Australian Government

Department of Health and Aged Care

Aged Care Bill 2024 –Overview of Aged Care Funding (Chapter 4)

Senate Community Affairs Legislation Committee

Purpose

This document is to assist the Senate Community Affairs Legislation Committee in their inquiry into the Aged Care Bill 2024 (Bill) by providing an overview of what can be expected in the Aged Care Rules 2024 (Rules) regarding funding of aged care services ahead of their publication as an exposure draft on the Department of Health and Aged Care's website: health.gov.au/aged-care-act-consultation

This paper is provided ahead of the finalisation of the Rules and any policy included is subject to change pending legal advice and continued drafting.

This paper is not to provide explanation of policy contained in the Bill and should be read alongside the Bill and the explanatory memorandum where needed.

Context

The Australian Government introduced the Aged Care Bill 2024 (Bill) to Parliament on 12 September 2024.

The Bill brings together work on the new Support at Home program, recommendations of the Aged Care Taskforce (Taskforce) and responds to around 60 recommendations of the Royal Commission into Aged Care Quality and Safety (Royal Commission).

The Bill replaces the *Aged Care Act 1997* (Cth) (1997 Act) and the *Aged Care Quality and Safety Commission Act 2018* (Cth), and brings together the funding and regulatory arrangements for multiple existing and new aged care programs including:

- residential care,
- the Commonwealth Home Support Programme (CHSP),
- the National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC Program),
- the Multi-purpose Services (MPS) Program,
- the Transition Care Program (TCP), and
- the new Support at Home program.

The Bill enables fair co-contributions from those who can afford to contribute to the cost of their care, which are based on recommendations of the Taskforce. The aim of these reforms is to ensure that the aged care system is financially sustainable into the future.

As the Rules contain operational detail, drafting will take time, and stakeholders will also need time to consider them before they are finalised.

While it is difficult to commit to providing a defined set of Rules by a given time due to the complexity that can arise during drafting, the Department of Health and Aged Care (department) has released the Service List and we are prioritising the development of Rules for Chapter 4 relating to aged care funding arrangements.

Our intention is to have as many Rules as possible for Chapter 4 ready to support this Committee inquiry process, with a view to providing key aspects of them in October.

Overview of Chapter 4 of the Bill

Chapter 4 incorporates the Government's response to the Taskforce's recommendations.

Chapter 4 sets out the subsidies that apply to individuals for certain funded aged care services. The subsidies are described in two groups. Person-centred subsidies are linked to the eligibility of an individual, and provider-based subsidies are linked to a registered provider's characteristics such as their location, capacity, or specialisation. The new funding arrangements for person-centred subsidies covers the new Support at

Home program design features, including the end-of-life pathway, a restorative care pathway, and a new Assistive Technology and Home Modifications scheme.

Chapter 4 also sets out the individual fees and contributions that are payable for funded aged care services, including means testing rules to determine what an individual's contributions will be. Individuals' contributions to funded aged care services delivered in a home or community setting will be based on a combination of the individual's income and the kind of service delivered to them. No contributions will be required for the delivery of funded aged care services in the clinical supports category (e.g. nursing and physiotherapy). Contributions will be required for the delivery of funded aged care services in the independence category (e.g. personal care), and for the everyday living category (e.g. domestic assistance and gardening). There will be different rates for independence and everyday living in Support at Home. Assistive technology and home modifications will be equivalent to the independence category and prescriptions for assistive technology and home modifications will be fully funded by the Government under the clinical supports category. The Government will pay the remainder of the price as a subsidy to the individual's registered provider.

Chapter 4 contains rules about registered providers entering into accommodation agreements with individuals, the charging of accommodation payments and accommodation contributions, and the management of refundable accommodation deposits.

Defined terms

Service list

The Bill introduces the aged care service list which will prescribe the list of services for which funding may be payable. The draft service list had been released for consultation.

