they charge extra for this service, what it covers, how it is calculated, and how it will be applied.
>
> Where costs are variable, providers may publish minimum and maximum dollar figure price points. Published prices must be a dollar figure and not percentage. If a percentage is used to calculate the variable charge within the min/max dollar figure range, it also must be justifiable and reasonable for the types of services coordinated.

The Review team considers the lack of a reasonable cap on third party surcharges by some providers, whether it is for third party goods or services, as detrimental to care recipients' value for money outcomes. In addition, the Review team does not consider it appropriate for providers to 'pocket' the differences between the HCP Home Care Agreement's agreed dollar amount and the actual charge (when this is lower). Providers need to establish arrangements that are fair and transparent for the care recipient. In the case where a third-party provider of the care recipient's choice is used, if there are invoice processing costs (i.e. a surcharge) that a provider needs to recover, then these should be clearly listed separately so the care recipient understands and informedly agrees to when these would be charged. Such charges should not be 'hidden' inadvertently due to the desire for administrative ease. The Review team finds it unlikely that invoice management for the same service from the same provider would require the same effort time after time, particularly where a third-party provider is already set up in the HCP provider's system. This approach does not support value for money outcomes for care recipients.

Program guidance improvement

The requirements (captured above) should be included in the published Program guidance.

The *Home Care Pricing Schedule Definitions* document was found by the Review team to be a very useful resource in engaging with providers on indirect and care management charges. It was last published in 2019 and will benefit from a review for currency.

5.10. Monthly statements do not clearly list costs separately

Review findings

The Review found that several providers do not list the third-party services/goods handling charges separately in monthly statements. In limited cases, it was found that providers use generic, 'catch all' descriptions for care and services delivered. In these cases, care recipients would not be able to check if they were being charged correctly and only for services they agreed to receive, and in the right month. Some providers stated that this was a new requirement (which is not the case).

Review observations

Care recipients require full transparency of all charges to make informed decisions and to keep providers accountable for their HCP funds. The requirement for an itemised list of care and services in monthly statements is *not* a new requirement.

Providers are reminded that the HCP Program Operational Manual, Section 10 reiterates that monthly statements include an itemised list of care and services provided to the care recipient during the month, including any travel, any subcontracting arrangements and package management, for which the care recipient was charged. This must include total and line-item dollar amounts. Regarding sub-contracting, Section 21B – Financial Information statements for payment periods of the User Rights Principles 2014 states that an itemised list of any subcontracting arrangements for which the care recipient is charged must be included on the care recipient's monthly statements.

In this context, the Review team notes that the Program area of the Department has issued a Better Practice Monthly Statement earlier this year. This was co-designed with consumers, providers and peak bodies over a three-year period to support the implementation of the Improved Payments Arrangements and was also in response to Recommendation 124 made by the Royal Commission into Aged Care Quality and Safety.

The purpose of the Better Practice Monthly Statement is to provide practical advice to providers and consumers on how to interpret section 21B of the User Rights Principles 2014. The template will support providers to improve the overall quality of their HCP statements, making it easier for care recipients to understand and be supported to make informed choices around use of Package funds for their care. The template can be found here: Monthly statements for Home Care Packages.

While the better practice template is not mandatory, it is important that providers understand that some monthly statement requirements are mandatory[29] (regardless of which template providers use) and providers must remain compliant with those.

[29] Available here: User Rights Principles 2014 (legislation.gov.au)

Program guidance improvement

Nil.

The Review notes that the Department has good resources and explanations regarding monthly statements, including consumer guidance, and that the monthly statement template (and associated materials) has been developed after significant co-design and consultation effort.

5.11. Incorrect allocation of business costs to indirect charges

Review finding

Business costs are costs of running a business (for example, business insurance, general training of staff, rent etc). Where such charges need to be covered through HCP funds, a reasonable component can be added to the unit price of HCP services provided to care recipients.

Review observations

In a small number of cases (and where this was evident based on documentation before the Review team) it was observed that some providers were incorrectly charging business costs in package management or other indirect charges. It was also unclear whether there was an inadvertent 'double dipping' in relation to such charges – that is, a provider could have built these into their hourly rates for services and also charging these through package management charges.

Program guidance improvement

This requirement was found to be clear in the published program materials including, for example, the HCP Program Operational Manual for Providers and pricing transparency information.

However the Program area may wish to consider a simple revision to the Home Care Pricing Schedule Definitions document to clearly call out business costs under a separate heading (at present these are referred to under the heading of package management and could be missed).

6. Additional observations

While out of scope of the Review, the Review team also observed the following. These were included in providers' individual reports where relevant:

6.1. Exclusions/inclusions

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

As such, where these were found in monthly statements and reasons for purchase were unclear, then the Review team was obliged to record this. These items were individually raised with relevant providers to seek justification. In some circumstances, such items could reflect an assessed care need.

