



AGED CARE ASSOCIATION AUSTRALIA

SUBMISSION

TO

REVIEW OF

THE

AGED CARE FUNDING INSTRUMENT

12 MARCH 2010

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2. Executive Summary

Aged Care Association Australia (ACAA) represents the providers of residential care, community care and seniors housing services across Australia.

ACAA welcomes the opportunity to comment on the operations of the Aged Care Funding Instrument (ACFI) which has now been in operation for close to two years.

This submission contains a list of objectives that ACAA has striven to ensure would be delivered under the ACFI regime.

It is pleasing to report that many of those original objectives have been met in whole or in part following the deployment of ACFI.

However, as is the case with any complex funding tool, not all planned objectives are fully delivered and not all outcomes are achieved as anticipated. This review is therefore very timely as it allows a thorough analysis of the lessons learnt to date and the opportunity to fully understand the acknowledged weaknesses and how best to address these weaknesses.

3. Recommendations

Set out below are the recommendations contained within this submission:

Matching Funding to Care Needs

It is Recommended the Review consider modification to ACFI to better reflect the following components of care:

- hydration
- maintaining independence in question 1 - 4
- behaviours that are not listed in questions 7 – 9
- assessment instruments that are appropriate to culturally and linguistically diverse groups
- adequate recognition of palliative care resource requirements
- inadequate recognition within question 12 of:
 - blood pressures
 - weight management
 - pain management
 - special feeding
 - nightly uridome placement
 - colostomy care
 - allied health supervision
 - crushing medications

Funding Outcomes

ACAA Recommends that approvals for entry into care actually attract minimum ACFI dollars to ensure an income stream from all sources of at least \$70.00 per resident per day.

ACAA Recommends that the Review undertakes an in-depth analysis to compare pre and post ACFI income streams against standard resident mix distribution and an analysis of what ACFI has delivered by way of an industry and individual site comparison.

Design of ACFI Instrument & role of health professionals

ACAA Recommends that the Review consider how to best modify the ACFI so as to allow a more flexible response to services specialising in services for clients with special needs.

ACAA Recommends that the system recognises the changes in the scope of practice of EN/RN and Division 2 staff within the CHC descriptions and directives.

Documentation and administrative arrangements

ACAA Recommends that the current requirement that a facility undertake a reassessment six months after admission from hospital be removed.

ACAA Recommends that the Business Rules surrounding the transfer of residents and the documentary evidence that can be used together with security and supportability of the ACFI assessment between facilities needs to be more clearly enunciated to providers.

ACAA Recommends that ACAT Low Care and ACFI High Care assessments be retrospectively funded from date of admission where ACAT confirms the ACFI High Care assessment.

ACAA Recommends that the Review consider permitting the use of the MMSE as an alternative to PAC-CIS.

ACAA Recommends the Review consider permitting the use of RUDAS tool or the KIKA tool as an alternative to the Cornell tool.

ACAA Further Recommends that the industry be permitted to use the Modified Geriatric Depression Scale as an alternative to the Cornell tool.

ACAA Recommends the continued development of eValidation to enable more efficient validation work flows.

Specified Care and Services

ACAA Recommends that a suitably qualified team of industry experts be convened to review the components of Schedule 1 – Specified Care and Services.

ACAA Further Recommends that the Review considers options for the future regular review of specified care and services.

ACAT/ACFI Interface

ACAA Recommends that research be undertaken to explore the interoperability between ACAT assessment outcomes and ACFI to determine whether there is sufficient statistical correlation between an ACAT assessed outcome and an ACFI assessed outcome to actually use one to confirm the other for validation purposes.

ACFI/Accreditation Interface

It is Recommended the Department foster dialogue with the industry through the ACFI and Accreditation Review Processes in order to achieve revised documentation integration between accreditation and industry systems.

Research

ACAA would strongly recommend that the minimum data set now available through ACFI documentation be created and shared as a source of information and learning about aged care and that this data be published to the industry at large.

Training

ACAA Recommends that the Department consider allocating a small portion of funding in future years that will support the industry's desire to maintain the assessment skills of staff involved in the ACFI assessment process.

4. Introduction

ACAA was instrumental in working with the Department of Health and Ageing and various consultancies to develop a funding assessment tool which adequately reflected the future requirements of the industry.