Service groups

The service groups as introduced in the Bill are:

- Home support
- Assistive technology
- Home modifications; and
- Residential care

Classification types

The classification types as introduced in the Bill are:

- Ongoing;
- Short-term; and
- Hospital transition

Classification levels

The Bill provides that the Rules must prescribe classification levels for each classification type for each service group. The classifications levels will be outlined in the Rules and may specify different levels for different service groups and set out different criteria for each classification level that are to be used in deciding an individual's classification level for a classification type for a service group.

Specialist aged care programs

The specialist aged care programs under the Bill are:

- CHSP;
- NATSIFAC Program
- MPS Program; and
- TCP

Service delivery branch

The term service delivery branch will replace ‘notified home care service’ from section 9 of the 1997 Act (also known simply as a ‘home care service’). The name change is to avoid confusion between ‘aged care services’ and ‘home care services’, but does not represent any intended operational changes for providers.

Person-centred subsidy

A person-centred subsidy is a payment made from the Commonwealth to a registered provider on behalf of an individual where the registered provider has delivered a Commonwealth subsidised service to that individual.

Primary person-centred supplements – supplements that are calculated before the subsidy reductions

The Bill establishes primary person-centred supplements for individuals accessing funded aged care services through the Home Support service group.

The power to create primary person-centred supplements in the Rules is consistent with the current approach for primary supplements in the 1997 Act, which are delegated to the Rules to allow for the Government to change rates to reflect cost increases, and to respond quickly to changing community need – updating eligibility and amounts, as well as creating new supplements where required. As an example, if a global pandemic were to impact aged care, the Rules could be updated to add a new supplement which would provide additional funding to registered providers without increasing administrative burden on the sector.

Secondary person-centred supplements – supplements that are calculated after the subsidy reductions.

The Bill establishes secondary person-centred supplements for individuals accessing funded aged care services through the Home Support service group. The power to create secondary person-centred supplements is delegated to the Rules to allow for the Government to respond quickly to changing community need – updating eligibility and amounts, as well as creating new supplements where required. This is consistent with the current approach for other supplements in the 1997 Act. As an example, if a group of persons need to be eligible for the fee reduction supplement, this group could be added to the eligibility criteria for the fee reduction supplement quickly and responsively, without an Act of Parliament.

Provider-based subsidy

The Bill sets out provider-based subsidies to help registered providers meet the fixed costs of aged care services. Funding will be linked to a service delivery branch or approved residential care home of the registered provider, to enable appropriate management of how services are delivered across individuals. Provider-based subsidies give registered providers the flexibility to deliver services in accordance to need.

Provider-based supplements

The Bill sets out that the provider-based supplements that apply to a service delivery branch or approved residential care home will be set out in the Rules. The Rules may prescribe the circumstances in which the supplements will apply to the service delivery branch and the supplement amount. As an example, a provider-based supplement may be applicable for a service delivery branch that is providing funded aged care services to an individual who is homeless.

Individual contribution rate

The Bill defines the individual contribution rate for a funded aged care service delivered to an individual on a day as the percentage specified in the individual contribution rate determination for the individual for the means testing category the service is in.

Means testing category

Each of the following is a means testing category for a service type delivered in a home or community setting:

- clinical supports;
- independence;
- everyday living.

Part 2—Commonwealth contributions

The Rules for Divisions 1 to 6 of Part 2 will replace the *Subsidy Principles 2014* (Cth) (Subsidy Principles) and Chapters 2A, 3 and 4 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014* (Cth) (Determination).

Division 1—Subsidy for home support

This Division allows for the Support at Home funding arrangements to be legislated. This Division does not apply to other programs delivered in a home or community setting, such as CHSP.

Subdivision A—Person-centred subsidy

An individual will be eligible for subsidy per section 191 where those requirements are met, and the individual does not have a CHSP classification in effect (to be prescribed under subparagraph 191(2)(d)(ii)) and the service is not one that has been funded via other means such as Medicare (to be prescribed under paragraph 191(2)(f). There are no circumstances to be prescribed under subparagraph 191(2)(e)(ii).

Note: if an individual has a Support at Home classification in effect, they may still be able to access CHSP funded services in specified circumstances, aligning with current policy settings between the Home Care Packages program and CHSP.