The following excluded items were noticed in one or more instances:

- fuel gift cards
- purchases of TVs, entertainment items
- air conditioners
- kitchen appliances and vacuum cleaners
- holidays including flights, accommodation (categorised as respite)
- non-specialised furniture such as beds, mattresses, recliners
- significant gardening expenditure in the one month
- using HCP funds to cover contributions for permanent/respite care in a residential aged care service
- subscription services
- large household maintenance/renovations (not specific to accessibility)
- medicine
- grocery charges.

While it is evident to the Review team that the Program guidance around excluded/included items could be enhanced (and the Program area is consulting with the sector on inclusions/exclusions), it also notes that the requirements around excluded items are relatively clear. What is particularly concerning is that the Review team was not

deliberately looking at expenditure on such items (as these were out of scope for this Review), however, these examples were hard to miss as they were quite explicit in some of the monthly statements and invoices reviewed.

6.2. Charging for contingency funds

The Review found that a very small number of providers were accumulating 'contingency funds' on behalf of care recipients. These were not a 'charge' but appeared as such on the relevant monthly statements, hence drawing the Review team's attention. When queried by the Review team, it was evident that these were essentially unspent funds by another name, being held for 'a rainy day' for a care recipient, with their agreement.

The Review team reminds HCP providers that the practice of charging for 'contingency' is not consistent with the policy intent of the HCP Program. Care recipients should not be charged for future needs. Under Improved Payment Arrangements (IPA), from 1 September 2021, the new payment by Services Australia is only paid in arrears for services *already delivered* and *providers should no longer be accruing unspent funds*.

Despite the IPA reforms being now in place for some months, some providers may still be unaware that this is not acceptable. As such, the Program area should consider clearly listing 'contingency charges/funds' as an unacceptable practice in Program guidance materials.

6.3. Care plans and budgets

The Review found that a noticeable proportion of care plans and budgets were not detailed and/or out of date and not aligning with the charges in a care recipient's monthly statement. This included care recipients being charged a higher package rate or for items that were not justifiable through their care plan. There were also some instances where charges on monthly statements did not align with the provided Home Care Agreement or pricing schedule.

A few care plans were not signed or did not appear to be care recipient approved. Care plans are an important foundational document for the HCP Program and Consumer Directed Care. They should reflect current care needs, should only be changed with the care recipient's agreement, and providers must make full use of the HCP budget to best meet a person's care needs. See 19AD — Responsibility to provide written plan of care and services in the User Rights Principles 2014.

7. Better practice

The Review team observed some relevant better practices including but not limited to:

- use of a payment platform for all invoicing and payments which allows care recipients to access real-time statements, including the HCP subsidy that is credited daily, as well as expenditure notifications. Care recipients can view their statements online or via a mobile phone app giving self-managed care recipients greater visibility and control over their funding
- an innovative approach to enable a care recipient's loved ones to have peace of mind that daily routines are being completed
- an innovative approach to enable staff members to share moments in the care recipient's day with their loved ones
- time tracking tools which present evidence for charges applied for care management provided, and
- [while out of scope for the Review] care plan templates directed at consumer driven care through clear questions like 'what I would like to achieve by working together'.

The Review team emphasises that the above examples are not an endorsement of a particular approach.

8. Value for money considerations for care recipients

The Review team has collated the following 'assuring value for money' guidance for HCP care recipients based on observations from the sampled 100 providers.

Pricing transparency is key to supporting care recipients to make value for money decisions about their HCP funds – care recipients should seek this from their provider

- Providers are required to provide care recipients pricing transparency. These requirements are in place to support care recipients to make 'like for like' comparisons. Providers need to be consistent with HCP Program's pricing transparency requirements.

Care recipients should ensure they are making a like for like comparison of charges

- The Review team found considerable variation across providers for similar charges. When care recipients are comparing across providers, they should keep in mind that some providers offer an all-inclusive hourly rate (and this may appear to be higher on face value) while others may have less evident additional charges.

Monthly statements are very important in the HCP Program context – care recipients should Review them carefully and ask questions of their provider if in doubt

- The HCP Program has issued a better practice monthly statement template. This is not mandatory for providers to use. However, monthly statements should make sense to care recipients. The Program has issued some consumer guidance to assist care recipients.
- Regardless of what template providers use, there are some long-standing requirements on providers in relation to monthly statements – for example, monthly statements need to list the details and cost of each service and item so care recipients can review if Package funds are being used in the best way possible and in accordance with the HCP Program rules.

There may be third-party sourcing and invoice processing charges where care recipients have a preferred provider that they want their HCP provider to use on their behalf

- Care recipients should take time to understand the methodology for such charges when signing their HCP Home Care Agreement. While a 10% surcharge on $100 may seem reasonable ($10), a 10% surcharge just for processing an invoice for a $1,000 good ($100) does not seem value for money on face value, particularly if the third-party provider preferred by the care recipient has been previously used through the current HCP provider.

