ANZ HEALTH

FIRST IMPRESSIONS: KEY FUNDING MEASURES FOR RESIDENTIAL AGE CARE IN THE AGED CARE BILL 2024

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- The Commonwealth Government's response to the Aged Care Taskforce's recommendations on funding is manifest in the Aged Care Bill 2024 ("the bill").[1]
- If enacted—deemed likely, given reported bipartisan support—the bill lays the foundations for Support at Home (SAH), the new home care system, and introduces some significant measures aimed at improving financial viability of residential aged care operators.
- As also slated in the Aged Care Taskforce's Final report, the bill introduces significant user pays elements into the residential care system.
- This document provides ANZ's first impressions, focusing specifically on residential aged care in the funding-related chapter of the bill.

Funding category	Current	Future	Key points
 Care	Care fee: • asset and income means-tested care fee - residents with means (non-supported residents) pay care fee	Clinical care: • clinical care for all residents paid by Comm. Gvt. Non-clinical care: • asset and income means-tested non-clinical care fee paid by non-supported residents	• non-supported residents paying non-clinical care fee, up to max. $101.16 per day, for first four years in care; • not payable after the resident has paid $130k in contributions for SAH and non-clinical care fee contributions in residential aged care
 Everyday	Basic Daily Fee (BDF): • all residents pay BDF at 85% of basic aged pension, $63.57 Hotelling supplement: • Comm. Gvt. funds for all residents, $12.55 per day	Basic Daily Fee: • unchanged Hotelling supplement: • asset and income means-tested hotelling contribution paid by non-supported residents	• non-supported residents paying hotelling contribution
 Accommodation	Concessional (supported) residents: • accommodation for supported residents (full or part pensioners) paid by Comm. Gvt.in full or part Non-supported residents: • accommodation paid by non-supported residents via Refundable Accommodation Deposits (RAD) or Daily Accommodation Deposits (DAP)	Concessional (supported) residents: • unchanged Non-supported residents: • RAD payers will incur monthly retention payments (deductions from RAD) equivalent to 2% p.a. for up to five years • DAP payers will see twice-yearly indexation on DAP payments	• incremental contributions from RAD-paying residents paying monthly retention payments (deduction from RAD) • incremental contributions from DAP-paying residents paying DAP payments with twice-yearly indexation

SUMMARY

- Several key elements should improve financial viability of operators while retaining RAD/DAP options in an overall framework that is weighted further towards user pays.
- All else equal, elements that should contribute to higher levels of viability and valuations include
  - the re-introduction of RAD retention payments on RADs, 2% p.a. on the RAD balance, capped at 5 years,[2] which will be a new cash inflow for operators and, assuming stable cap rates, add to valuations;
  - an increase in the maximum room price, from $550k to $750k,[3] which may contribute to similar outcomes; and
  - biannual (twice yearly) indexation of DAPs,[4] which should smooth and bolster cash inflows and help operators manage the impacts of cost escalation.
- Typically, larger scale operators in metro areas have seen accommodation weighted towards RADs and as such may see relatively greater financial benefit from the proposed RAD retention measure.
- Still, operators more widely should see marginal revenue and EBITDA uplift from the move to greater consumer contributions. This should reinforce the broader trend towards improved financial viability across the sector, when coupled with the recently released AN-ACC indexation updates.[5]
- Longer term, as the Aged Care Taskforce reiterated, the ultimate replacement of RADs and shift to a "rental model" is still expected to be contingent upon an independent review finding "*that there is improved financial sustainability, diversified and adequate sources of capital to meet future demand and residential aged care is affordable for consumers.*"[6] The bill stipulates that review must commence by no later than 31 January 2029 and report by 31 March 2030.[7]
- Meanwhile, the bill also proposes "tapering" changes in the means testing: i.e., the inclusion of additional thresholds and changed tapering rates, so that benefits to residents decrease—and contributions from residents increase—progressively as residents' means increase (means-tested resident contributions in residential care will apply for everyday living, non-clinical care, and accommodation).[8]
- These are additional elements through which the proposed measures in the bill should also contribute positively to the Commonwealth Government's financial outlook, to the extent that residents (mainly non-supported residents) shoulder a greater proportion of costs outside clinical care costs.