Under the Support at Home program, individuals will have an ongoing home support account balance (ongoing quarterly budget) where funding will accrue on the first day of the quarter to be used until the end of that quarter. To ensure that individuals can access any unspent credits from their quarterly budget, the Rules (subsection 193(5)) will provide that the amount to be rolled over each quarter is the higher amount of:

- $1000; or
- 10% of the amount credited under subsection 193(4), which is the base individual amount (noted below under section 194) and the sum of any primary person-centred supplements (section 196).

When there are multiple services delivered in a day, the order prescribed by the Rules (subsection 193(8)) will be in order of receipt.

The ongoing quarterly budget will not be credited in the following circumstances (subsection 193(10)):

- 393 days after a cessation notification is given by a registered provider (see paragraph 149(d) of the Bill) and no subsequent start notification is provided in this period (see paragraph 149(b) of the Bill).
- if no cessation notification is provided by the registered provider - 393 days after the date of the last service delivered and no subsequent start notification is provided in this period.
- 60 days after a residential start notification is provided by a registered provider for an individual accessing funded aged care services in the service group residential aged care and who was previously accessing the ongoing classification type for the home support service group.

Note: 393 days is the period of one year and four weeks.

The account will cease (subsection 193(11)) 60 days after an individual dies unless an extension has been granted by the System Governor for the provider to finalise claims under section 251 of the Bill.

The Rules (section 194) will provide that the base individual amount will be dependent on the individual's classification level and whether they have been allocated an interim budget or a maximum budget. The Rules will prescribe 8 ongoing classification levels and 2 short term classification levels for Support at Home. The classification levels were selected for smaller differences of funding across the classification levels to:

a. ensure that individuals were being allocated the most appropriate classification and level of funding based on their specific aged care needs; and
b. reduce the under-allocation and over-allocation of funding.

The classification levels are proposed to be:

Item	Classification Type	Classification Level	Indicative Annual Amount
1	Ongoing	SAH Classification 1	~ $11,000
2	Ongoing	SAH Classification 2	~ $16,000
3	Ongoing	SAH Classification 3	~ $22,000
4	Ongoing	SAH Classification 4	~ $30,000
5	Ongoing	SAH Classification 5	~ $40,000
6	Ongoing	SAH Classification 6	~ $48,000
7	Ongoing	SAH Classification 7	~ $58,000
8	Ongoing	SAH Classification 8	~ $78,000
9	Short-term	SAH Restorative Care Pathway	$TBC
10	Short-term	SAH End-of-Life	Up to $25,000 (for 16 weeks)

Note: The annual amounts are only indicative. The final budget amounts will be confirmed before the start of the program. The annual amount will be presented as a daily amount in the Rules. The Restorative Care pathway is still being evaluated to ensure that participants are receiving appropriate support to increase their independence to remain at home and restore function.

Should there be longer than expected wait times under the Support at Home program, the amount of subsidy payable to an individual will be 60% of the full budget of their classification, with the individual to then wait to receive the additional 40% of their budget. The purpose of the interim budget is to ensure that the individual can access funded aged care services while they remain in a queue awaiting their full budget.

The primary person-centred supplements to be prescribed under section 196 are:

- *Oxygen supplement*: the amount of the oxygen supplement for a day for an individual is $14.11.
- *Enteral supplement*: the amount of the enteral feeding supplement for a day for an individual is:
  - for bolus feeding—$22.36; and
  - for non-bolus feeding—$25.11.
- *Veterans' supplement*: the amount of the Veterans' supplement for a day for an individual is 11.5% of the base individual amount for the individual for the classification type for the service group for that day (as prescribed under section 194).

Similar to the hardship supplement for the Home Care Packages program under sections 48-10 to 48-12 of the 1997 Act, the Rules (section 197) will prescribe a fee reduction supplement as a secondary person-centred supplement that may be applicable in the following circumstances:

- **Financial hardship grounds** – the System Governor considers that the individual paying the individual contribution would cause them financial hardship.
- **Equity of access** – the individual is an Aboriginal or Torres Strait Islander person.