Staff travel to get to a care recipient's HCP address

- Staff travelling to a care recipient's HCP residence without them is considered an indirect charge.
- If unclear from care recipient's HCP Home Care Agreement, care recipients should ask how this is calculated – do they have to pay for the round-trip (or only one way), do they have to pay more depending on what type of worker is travelling to see them, and do they have to pay for every kilometre travelled or only after a particular distance from the city centre or city outskirts.

Do providers claim to charge $0 or N/A for care management?

- If a care recipient is self-managed, or they are on a lower care package (as some providers have various tiers of care management support available) and their provider chooses not to charge them for any care management, they are still entitled to care management support.

- If a care recipient requires care management and their Home Care Agreement lists the charge for it as $0, they cannot be charged for care management.

Excluded/included items

- Providers are legally obliged to ensure that HCP funds are spent for purposes they are approved for by the Government. HCP funds are not the same as a care recipient's pension and are not for living expenses. Further details are in the Home Care Packages Program Operational Manual: A Guide for Home Care Providers or the Home Care Packages Program Operational Manual for consumers.
- Excluded items or contingency funds are not acceptable expenditure under a HCP.

Care recipients should not be afraid to complain if dissatisfied with the lack of pricing transparency of their current HCP charges

- Care recipients should complain to their provider first (every HCP provider must have a complaints handling mechanism in place).
- Failing that, care recipients[30] can complain to the Australian Competition and Consumer Commission.
- The Aged Care Quality and Safety Commission[31] can receive complaints about a care recipient's HCP provider.
    - Complaints can be made by calling the Aged Care Quality and Safety Commission on 1800 951 822 or in writing.
- Care recipients do not need to be afraid of adverse actions from the provider if they complain – providers are legally obliged to deliver Home Care Services.
- Providers cannot charge extra for handling complaints.

If a care recipient is new to a HCP and still choosing a provider, the Review team recommends they:

- Go to the My Aged Care Website and compare providers in their region.
- Care recipients can also compare their prices against the published National Median Prices for HCPs.

[30] Complaints & problems | ACCC

[31] https://www.agedcarequality.gov.au/making-complaint

- The HCP market is competitive in most areas so care recipients should shop around.
- Care recipients should see what social media HCP consumer groups in their area have to say about providers.
- Care recipients can also seek support from the Older Persons Advocacy Network or aged care system navigators.

9. Conclusion

There is public concern about unfair 'administrative' [32] charges by HCP providers. Providers operate in a market, and the Program does not currently set prices.

Providers are entitled to charge reasonable 'administrative' charges. As Approved Providers, they need to meet their regulatory obligations and provide quality and safe services to HCP care recipients. It is logical that providers need to cover relevant costs and, where appropriate, run a profitable business or make a surplus if operating as a not-for-profit. While the Review team appreciates providers' individual business needs and contexts, providers still need to ensure that most of the HCP funds are going to direct care and services.

While some program guidance needs clarity and enhancement, the HCP Program's publicly-known, core underpinning philosophy, 'Consumer Directed Care', requires a fairer relationship between care recipients and providers. The Program area has long-standing pricing transparency requirements. Pricing transparency is a core tenet of Consumer Directed Care and supports care recipients to make informed choices and 'vote with their feet' to change providers if needed.

HCP pricing is agreed between care recipients and providers. This Review has enabled direct visibility of such arrangements for the first time on a large scale. Through sourcing around 16,000 HCP documents from participating providers, including HCP Home Care Agreements, budgets and monthly statements, the Review has been able to understand what providers are charging, why, whether their approach is consistent with relevant HCP

[32] This is the colloquial term used publicly – this comprises package management, staff travel, third-party invoice processing and other such 'indirect' charges, and care management charges (which is a specific support service unlike indirect charges).

Program requirements and whether providers are consistently applying their pricing methodology across the sampled care recipients in relation to variable charges.

While many providers were able to justify what they were charging and why, there was noticeable variation across the 100 providers. This variation could be attributable in part to the different contexts[33] they operate under. Some providers may also be running more efficient businesses or systems that allow administrative charges to be lower.

The Review team is concerned about uncapped indirect and care management charges, and the significant variation in similar indirect charges across providers. It was also unclear how providers cover the costs of care management where they claim to charge $0, as they are legally obliged to provide care management as part of a HCP, even to self-managing care recipients.

Another concern for the Review team was the variation in self-management approaches – ranging from very hands-off to somewhat hands-off. Care recipients and providers must take care in setting up self-management options. Some self-management arrangements, such as charging a small amount for a hands-off approach by the provider, make the care recipient accountable by default for managing their own care and package funds. Such arrangements are inconsistent with the intent of the HCP Program.

While out of scope for the Review, the team noted that some providers appeared to be agreeing to excluded items or supporting expenditure for ‘living expenses’. If all providers do the right thing, the overall ‘market’ is fairer and supports stronger program integrity. A common complaint to the Review team was that providers doing the right thing lose care recipients to more ‘generous’ providers (i.e. providers who are more inclined to approve excluded items).