This process has taken many years and needed considerable tenacity and good faith between the various parties to achieve what ultimately has been a reasonably successful transition from the former RCS system to the ACFI system.

ACAA does not consider that the work of developing the ACFI is complete and doubts whether it will ever be complete as a funding instrument of this type needs to be a live instrument which is reflective of current practices and procedures employed by the industry and which clearly demonstrates a timely response to those changing practices and costs of care especially where those costs are reflective of changing care services producing enhanced quality outcomes for aged care clients.

ACAA is therefore pleased that the Government has met its commitment to undertake the 18 month review of the implementation of ACFI and has prepared this submission with the intent of providing the Department of Health and Ageing our considered opinion on a range of different issues which we believe need to be considered in the context of ongoing evolution and improvement to the ACFI as a funding tool for the industry.

5. ACFI Objectives

Any consideration of the ACFI and whether or not its implementation has been a success needs to be measured against the original objectives set by the aged care industry and the Department when initially framing the tool for implementation.

ACAA considered that the primary objectives for the implementation of the new funding instrument to replace the RCS were:

- a solution to the excessive documentation that the industry was routinely completing in an endeavor to meet the perceived validation requirements needed by Departmental validators;
- the need to radically change the corrosive nature of the relationship between the industry and the Department substantially driven by the ongoing tension between skilled professionals in the field having their professional judgment in making RCS assessments being then questioned and overruled by another professional from the Department;
- the need to recognize the escalating acuity level of high care residents requiring significantly higher levels of funding than the RCS was able to deliver;
- the need to provide a more objective and transparent methodology for undertaking the funding assessment process;
- the need to radically transform the existing validation process;
- the capacity of an electronically enabled new funding tool to significantly improve industry efficiencies through having the tool and supporting documentation electronically enabled and lodged through Medicare Australia;
- a recognition that an expansive and objective funding tool would enable a wealth of data to be provided to the industry at large on the nature and status of the residential aged care population; and
- the provision of a comprehensive minimum data set on residents would allow considerable improvement in planning and design once that data was able to be captured longitudinally.

6. Matching funding to care needs

Approved providers have reported that there are a number of care needs the ACFI tool does not capture that requires the involvement of significant staff time on a daily basis. These include:

- providing hydration frequently over a 24 hour period for the elderly who are prone to dehydration. This is due to a reduced thirst mechanism increasing the risk for urinary tract infections and subsequently requiring resources such as pathology, antibiotic medications prescribed by their doctor or a hospital stay;
- encouraging independence, which can only be claimed as “supervision” in Questions 1-4, can be more labour and time intensive than providing “physical assistance” yet this is funded at a lesser rate;
- behaviours that are often seen in residential care facilities have not been identified in Questions 7-9. These include, but are not limited to, emotional dependency and passive aggressive behaviours. Other behaviours exhibited in chronic psychiatric conditions such as bipolar disorders, schizophrenia and personality disorders as well as residents with intellectual disabilities are also not recognised in the ACFI;
- Australia is a multicultural society with 25% of the population aged over 65 years from culturally and linguistically diverse backgrounds. (*Ref: Dementia Resource Guide 2008 - Department of Health and Ageing*). Cultural and spiritual support, requiring staff time, is not currently recognised in the ACFI tool;
- lack of recognition that palliative care may extend over a number of weeks, months or years with periods of remission when care needs are not as heightened as in the other periods. The ACFI seems to only cater for “end of life” period. If this is the sole determinant, the end-of-life can happen quickly over 1-2 days and the Approved Providers should be able to claim retrospectively rather than the current experience where payment is only received from the date of the lodgment of the claim;
- not all residents requiring palliative care experience pain, yet this is a “requirement” for claiming in Question 12. Anecdotal evidence from members has identified that validators will not approve a claim for palliative care if the resident is not receiving pain relief via a syringe driver;