Subdivision B—Reduction amounts for person-centred subsidy

The compensation payment reduction for person-centred subsidy will mostly replicate the compensation reduction amount provisions under section 48-5 of the 1997 Act. The substantial difference in the Rules will be that if liability has not been apportioned to the individual, the amount of compensation payment reduction is the amount equal to the person-centred subsidy including any primary person-centred supplements, *and* the individual contribution amount. Under the 1997 Act, the compensation payment reduction amount is equivalent to the amount of person-centred subsidy including any primary person-centred supplements.

Subdivision C—Provider-based subsidy

The funded aged care service to be prescribed by the Rules for paragraph 201(b) is care management.

The Rules prescribed under section 203 will give effect to the pooled care management funding arrangements for Support at Home.

A newly established service delivery branch will be unable to be credited an amount from their previous quarter. Subsection 203(4) ensures that a newly established service delivery branch will be credited for the base provider amount and provider-based supplements for each individual over the first two quarters of the service delivery branch's operation. This ensures that newly established service delivery branches have sufficient credit in their account to deliver care management services.

The Rules will provide that on the first day of each financial year, the service delivery account (care management account) for a service delivery branch will be set as (subsection 203(6)):

- The account balance at the end of the previous financial year, provided it does not exceed the total care management amount at the first day of the final quarter of the previous financial year (subsection 203(5) of the Bill).
- If the amount in the account balance at the end of the previous financial year exceeds the amount credited on the first day of the final quarter of the previous financial year (subsection 203(5)), the account is credited by the amount that was credited at the start of the first day of the final quarter of the previous financial year.

For service delivery branches established in the last two quarters of the financial year, the care management account for a service delivery branch will be set as:

- The account balance at the end of the previous financial year (subsection 203(4)).

The base provider amount to be prescribed under section 204 will be equivalent to 10% of the base individual amount for each individual.

The Rules (subsection 205(1)) will provide that the provider-based supplement is defined as the care management supplement. The circumstances in which the care management supplement for a service delivery branch of a registered provider will apply are if the individual (as prescribed under subsection 205(2)):

- is an Aboriginal or Torres Strait Islander person; or
- is homeless or at risk of homelessness; or
- is a care leaver; or
- is referred from the Care Finders Program through the department to an aged care needs assessment; or
- is a veteran with a mental health condition that the Department of Veterans' Affairs (DVA) accepts is related to their service and has been approved for the primary person-centred supplement for Veterans under section 196.

Division 2 and 3 — Subsidy for assistive technology and home modifications

These Divisions allow for the Support at Home funding arrangements for the Assistive Technology and Home Modifications Scheme (AT-HM Scheme) to be legislated. This Division does not apply to other programs delivered in a home or community setting, such as CHSP.

The AT-HM Scheme will give individuals access to assistive technology and/or home modifications without needing to save up funds from their individual budgets. The funding will cover prescription from allied health professionals, when required, with wraparound supports to ensure the item is used safely and effectively.

Subdivision A—Person-centred subsidy

Assistive Technology

An individual will be eligible for subsidy per section 209 where those requirements are met, and the individual does not have a CHSP classification in effect (to be prescribed under subparagraph 209(2)(d)(ii)) and the service is not one that has been funded via other means such as Medicare or Continence Aids Payments Scheme (CAPS) (to be prescribed under paragraph 209(2)(f)). There are no circumstances to be prescribed under subparagraph 209(2)(e)(ii).

The Rules will provide that the account period and amount for each assistive technology tier are the following (sections 211 and 213):

Item	Classification Type	Classification Level	Amount	Account period
1	Short-term	(a) AT Low; or (b) AT Medium; or (c) AT High.	(a) $500 (b) $2,000 (c) $15,000	12 months from start day
2	Short-term	Short-term specified needs	$TBC	24 months from start day
3	Ongoing	Ongoing specified needs	$2,000	Until the individual's death or the classification goes out of effect under section 80.

Note: The short-term specified needs tier amounts for specific impairments are pending research from Monash University's Rehabilitation, Ageing, and Independent Living (RAIL) Research Centre and will be finalised and published closer to the commencement of the program.