Of most concern to the Review team is that some providers are still not delivering to well-established pricing transparency requirements. Some providers argued the finer points of the guidance materials rather than assuring the Review team that they are committed to delivering to the intent of Consumer Directed Care and the HCP Program. To be effective, pricing transparency should be complied with by all providers, not because this is

[33] For example, it is understandable if in regional and remote areas some indirect charges are higher for providers, or difficult to absorb (for example longer distances need to be travelled by staff to get to a HCP residence in rural areas).

regulated, but because this is the right thing to do by care recipients. Providers also have obligations under Australian Consumer Law in regard to displaying prices.

In conclusion, the Review team acknowledges that many providers are trying to do the right thing in the complex and regulated business environment of the HCP Program. In determining their indirect and care management charges, providers do need to cover all applicable costs and offer quality and safe services to HCP care recipients. However, in return, they must maintain the integrity of program funds, give care recipients and the public full transparency, and support care recipients to exercise true choice and control. Ultimately, the more informed and empowered the care recipients are, the fairer the ‘market’ will be for all providers.

Attachment A: Inaugural Program Assurance Review of Indirect and Care Management Charges – further details of scope, purpose and methodology

Scope

The purpose of the Review was to understand and assess how selected providers calculate and charge indirect and care management charges related to the provision of the HCP Program policy and guidance. Consistent with the notice issued to selected providers, the Review aimed to answer the following questions:

- what are HCP providers charging for indirect and care management and why
- whether HCP providers are charging consistently with departmental policies and guidance[34]
- whether the methodology applied by HCP providers for determining care management and indirect charges can be verified[35], and
- whether care management and indirect charges have been applied to HCP care recipients on a consistent and accurate[36] basis by HCP providers and can be verified.

The 95 Approved Providers were selected for this Review to cover the largest number of care recipients for HCP – this was considered as supporting the biggest impact on improving value for money and consumer driven choice, consistent with the purpose of this Review. In addition, six HCP Providers self-nominated to participate of which five were selected, totalling to 100 Approved Providers for the first Review.

Generally, a sample of 10 HCP care recipients per approved provider (1,000 care recipients in total for this Review) was selected by the Department as part of this Review. The Review team notes that the HCP Program does not set indirect or care management charges; these are agreed between the care recipient and provider. Consistent with the purpose and scope of this Review, Review officers used the 10 care recipient samples to assure that the provider's statements were backed by actual care recipient documentation

[34] Departmental policies and guidance on indirect and care management charges.

[35] The Review team verified the calculations applied within the provider's methodology submitted to the Department as part of the Review, where relevant and possible.

[36] In line with the provider's methodology for these charges.

and that the charges were agreed with the care recipient and were transparent. The Review was not required to make a finding regarding the amount being charged, and the Review team therefore focused on assuring consistency of the charges with the HCP Program's requirements as articulated in its pricing definitions.

While the Review was not an audit of the provider, the Review was designed with reference to the standard AS/NZS ISO 19011:2019 (Guidelines for auditing management systems). The Review processes also adhered to the HCP Assurance Framework principles:

- continuous improvement
- risk-based and data driven
- collaboration, engagement and trust

While consideration was also given to guidance from The Institute of Internal Auditors, Australia (IIA)[37] for random sampling, the sample size was judgement-based, selected to check provider statements against actual care recipient documentation, while also keeping it manageable to support the in-depth nature of the Review. Where appropriate, the Review's approach to sampling aligned to better practice within *ISO19011:2019(E) Guidelines for auditing management systems.*

Out of scope

The following elements were out of scope for this Review:

- defining a preferred methodology for HCP providers to determine[38] indirect and care management charges, including specific unit costs, allocations or percentages
- defining appropriate profit margins[39] to be applied by HCP providers and assessment and review of profit margins
- assessment and review of other charges – these were reviewed only where they were relevant to understanding indirect and/or care management charges

[37] IIA Whitepaper: Internal Audit Sampling

[38] The HCP Program does not mandate indirect and care management charges related methodology or mandate charges.

[39] Providers need to run a profitable business while also supporting the delivery of quality and safe care to HCP care recipients.

- assessment and review of unspent funds as a contributor to total revenue of the provider
- site visits to HCP providers, and
- determining whether the provider is compliant with the *Aged Care Act 1997* and associated Regulations[40], or any other legislative obligations. However, the Review team identified obvious inconsistencies with relevant program requirements during the Review process. These were included in the draft report to allow the provider an opportunity to respond prior to the finalisation of that report.

Review process

The Review was conducted by the Home Care Packages Program Assurance Reviews Section, within the Program Assurance Branch. Departmental officers conducted the reviews as a team with a team leader to assure consistency. For the purposes of this process and report they will be referred to as Review officers.

The Review commenced in October 2021 by issuing a formal notice of commencement and concluded with the issuing of the final report. The Review was initiated by sending a s95AB-5 notice to the relevant senior official of the provider.