- Question 12 requires significant reworking to address the complex health care procedures undertaken by staff. These include:
 - recognition that blood pressures and blood glucose monitoring may occur less frequently than daily but still occur 2-3 times per week;
 - lack of recognition that residents may need to be weighed weekly over extended periods because of significant weight loss/gain;
 - pain management should recognise varied care interventions such as mobilizing residents or using aromatherapy or distraction therapy such as group activities or using reminiscence. Delivery of these therapies by staff including physiotherapy assistants and diversional therapy staff should also be included. These staff have the necessary skill levels to undertake interventions under delegation of the allied health professional, registered nurse or medical officer;
 - management of special feeding should be extended to suitably skilled staff other than a registered nurse. The skills shortage of RN's in the industry makes it almost impossible for Approved Providers to successfully claim in this area;
 - residents who require nightly uridome placement, which can sometimes take significant time, are only funded at the level of "supervision" in Question 4 when it should be funded at the level of "physical assistance";
 - management of colostomy care appliances by staff should also be claimable under "physical assistance";
- the previous funding tool (RCS), allowed claims for social and human needs. This captured the minority of anxious family members and the dysfunctional families where conflict occurs as to care delivery for the resident. Dealing with these residents and their families takes significant amounts of time throughout the day and may even occur every day. ACAA acknowledges this is a difficult area to quantify within a funding tool but would welcome reconsideration of this scenario;
- time spent providing physiotherapy, occupational therapy, podiatry and dental care for residents by staff under the direction of the allied health professionals should be a valid claim. The Allied Health Professionals are usually only on site for short period of time to assess, monitor and review resident needs and staff practices and may not have the time to provide weekly interventions; and
- Question 11 - Residents routinely require medications to be crushed. This takes staff time and is an important step in the process to ensure that the resident's medication is administered appropriately. Similarly, staff time is spent checking out controlled drugs to be administered to residents, but this is also not acknowledged within the funding tool.

7. Funding Outcomes

There is considerable disquiet within the industry that ACFI actually commences its paypoint from zero, in other words, ACAT can approve a person as eligible for entry into care but once the ACFI is applied the paypoint at which any dollars commence to flow are set so high that the first possible paypoint in all scenarios can be as high as \$6.80.

ACAA considers that there should be a minimum floor that is agreed by industry and the Department at which it is reasonable to accept that quality care and services cannot be provided at a point less than the agreed funding.

An analysis of hotel and accommodation services has estimated that the minimum cost of housing and supporting a person within a care setting is approximately \$70.00 per resident per day.

The frequency with which ACAT assessments for approval into care are attracting zero dollars under ACFI is a major concern. ACAA considers that it is a systemic flaw in the current system that an ACAT can assess somebody as requiring admission into care and yet that person when assessed by ACFI, actually attracts zero dollars.

ACAA is concerned that persons who fit this category are actually falling through the cracks and may not be able to access any form of care.

ACAA Recommends that approvals for entry into care actually attract minimum ACFI dollars to ensure an income stream from all sources of at least \$70.00 per resident per day.

ACAA considers that the CAP arrangements that have been applied to high high care have been a major impediment to providers who are caring for residents at the high end of care.

ACAA does not believe that the current ACFI model adequately addresses some of the complex care and service requirements that providers face:

- the cost of complex wound management is not adequately addressed;
- the clinical care requirement faced by a facility undertaking palliative care is not adequately reflected in the ACFI instrument. A person being provided with palliative care can face a considerable decline in functionality and place a strain on a facility's resources but for a limited period of time. ACAA believes that there needs to be some recognition that adequate palliative care requires considerably more resources than ACFI currently provides and should again be treated as a special supplement;

- there are uneven steps in the points between different levels on the ACFI claiming scale, for eg: very large steps in movement between low to medium ADLs;
- in a similar vein, the initial steps to gain any funding in any domain is substantial, thus leading in many instances to there being zero funding attached to a particular resident;
- the industry has expressed considerable concern about the funding attached to behavior management and as well the range of claimable behaviors that may be claimed under ACFI, does not adequately reflect the clinical care regime that most providers experience; and
- in addition to the wound management item referred to earlier, there are a range of additional high cost consumables that ACFI fails to adequately address, eg: tracheostomy care.

Based upon Departmental data, it would appear that the funding outcomes flowing from the ACFI have generated additional income for approximately 80% of providers or 70% if there had been no grandparenting. The Access Economics preliminary report on the first block of ACFI reassessments following implementation indicated an estimated additional funding of 2.9% over the four year implementation period.