The Rules will provide that individuals may access ongoing assistive technology if they have a valid prescription from a health professional that they require:

- The ongoing maintenance of an assistance dog, but only if a care recipient is not eligible for the Government funded Physical Assistance Dogs Program.
- Continence products, but only if the individual has exhausted their funding for the Continence Aids Payment Scheme or any jurisdictional programs they are eligible for.

Individuals may also access assistive technology that exceeds the above maximum $15,000 with a valid prescription from a health professional (section 212).

Home Modifications

An individual will be eligible for subsidy per section 218 where those requirements are met, and the individual does not have a CHSP classification in effect (to be prescribed under subparagraph 218(2)(d)(ii)) and the service is not one that has been funded via other means such as Medicare (to be prescribed under paragraph 218(2)(f)). There are no circumstances to be prescribed under subparagraph 218(2)(e)(ii).

The Rules will provide that the account period and amount for each home modifications tier are the following (sections 220 and 222):

Item	Classification Type	Classification Level	Amount	Account period
1	Short-term	(a) HM Low; or (b) HM Medium;	(a) $500 (b) $2,000	12 months from start day

2	Short-term	HM High	$15,000	12 months from start day, or extended to 24 months on application

As noted in the table above, individuals may extend the account period in the HM High tier if they meet the following:

- the individual has been approved for the high classification tier amount, and
- the registered provider has ongoing home modifications work that will take longer than the home modifications account period (i.e., 12 months).

Primary person-centred supplement

The AT-HM Scheme will introduce primary person-centred supplements for individuals living in rural or remote locations to offset higher costs possibly involved in the supply of assistive technology or home modifications. The Rules will provide that the primary person-centred supplement for an individual for the Assistive Technology and Home Modification service groups is the rural and remote supplement. The rural and remote supplement will apply where an individual lives in an area in the Modified Monash Model (MMM) 6-7 area. The amount of the rural and remote supplement will be confirmed before the start of the program.

Secondary person-centred supplements

The Rules will provide that the same rules for a fee reduction supplement for the Home Support service group (discussed above) are applicable for the Assistive Technology and Home Modification service groups.

Subdivision B—Reduction amounts for person-centred subsidy

The Rules will provide that the same rules the compensation payment reduction for the Home Support service group (discussed above) are applicable to the Assistive Technology and Home Modifications service groups, except the following change:

- the amount of compensation payment reduction excludes any primary person-centred supplements (i.e., the rural and remote supplement) under section 213 and 223 of the Bill.

Division 4—Subsidy for residential care

As far as possible, the Rules relating to residential care subsidies will not deviate from the existing arrangements of the Subsidy Principles and Determination, except as required to facilitate an agreed change, such as Taskforce recommendations. The amounts of subsidy included in the exposure draft will reflect the latest provisions, as at the date of publication; however, the final amounts on commencement of the Bill (subject to passage) will be subject to further indexation.

The Rules for Division 4, Chapter 4 will substantively replicate Chapter 2 of the Subsidy Principles and Chapter 2A of the Determination. While the substance of the Rules will not change, some of the subsidies and supplements have new names and have been grouped differently to facilitate the addition of the hotelling and non-clinical care contributions which replace the care subsidy reduction (section 44-21 of the 1997 Act). The new groupings and names are as below.

Rules name	1997 Act name	Subsidy Principles	Determination
Person-centred subsidy			
Base rate	Classification amount of the basic subsidy	Division 2, Part 3, Chapter 2	Section 64K
Primary person-centred supplements			
Accommodation supplement	Accommodation supplement	Subdivision A, Division 5, Part 3, Chapter 2	Section 64ZP