The notice included details of the planned Review, the Terms of Reference, requested documents and contact details of the primary Review officer. An entry meeting was held with all providers to allow the opportunity to ask questions and seek clarifications.

Where a provider sought an extension to the 14-calendar day timeline for response this was generally granted, particularly for COVID-19 reasons.

Almost all providers submitted constructive management responses.

The following documentation was requested and reviewed where received from the provider as part of the Review:

[40] The Aged Care Quality and Safety Commission is the national regulator of aged care including the Home Care Packages Program.

Documentation requested	Reviewing purpose
1) the HCP provider policy, procedure or guidance material in relation to establishing charges (revenue) for HCP care recipients. When no such policy, procedure or guidance material existed, a narrative/description of the methodology was used in determining indirect and care management charges, including documentation which showed the charges were approved by an individual within the HCP provider with appropriate authority.	This information was used to understand how indirect and care management charges are determined by the provider and was used as basis for checking consistency and accuracy of charges for the sample care recipients selected by the Review team. The information was also used to understand whether the charges are consistent with departmental policies and guidance *(Home Care Pricing Schedule Definitions* and the *Home Care Packages Program Operational Manual* content (as applicable to the publishing of indirect and care management charges).
2) an Excel file, which provided: Table A: ▪ HCP provider charges (revenue) for the period 1 July 2020 to 30 June 2021. ▪ A description of the methodology applied by the HCP provider to determine HCP care recipient revenue rates for each charge (revenue). Where a cost-based methodology was used, the calculations model	This information was used to understand the percentage of each charge as a proportion of the total HCP revenue and the methodology applied by the HCP provider to determine these charges.

Documentation requested	Reviewing purpose
developed by the HCP provider to determine charges (revenue) for HCP care recipients in accordance with item 1 (it was acknowledged not all HCP providers would have created a model).	
and Table B: ▪ HCP provider revenue for the sample of 10 care recipients selected for the Review, for each charge.	This information was used to understand the percentage of each charge of the HCP subsidy for the Department's selected sample care recipients and how this percentage compared to all care recipients in Table A, *noting some variation between the two Tables was expected for various reasons, including circumstances of individual care recipients and the sample size.*
3) the audited Financial Statements for the HCP provider. Where audited Financial Statements were not available, unaudited Financial Statements or Management Accounts or relevant Home Care Packages part of financial records were accepted.	This information was used to verify if the Total Revenue (earned from direct and indirect charges) in Table A agreed with the relevant revenue identified in the audited Financial Statements where available/accessible.
4) the signed Home Care Agreements, Care Plans, individualised budgets and relevant pricing schedule (if different from published	This information was used to verify if the provider's methodology was applied consistently and accurately across the sample care recipients, *noting some variation was expected for various*

Documentation requested	Reviewing purpose
pricing schedule) and monthly statements for the period 1 July 2020 to 30 June 2021 for the selected sample care recipients.	*reasons, including circumstances of individual care recipients in the sample and the sample size.*
5) In relation to the March 2021 monthly statement (or the last monthly statement where a HCP care recipient ceased their package during the period) verifiable information for all variable indirect and care management charges (revenue) (e.g. log books, timesheets or another verifiable source).	This information was used to verify if the variable indirect and care management charges were applied consistently and accurately as per the provider's claimed methodology, where applicable.

Once documentation was received, Review officers commenced a desktop review using a standard worksheet to record the review process:

1) Review officers first reviewed the submitted documents to confirm that all requested information was provided for the Review. Providers were only contacted at this stage if there was not sufficient documentation to undertake the Review. Providers were contacted where documentation was incomplete.
2) Review officers then reviewed the submitted documents to understand, consistent with the scope of the Review:

    2.1) what HCP providers are charging for indirect and care management,
    2.2) why are they charging the amounts advised to the Department,
    2.3) whether this is consistent with departmental policies and guidelines, and,
    2.4) whether the provider's methodology/statements can be verified.

3) Review officers reviewed the detailed documentation supplied for the 10 care recipients to determine whether the care management and indirect charges were

applied on a consistent and accurate basis in line with the provider's methodology for these charges. This documentation was for a 12-month period. In addition, to verify that any variable care management/indirect service charges were applied consistently and accurately as per the HCP provider's claimed methodology (for example, brokerage and travel charges that could be different for care recipients depending on the direct services received in the relevant month), Review officers used invoices (and other relevant information) from March 2021 for the sampled care recipients.