KEY FUNDING MEASURES

RAD retention payments support improved viability and higher asset valuations. However, the market impacts on development flowing from the proposed changes will take some years to become apparent.

- At face value, **the re-introduction of RAD retention payments** (deductions from a resident's RAD balance) represents the key funding measure.
- The bill proposes monthly accrued retention payments calculated on 2% p.a. of the RAD balance (though exact details regarding the calculation remain subject to the guidance in the rules yet to be released). The timeframe for retention payments is capped at five years.
- The proposed measure reflects the Aged Care Taskforce's "*Recommendation 13: Require providers to retain a portion of the RAD in the near term to make an immediate improvement to sector financial sustainability.*"[9]
- Operators with higher RAD/DAP ratios or larger RAD portfolios in absolute dollar terms will experience greater cashflow improvements from this measure.
- For example, retention on a RAD balance reflecting the proposed higher maximum balance of $750k would deliver incremental annual revenue uplift of ~$15k per bed; and assuming a multi-site operation with 1,000 beds, a 70% RAD payer split, and a stable cap rate, this would translate into a ~$10.5m uplift to income that should all else equal bolster valuation. With average length of stay currently less than two years, the five-year cap on retention payments provides some further potential upside as well as provides some protection for long-staying residents.[10]
- As with the current Act, the new bill stipulates that use of RADs remains subject to prescribed purposes tests.[11] This is to ensure RADs are used appropriately, primarily for enhancing aged care infrastructure and prudent financial management. The bill provides scope for the income derived from RADs to be applied to the broader financial viability of operators.[12]

Bi-annual (twice yearly) indexation of DAPs also supports higher cash inflows, all else equal.

- The bill also proposes **bi-annual indexation of DAPs**, from 1 July 2025, providing further incremental financial uplift for operators which may also offset operating cost escalation.
- While the maximum permissible interest rate (MPIR), the interest rate used to calculate the DAP, remains elevated, RADs may remain more attractive than DAPs for many residents with the means to pay. This may persist, even with the re-introduction of retention payments. The MPIR may have to decline materially to make a DAP more economically attractive, although indexation could change that.[13]
- This measure reflects the intent in the Aged Care Taskforce's "*Recommendation 3: It is appropriate older people make a fair co-contribution to the cost of their aged care based on their means" to the extent the bi-annual uplift from indexation in DAP payments covers cost escalation.*[14]

A higher maximum permissible room price removes administrative burden and supports higher earnings and valuations.

- An **increase in the maximum room price from $550k to $750k with annual indexation** is another proposed measure taken from the Taskforce recommendations[15] (the current maximum permissible room rate has not been indexed in almost a decade). The indexation method is expected to be detailed in the rules yet to be released.[16]
- Higher maximum room prices may provide for higher RAD retention payments and higher valuations. The changes should also see a reduction in regulatory burden (i.e., having to apply and justify room prices above the current $550k maximum).
- This proposed measure was incorporated in the Aged Care Taskforce's "*Recommendation 15: In addition to the other accommodation recommendations, develop a package of measures to improve accommodation funding, equity between residents and transparency in the near-term. This will help place accommodation income on a long-term sustainable footing and position the sector for the ultimate phase out of RADs.*"[17]

A hotelling contribution establishes means-tested user pays for hotelling costs.

- The **new hotelling contribution proposed establishes a user pays-style contribution for accommodation costs for residents with means (non-supported residents)** based on means-testing criteria.[18]
- The Commonwealth Government has paid the Hotelling Supplement (currently $12.55 per resident per day) for all residents given the BDF (85% of the single base rate pension) does not fully meet accommodation costs.[19]
- The Aged Care Taskforce referred to aged care hotelling as part of "everyday living" in its "Final report," and so this proposed hotelling contribution directly reflects the "supplement" alluded to in "*Recommendation 10: Funding for daily living needs to cover the full cost of providing these services. It is recommended this be composed of the Basic Daily Fee and a supplement.*"[20]
- Of course, the new hotelling contribution also partly reflects "*Recommendation 9: Continue to focus government funding in residential aged care on care costs, with a significant role for resident co-contributions in non-care components*" given the intent is that the combination of the BDF and the Hotelling Supplement cover the costs of residents' accommodation—and all but a cohort of Concessional residents will be contributing for their accommodation while the Commonwealth covers the costs for all residents' clinical care services.[21]

A "non-clinical care contribution" establishes another means-tested user pays element.