Based upon information from the industry, these indicators seem to be borne out where providers can apply ongoing and significant resources towards the training, education and skills maintenance of staff who have been delegated responsibility for maintaining the ACFI assessment processes for an aged care provider.

ACAA considers that the ongoing training requirements for the industry are a constant burden and should be recognized by the Government as a significant cost to the industry which if done well, relieves much of the anxiety that Government has regarding the skills and adequacy of aged care staff in undertaking the ACFI assessment processes accurately. This issue is addressed later in this submission under the heading of training.

What is difficult for the industry to determine is a comparative analysis of the pre and post ACFI income stream particularly with the CAP on high end care and the grandparenting arrangements significantly distorting any comparative analysis.

ACAA Recommends that the Review undertakes an in-depth analysis to compare pre and post ACFI income streams against standard resident mix distribution and an analysis of what ACFI has delivered by way of an industry and individual site comparison.

8. Design of ACFI Instrument & role of health professionals

General Comment

The ACFI instrument has seen a significant change compared to previous tools used by the industry, though it has built on the capacity of former instruments and the models created as a driver within this industry.

We have listed below a range of ACAA comments on the current design and improvements we believe could be achieved to the ACFI instrument:

- there is ongoing change in the scope of practice for EN/RN Div 2 staff – this is not reflected in the CHC descriptions and directives;
- preparation of medication should be included in medication claim as this can be quite time consuming for residents with behavior or swallowing issues;
- behavior management is not always possible to claim – specialist psychiatric facilities have reported that their strategies are designed to **prevent** the triggers – so the behavior does not re-occur, but when they manage resident care in this manner, no funding is then provided to back up this specialist management;
- issues with mobility and ability to claim for ‘wanderers’ – How do you claim for a resident with dementia who ‘wanders’ but is a falls risk and so should be supervised – but is not able to remember that they should wait for staff; and
- there needs to be consideration of the inclusion of the fitting and removal of calipers in either mobility or CHC.

ACFI is not sufficiently flexible in recognising the particular needs of special needs groups such as former homeless persons, alcoholics, some ethno specific groups, indigenous services and some rural and remote services.

ACAA Recommends that the Review consider how to best modify the ACFI so as to allow a more flexible response to services specialising in services for clients with special needs.

ACAA Recommends that the system recognises the changes in the scope of practice of EN/RN and Division 2 staff within the CHC descriptions and directives.

8.2 System design

The following issues reflect industry concern about current design issues:

- incongruence between 'care needs' is the basis of all questions other than CHC- which is frequency based and reliant on charting to prove treatments;
- good that there has been an increased recognition of depression and pain BUT- denoting only a small number of treatments for pain management is contrary to ensuring 'best practice' and being able to individualise treatment to best meet resident needs;
- acquired brain injury not recognised as a diagnosis, yet there are an increasing number of residents presenting with this diagnosis;
- issue with dependence on diagnoses e.g. dementia and depression. There has been an issue with GPs being willing to document these as specific diagnoses (and reconfirm these within the timeframe), which can affect the level of the claim for some questions. The Commonwealth is requiring something which is outside a facility's control. GPs are only willing to document 'depressive symptoms' or 'cognitive impairment';
- a GP documentation of 'cognitive impairment' should be acceptable, instead of 'dementia'. It is an inappropriate expectation put on a facility to persuade a GP to document using specific 'wording' purely for the sake of ACFI- and they are often not willing to do so;
- the industry is also reporting residents who do not have a 'behavioural diagnosis' but have significant behaviours. When queried with the GP and/ or families, facilities are told that 'this is just their personality', so no diagnosis is forthcoming.
- some difficulties with changing between care levels particularly within the ADL domain. The 'jumps' are unequal e.g. a resident with 3 'B's in ADLs still does not have enough points; and,
- issue with severely debilitated residents who requires full care for all functions and who is on PEG feeding but unable to be classified as high in ADLs is not an accurate reflection of the actual level of care needs of the resident.