4) Review officers contacted HCP providers either during fieldwork and/or during finalising the draft report to provide an opportunity to clarify any queries or supply additional information. Where a HCP provider's response could not be included in the formal findings of the Review, these have been noted in this report along with any comments from the HCP provider.
5) Once the desktop review was completed, Review officers prepared the individual HCP Provider Report using a standard template[41]. The draft report was reviewed for consistency and quality and then sent to the HCP provider ahead of an exit meeting with the Review team.
6) The issuing of a final report marked the formal conclusion of the Review for the Approved Provider. The Approved Provider received this Report following the exit meeting. The final report included any relevant management comments from the Approved Provider. Any consequent factual amendments have been made to this Report at the time of finalisation. Timeframes for finalising the draft reports were considerate of potential COVID-19 impacts on providers.
7) The Department issued a public-facing summary report for the Review drawing on individual provider reports findings.

Natural justice for providers

The Department has supported natural justice throughout the Review process for HCP providers. This included the following:

1) Provided detailed Terms of Reference for the Review prior to the entry meeting.
2) Conducted entry meetings with HCP providers to answer questions about the Review before the 14-day response time commenced.

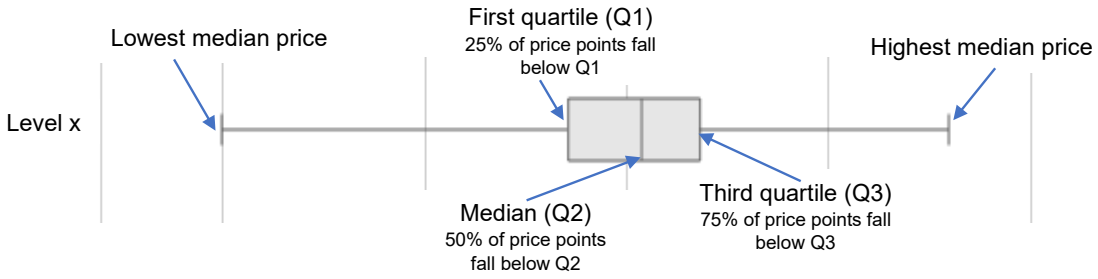
[41] A standard template supported consistency of approach.

3) Allowed a minimum of 14 days for supply of documentation and granted extensions where relevant based on justification provided, noting most extension requests were granted.
4) Sought additional information or clarification where Review officers were unclear on documentation provided, either during fieldwork and/or during finalising the draft report. In instances where a provider's clarification was contrary to the Department's findings, this has been covered in the final Individual HCP Provider Report.
5) Provided a draft copy of the Individual HCP Provider Report with sufficient time to respond with any concerns – all requested extensions were granted.
6) Offered an exit meeting to discuss the draft Individual HCP Provider Report.
7) Incorporated comments from the HCP provider where appropriate and/or amended the draft report's findings (e.g., factual errors and recording the management response).
8) Each provider was made aware through the process of finalising individual reports that there were Review observations/findings in their report that could be included in the public-facing summary report and attributed to them (i.e., relevant providers could be named in the summary report against relevant findings). Providers were given an opportunity to review these findings as part of the process of finalising[42] their individual report. Providers were aware that this was their only opportunity to review these potentially public-facing observations.
   However, the Department further refined this process and, as this was the first Review, all participating providers were issued an embargoed final summary report. Therefore, the public summary content was removed from Individual Provider Reports at the time of issuing those reports as final.
9) Established and shared a dispute resolution process detailed in the HCP Program Assurance Framework.

[42] Due to potential impact from COVID-19 on some providers, the Department proactively extended the finalisation period to four weeks.

Attachment B: Distribution of median fortnightly charges across the 100 Providers reviewed

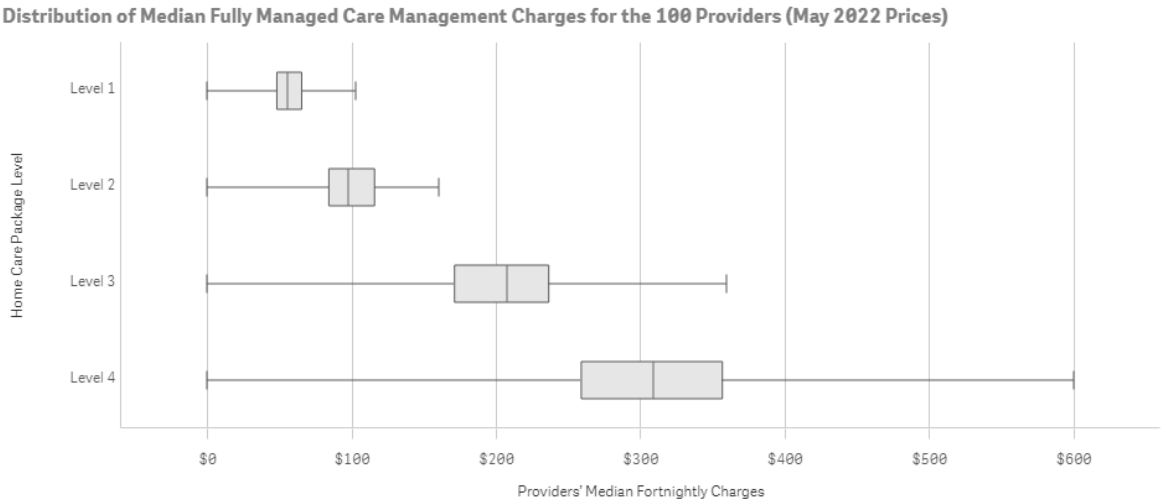
The distribution of median fortnightly fully managed care management, self-managed care management and package management prices for the 100 providers reviewed, published on My Aged Care as of 31 May 2022, are presented below. There are approximately 1,400 services across the 100 providers on My Aged Care. Median prices for each service type and level are derived for each of the 100 providers to form the distributions (fully managed care management Levels 1 to 4, self-managed care management Levels 1 to 4 and package management Levels 1 to 4). Box and whisker plots are used to depict each of the distribution. The middle 50% of the distribution is represented by the box with the first quartile[43] (Q1) and third quartile[44] (Q3) enclosing the median line (Q2). The whiskers extend to the lowest and highest **median prices** in the distribution for each HCP level. Factors such as type and duration of support and services, remoteness, care recipient mix, provider profile, cultural differences, chronic conditions, and others that may also impact charges for service delivery on the ground, are not considered in this analysis.