- The **new non-clinical care contribution proposed establishes another user pays-style contribution for non-supported residents**, again based on a resident's daily means-tested amount (the sum of the per day income tested amount and the per day asset tested amount).[22]
- This is another proposed measure in the bill that reflects the Aged Care Taskforce's guiding principle of "*Equitable and sustainable funding*," which the Taskforce linked to personal co-contributions focused on accommodation and everyday living costs.[23]
- The means testing proposed is broadly similar to that under the current Act but includes additional income and asset thresholds and updated taper rates: i.e., the additional thresholds and changed taper rates drive progressive reductions in residents' benefits (increases in residents' contributions) as residents' means increase.[24]
- As with the hotelling contribution, this proposed measure also reflects the Aged Care Taskforce's "*Recommendation 9*" and the Taskforce's suggestion for "*a significant role for resident co-contributions in non-care components*" on the basis that higher contributions here would "*improve funding in the 2 areas (everyday living and accommodation) where providers are currently making substantial losses. Doing so will improve sector viability, which will increase the sector's capacity to improve quality, accommodation and service offerings for residents.*"[25]

A new Higher Everyday Living Fee (HELF) facilitates streamlining of, and improved consumer protection around, additional services.

- The **HELF replaces existing fees for discretionary non-care services**: the Additional Service Fees and Extra Service Fees.[26]
- Although discretionary services (not covered under the Basic Daily Fee and the Hotelling Supplement) had already been covered under the two pre-existing fees, the intent in introducing the new single fee is to streamline administration and increase flexibility for providers and residents while providing improved consumer protections.[27]
- Thus, the proposed measure reflects the Aged Care Taskforce's "*Recommendation 11: Enable residents and their representative and providers to negotiate better or more daily living services for a higher fee, subject to at least: publishing prices and services; only allowing agreement to higher fees for agreed services to be made after a participant has entered care; and a cooling off period and regular review opportunities to ensure the resident still wants the services and can still use them.*"[28]
- Based on amounts between providers and individuals in written agreements, the HELF provides for some further potential financial upside for operators, including scope for annual indexation, as well as quality of life benefits for residents wanting to procure such services (e.g., alcoholic beverages with meals or subscription TV services).[29]
- At the same time, the intent is also to protect residents from unfair pricing and pressure to pay for unnecessary services through requiring written agreements between providers and residents detailing the agreed fee and including indexation limits to prevent unfair price increases.[30] Further guidance is expected in the rules yet to be released.

Replacing existing annual and lifetime caps with a new lifetime cap facilitates greater user pays.

- The **new lifetime cap will be triggered if an individual paying a non-clinical care fee stays in residential care for four years or reaches $130,000 in total out-of-pocket contributions between Support at Home and non-clinical care in residential care, whichever occurs first**.[31] The Commonwealth Government will subsequently cover the individual's full care costs for the rest of their time in residential care.
- Such limits on long-term charges will affect revenue from residents who remain in care for extended periods.

Grandfathering ensures a fair transition for those already in the system.