9. Documentation and Administrative Arrangements

The PAS-CIS tool

Feedback from providers indicates that a majority would prefer to use of the MMSE rather than the PAS-CIS tool. Their reasons include:

- the MMSE is still being used by doctors in the community and in hospitals as well as the ACAT teams. The MMSE score is often included on documentation from these professional bodies and provides a baseline which could then be used by clinical staff in facilities;
- when compared with the MMSE, the PAS-CIS does not allow clinical staff to more clearly define the particular difficulties that the resident is experiencing in the dementing process. Feedback from Approved Providers indicates that the MMSE allows for quicker assessment, care planning and use of the most appropriate interventions; and
- as defined by the Cognitive Skills Assessment Summary checklist found in the User Guide, there are significant numbers of residents entering aged care facilities where the PAS-CIS tool cannot be used. However some of these groups could be assessed using the MMSE.

ACAA Recommends that the Review consider permitting the use of the MMSE as an alternative to PAC-CIS.

The Cornell tool

Approved Providers catering for culturally and linguistically diverse residents (CALD) and aboriginal residents would like to be able to use the RUDAS tool or the KIKA tool and believe these should be incorporated into the ACFI assessment pack as validated tools.

Similarly members have requested the review process consider the use of the Modified Geriatric Depression Scale rather than the Cornell tool. Members state that it is simpler to use and does not require as much staff time to complete. It is the experience of Approved Providers that faced with scarce resources in terms of qualified staff, the Cornell tool is not being utilised as well as it might.

ACAA Recommends the Review consider permitting the use of RUDAS tool or the KIKA tool as an alternative to the Cornell tool.

ACAA Further Recommends that the industry be permitted to use the Modified Geriatric Depression Scale as an alternative to the Cornell tool.

Information Technology

The industry was insistent that with the implementation of the new funding tool, the tool be electronically enabled from implementation commencement. This objective was achieved and has had considerable uptake by the industry with a substantial expansion of the number of forms which are now available as a web form and over 80% of providers are now registered with Medicare Australia and over 70% lodging some or all of their documentation electronically.

What is, in the opinion of ACAA, even more important, is that this change in electronic capability following the implementation of ACFI is driving a rapid industry conversion to electronic care plans and the IT capability of the industry to achieve better integration between care plans and funding tool and to deliver clearer and more accurate outcomes that will objectively illustrate the industry's performance, through validation, accreditation and external clinical benchmarking.

eValidation

The trialing under the new instrument is still relatively new and there is a degree of learning by all parties in the process.

ACAA has welcomed the initial data on validations showing that there has been a drop in downgrades to an average of 16% accompanied by a substantial increase in the number of validations where validators are finding it appropriate to upgrade the resident classification. The industry has had considerable anxiety about what would happen when validations commence and it has been pleasing to see that to date, the Department's approach has been objective and cognizant of the learning exercise that all parties are currently facing.

ACAA also welcomed the convening by the Department of a sub-committee of the ACFI Reference Group to undertake the task of looking at eValidation as an option for the future.

The sub-committee has now met twice and it is hoped that there will be considerable progress shortly on how the industry's considerable uptake of IT capability can be converted into a process whereby Departmental validators can readily access the information that they require and streamline

the review of ACFI, particularly the possibility of undertaking a much higher proportion of desk audits so as to create less interference with the day to day operations of aged care facilities.

ACAA Recommends the continued development of eValidation to enable more efficient validation work flows.

Business Rules

Admissions from Hospital

ACAA considers that the six month reassessment required after admission from hospital is an unnecessary burden on the industry and is not adding to client outcomes or systems improvement.

ACAA would recommend that the current requirement that a facility undertake a reassessment six months after admission from hospital be removed.

Resident Transfers

It is still concerning that many providers are confused by the Business Rules surrounding resident transfers and what documentation is to accompany a transferring resident.

Similarly, providers are still confused regarding the possibility of accepting the existing ACFI and / or the requirement to undertake a fresh ACFI assessment.

ACAA would recommend that the Business Rules surrounding the transfer of residents and the documentary evidence that can be used together with security and supportability of the ACFI assessment between facilities needs to be more clearly enunciated to providers.

Low care default rate

ACAA believes that where an ACAT assessment has determined that a resident is low care and the ACFI determines that the resident is high care with a subsequent confirmation by an ACAT reassessment that the high care category is correct, that the ACFI high care status as agreed should be funded from the date of entry.

ACAA Recommends that ACAT Low Care and ACFI High Care assessments be retrospectively funded from date of admission where ACAT confirms the ACFI High Care assessment subsequently.