[43] 25% of data points fall below the lower quartile, or first quartile, Q1, when arranged in an increasing order.

[44] 75% of data points fall below the upper quartile, or third quartile, Q3, when arranged in an increasing order.

Median fully managed care management charges



Levels 1, 2, 3 and 4 (n=98)

Distribution of Median Fully Managed Care Management Charges for the 100 Providers (May 2022 Prices)

Pricing Type	HCP Level	Lowest Median Price	First Quartile (Q1)	Median (Q2)	Third Quartile (Q3)	Highest Median Price
Fully Managed By Provider Per Fortnight	Level 1	$0	$48	$55	$65	$103
Fully Managed By Provider Per Fortnight	Level 2	$0	$84	$98	$115	$160
Fully Managed By Provider Per Fortnight	Level 3	$0	$171	$208	$236	$360
Fully Managed By Provider Per Fortnight	Level 4	$0	$259	$309	$356	$600

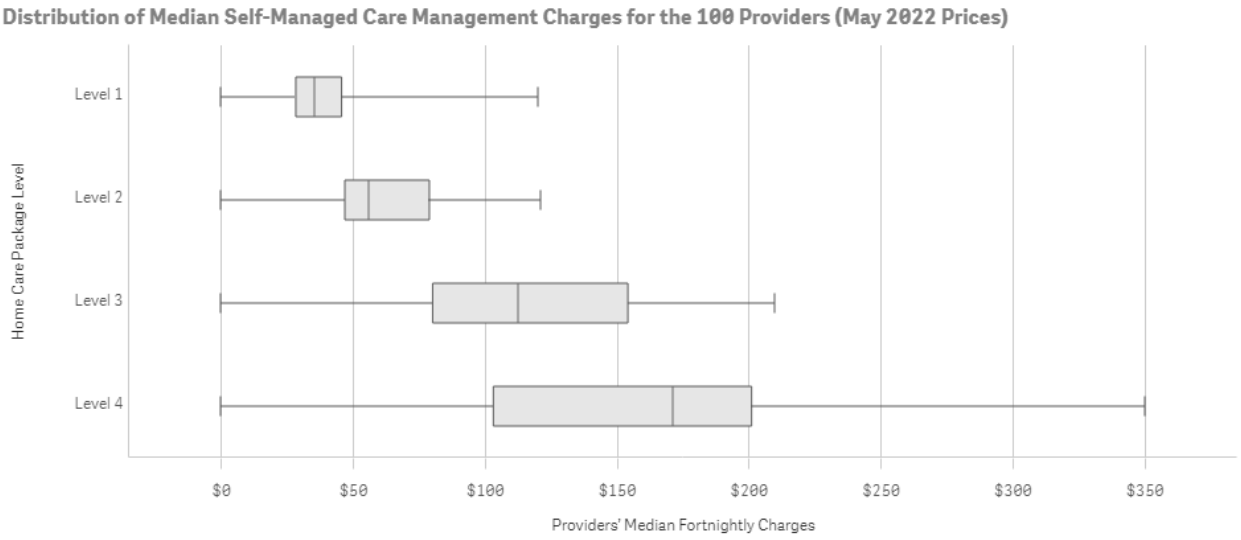
Median fully managed care management charges across the 100 providers ranged from:

- $0 to $103 for HCP Level 1,
- $0 to $160 for HCP Level 2,
- $0 to $360 for HCP Level 3, and
- $0 to $600 for HCP Level 4.

The table below presents the number of providers reviewed in each of the pricing groups for fully managed care management charges.