- **From 1 July 2025, new residential aged care entrants will follow the proposed new arrangements while those already in care will remain under current rules**.[32]
- Adoption of grandfathering across the proposed measures reflects the Aged Care Taskforce's "*Recommendation 6: Establish appropriate arrangements to allow older people and providers to smoothly transition to any new arrangements, including grandparenting arrangements for those already in residential aged care and phasing in for home care.*"[33]

NOTES AND SOURCES:

1. See the first reading of the Aged Care Bill 2024 and accompanying Explanatory Memorandum in relation to the bill: https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r7238; the Final Report of the Aged Care Taskforce ("Taskforce Report") for the Aged Care Taskforce's recommendations on funding: https://www.health.gov.au/sites/default/files/2024-03/final-report-of-the-aged-care-taskforce_0.pdf; and Case studies: residential care: https://www.health.gov.au/resources/publications/case-studies-residential-care?language=en
2. See Clause 308 of the bill; page 264 of the Explanatory Memorandum
3. See Response to the Aged Care Taskforce - Accommodation Reform: https://www.health.gov.au/resources/publications/response-to-the-aged-care-taskforce-accommodation-reform?language=en
4. See Clause 294 of the bill; page 259 of the Explanatory Memorandum
5. See "About the Australian National Aged Care Classification funding model": https://www.health.gov.au/our-work/AN-ACC/about, and "Funding higher wages in aged care": https://www.health.gov.au/our-work/AN-ACC/funding-higher-wages-in-residential-aged-care
6. See page 30 of the Taskforce Report
7. See Clause 600 of the bill; page 430 of the Explanatory Memorandum
8. See page 271 of the Explanatory Memorandum
9. See page 31 of the Taskforce Report
10. The median length of stay in residential aged care is 20.5 months (2022-23) according to the Australian Institute of Health and Welfare (AIHW): https://www.gen-agedcaredata.gov.au/topics/people-leaving-aged-care
11. See Clause 310 of the bill; page 265 of the Explanatory Memorandum
12. See Clause 310 of the bill; page 265 of the Explanatory Memorandum
13. For the current MPIR, see ""Base interest rate (BIR) and maximum permissible interest rate (MPIR) for residential aged care:" https://www.health.gov.au/resources/publications/base-interest-rate-bir-and-maximum-permissible-interest-rate-mpir-for-residential-aged-care?language=en
14. See page 20 of the Taskforce Report
15. See page 35 of the Taskforce Report
16. See Clause 290 of the bill; page 256 of the Explanatory Memorandum
17. See page 33 of the Taskforce Report
18. See Clause 235 of the bill; page 228 of the Explanatory Memorandum, and Clause 278 of the bill; page 247 of the Explanatory Memorandum
19. See page 3 of the Explanatory Memorandum Attachment B.6, Reform Means Testing in Residential Care and Changes to Treatment of Payments for Recipients of National Redress Scheme, Supplementary Impact Analysis, Department of Health and Aged Care
20. See the reference to aged care hotelling as part of "everyday living" on page 8 and Recommendation 10 on page 27 of the Taskforce Report
21. See page 26 of the Taskforce Report
22. See Clause 279 of the bill; page 247 of the Explanatory Memorandum
23. See page 11 of the Taskforce Report
24. See Clause 319 of the bill; page 271 of the Explanatory Memorandum
25. See page 25 for the reference to everyday living and accommodation and page 26 for Recommendation 9 of the Taskforce Report
26. See Clause 284 of the bill; page 251 of the Explanatory Memorandum
27. See Clause 284 of the bill; page 251 of the Explanatory Memorandum
28. See page 28 of the Taskforce Report
29. See Clause 284 of the bill; page 252 of the Explanatory Memorandum
30. See Clause 284 of the bill; page 251 of the Explanatory Memorandum
31. See Clause 279 of the bill; page 248 of the Explanatory Memorandum; and page 4 of the Explanatory Memorandum Attachment B.6, Reform Means Testing in Residential Care and Changes to Treatment of Payments for Recipients of National Redress Scheme, Supplementary Impact Analysis, Department of Health and Aged Care
32. See page 7 of the Explanatory Memorandum Attachment B.4, Aged Care Taskforce Response: Accommodation Reform, Supplementary Impact Analysis, Department of Health and Aged Care; and page 4 of the Explanatory Memorandum Attachment B.6, Reform Means Testing in Residential Care and Changes to Treatment of Payments for Recipients of National Redress Scheme, Supplementary Impact Analysis, Department of Health and Aged Care
33. See page 22 of the Taskforce Report

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