10. Specified Care and Services

ACAA does not feel that it is appropriate in this submission to comment directly on the individual items contained within Schedule 1 – Specified Care and Services, as we believe that this is a detailed clinical and technical exercise that needs to have clinical expertise employed to advise on any significant reform of the Schedule of Specified Care and Services.

ACAA recommends that a suitably qualified team of industry experts be convened to review the components of Schedule 1 – Specified Care and Services.

ACAA would be happy to nominate a number of industry representatives who have the skills to assist the Department in this exercise.

ACAA Further Recommends that the Review considers options for the future regular review of specified care and services.

11. ACAT/ACFI Interface

ACAA considers that the current ACAT/ACFI interface is functioning poorly and that there is a pressing need for the ACAT and ACFI assessment tools to be more closely aligned.

It is anticipated that by the middle of 2010, all ACCRs will be being submitted electronically. ACAA would contend that this presents an opportunity in which the ACAT and ACFI interface could be better aligned.

ACAA Recommends that research be undertaken to explore the interoperability between ACAT assessment outcomes and ACFI to determine whether there is sufficient statistical correlation between an ACAT assessed outcome and an ACFI assessed outcome to actually use one to confirm the other for validation purposes.

During the ACFI trial, a piece of work was undertaken to look at the correlation between the ACFI assessments and the ACAT assessments which demonstrated a high level of correlation between the two tools with an average disagreement of less than 10%.

It is timely to consider whether that trial and further research could be undertaken to look at possible improvements between the two assessment regimes.

12. ACFI/Accreditation Interface

ACAA is conscious of the improved documentation that has flowed from the implementation of ACFI, however sees that there is little integration between the requirements of accreditation assessors and the improvements achieved through the implementation of the ACFI tool.

Given the rapid adoption by the industry of electronic clinical care planning and the integration by many providers of clinical care planning and HR functions in IT support systems, there is we contend, an opportunity to achieve a much better integrated process between accreditation, clinical assessment and clinical care plans.

As the Department is currently undertaking a review of the accreditation system and standards as well as this review of the ACFI, it would seem logical that the Department foster some dialogue with the industry through both review processes to attempt to obtain a better documentary integration between the various systems.

It is Recommended the Department foster dialogue with the industry through the ACFI and Accreditation Review Processes in order to achieve revised documentation integration between accreditation and industry systems.

13. Research

One of the primary objectives agreed by the industry and the Department was that ACFI would create a wealth of data that had the capacity to inform the industry about the profile of residents, resident prognosis, resident diagnosis, length of stay within prognosis categories, disease prevalence and a range of other data.

ACAA has been very disappointed, that to date, the promised minimum data set has not been forthcoming.

The Department has recently commenced releasing a small data set specifically confined to ACFI assessed outcomes to enable the industry to continue some analysis of ACFI assessment profiles. This data though welcome, is quite a small component of what had originally been intended as one of the outcomes of the ACFI implementation.

ACAA would strongly recommend that the minimum data set now available through ACFI documentation be created and shared as a source of information and learning about aged care and that this data be published to the industry at large.

14. Training

ACAA is very conscious of the continuing ongoing need to maintain industry skills in the assessment processes that are fundamental to maintaining quality ACFI assessment outcomes.

It is in the best interest of the both the industry and the Department for quality assessment processes to be accurate and reliable. Outcomes achieving these objectives will at the end of the day lead to the lessening of Government concern about the exposure of public funds and much higher levels of certainty by Government that the industry's assessment skills are reflective of a client's needs.

It is therefore suggested that there is a mutual benefit to be achieved by maintaining and retaining the industry's skills at the highest possible level.

ACAA Recommends that the Department consider allocating a small portion of funding in future years that will support the industry's desire to maintain the assessment skills of staff involved in the ACFI assessment process.

15. Conclusion

ACAA is most anxious to see the benefits achieved through the ACFI implementation process maintained and to ensure that many of the negatives associated with the RCS scheme are not allowed to permeate the ACFI system as we continue to evolve this process.

ACAA would more than welcome the opportunity to provide further comment and evidence on any of the issues that we have addressed in this submission and look forward to working closely with the Department to ensure a highly successful outcome for the ACFI Review.