Number of Providers	Below First Quartile (Q1)	Below Median (Q2)	Below Third Quartile (Q3)	Below highest median price *(including highest median price)*
HCP Level 1	25	24	25	24
HCP Level 2	25	24	24	25
HCP Level 3	25	24	24	25
HCP Level 4	25	24	24	25

Median self-managed care management charges



Levels 1 and 2 (n=38)

Levels 3 and 4 (n=37)

Distribution of Median Self-Managed Care Management Charges for the 100 Providers (May 2022 Prices)

Pricing Type	HCP Level	Lowest Median Price	First Quartile (Q1)	Median (Q2)	Third Quartile (Q3)	Highest Median Price
Self Managed By You Per Fortnight	Level 1	$0	$28	$35	$46	$120
Self Managed By You Per Fortnight	Level 2	$0	$47	$56	$79	$121
Self Managed By You Per Fortnight	Level 3	$0	$80	$113	$154	$210
Self Managed By You Per Fortnight	Level 4	$0	$103	$171	$201	$350

Median self-managed care management charges across the 100 providers ranged from:

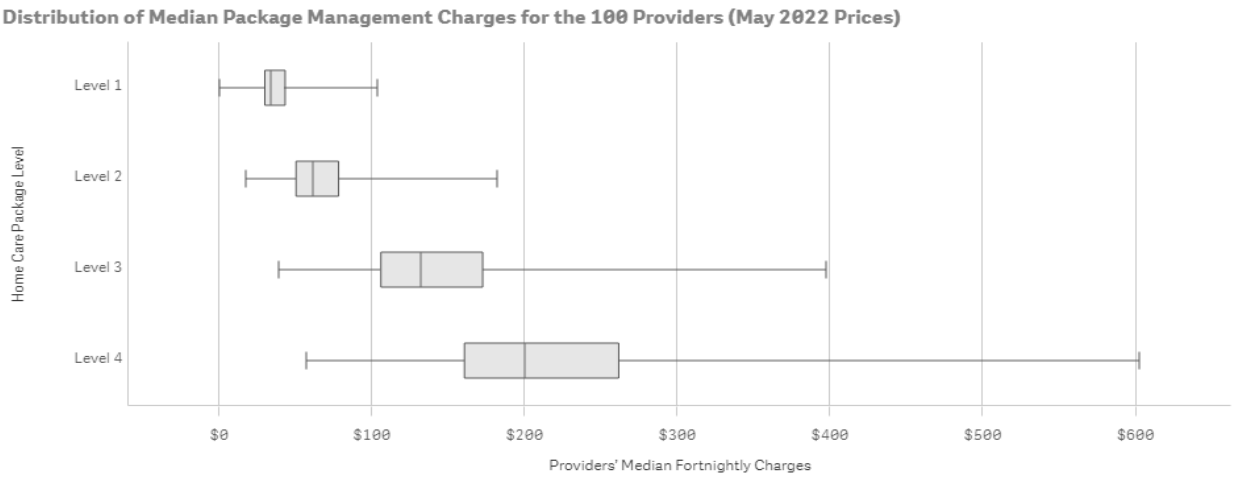
- $0 to $120 for HCP Level 1,
- $0 to $121 for HCP Level 2,
- $0 to $210 for HCP Level 3, and
- $0 to $350 for HCP Level 4.

Median self-managed care management charges are lower than median fully managed care management charges for all HCP levels, apart from HCP Level 1.

The table below presents the number of providers reviewed in each of the pricing groups for self-managed care management.

Number of Providers	Below First Quartile (Q1)	Below Median (Q2)	Below Third Quartile (Q3)	Below highest median price *(including highest median price)*
HCP Level 1	10	9	10	9
HCP Level 2	10	9	9	10
HCP Level 3	10	9	9	9
HCP Level 4	10	9	9	9

Median package management charges



Levels 1 (n=96)

Levels 2, 3 and 4 (n=98)

Distribution of Median Package Management Charges for the 100 Providers (May 2022 Prices)

Pricing Type	HCP Level	Lowest Median Price	First Quartile (Q1)	Median (Q2)	Third Quartile (Q3)	Highest Median Price
Package Management	Level 1	$1	$30	$35	$43	$104
Package Management	Level 2	$18	$50	$61	$78	$183
Package Management	Level 3	$40	$106	$133	$173	$398
Package Management	Level 4	$57	$161	$201	$262	$603

Median package management charges across the 100 providers ranged from:

- $1 to $104 for HCP Level 1,
- $18 to $183 for HCP Level 2,
- $40 to $398 for HCP Level 3, and
- $57 to $603 for HCP Level 4.

Unlike fully managed and self-managed care management charges, minimum median charges for package management increase from HCP Level 1 ($1) to HCP Level 4 ($57).

The table below presents the number of providers reviewed in each of the pricing groups for self-managed care management.

Number of Providers	**Below First Quartile (Q1)**	**Below Median (Q2)**	**Below Third Quartile (Q3)**	**Below highest median price *(including highest median price)***
HCP Level 1	27	23	22	24
HCP Level 2	25	24	24	25
HCP Level 3	27	23	23	25
HCP Level 4	27	24	23	24