Rules name	1997 Act name	Subsidy Principles	Determination
Hotelling supplement	Hotelling supplement	Subdivision J, Division 5, Part 3, Chapter 2	Section 64ZT
Reduction amounts			
Compensation payment amount	Compensation payment reduction	Subdivision A, Division 4, Part 3, Chapter 2	Nil
Person-centred subsidy reduction	Care subsidy reduction	Subdivision B, Division 4, Chapter 2	
Secondary supplements			
Respite supplement	Respite supplement	Subdivision A, Division 4, Part 3, Chapter 2	Section 64ZI
Oxygen supplement	Oxygen supplement	Subdivision B, Division 4, Part 3, Chapter 2	Section 64ZJ
Enteral feeding supplements	Enteral feeding supplements	Subdivision C, Division 4, Part 3, Chapter 2	Section 64ZK
Initial entry supplement	Initial entry supplement	Subdivision I, Division 5, Part 3, Chapter 2	Section 64ZS
Veterans' supplement	Veterans' supplement	Subdivision D, Division 5, Part 3, Chapter 2	Section 64ZR
Fee reduction supplement	Hardship supplement	Subdivision B, Division 5, Part 3, Chapter 2	Section 64ZQ
Provider-based subsidy			
Base provider amount	Service amount of the basic subsidy	Division 2, Part 3, Chapter 2	Section 64M
Reduction amounts			
Compensation payment amount	Compensation payment reduction	Subdivision A, Division 4, Part 3, Chapter 2	Nil
Provider-based reduction	Care subsidy reduction	Subdivision B, Division 4, Chapter 2	Nil
Provider-based supplements			
Registered nurse supplement	Registered nurse supplement	Subdivision K, Division 5, Part 3, Chapter 2	Section 64ZU

Similarly, the Rules relating to determining whether an approved residential care home has a specialised status will be the same as those in Part 2, Chapter 2A of the Determination.

Division 5—Subsidy for certain specialist aged care programs

There are no proposed changes to policy between the 1997 Act and the Bill. The Rules will align the current policy settings with the new legislative framework, replacing Chapter 4 of the Subsidy Principles and Chapter 4 of the Determination.

Division 6—Subsidy claims and payment

Subdivision A—Claims and payment for home support, assistive technology and home modifications

The Rules for paragraph 251(2)(c) of the Bill will provide that the relevant period for ongoing funded aged care services delivered to an individual through the service groups Assistive Technology and Home Modifications is 60 days after the last day of the account period (the relevant account periods are noted above under Division 2 and 3).

Subdivision B—Claims and payment for residential care

There is nothing to prescribe in the Rules under this Subdivision, which will align with the 1997 Act.

Subdivision C—Claims and payment for specialist aged care programs

There are no proposed changes to policy between the 1997 Act and the Bill. Some aspects of the Rules will include matters that were previously dealt with in the agreements between the provider and the Commonwealth to provide transparency about program settings.

Subdivision D—Miscellaneous provisions

This Subdivision provides for circumstances when multiple claims are submitted (i.e. which registered provider gets paid subsidy) and the transfer of service delivery branches (referred to as notified home care services in the 1997 Act) and approved residential care homes (referred to as residential care services in the 1997 Act).

To avoid the current confusion that exists in the sector, subsection 262(4) will provide circumstances in which the System Governor will accept or reject multiple claims for each service group or classification type in the service group. For example, when a claim has been accepted by the System Governor for the ongoing classification type in the Home Support service group in respect of an individual, the System Governor may accept another claim for the same day where the claim is for:

- Short-term classification type in the Home Support service group, where the individual has a classification level of restorative care;
- Ongoing or short-term classification type in the Assistive Technology service group;
- Short-term classification type in the Home Modifications service group; and
- When a claim has been accepted by the System Governor for the ongoing classification type in the Residential Care service group in respect of an individual, and it is the individual's start day at the approved residential care home.

Section 263 will provide the following rules in relation to the transfer of a service delivery branch of a registered provider (**transferor**) to another registered provider (**transferee**):

- The transferor must take reasonable steps to ensure all claims are finalised under section 251 of the Bill for the service delivery branches involved in the transfer, prior to the transfer day (agreed upon by the transferor and transferee).
- The transferee may submit claims and be paid subsidy for funded aged care services delivered prior to the transfer day as if they had delivered those services where a claim for that service has not been submitted.
- Subsidy will be paid to the transferor for any claims that are payable immediately before the transfer day but not finalised before the transfer day.
- The transferor's service delivery branch account under section 203 will be transferred to the transferee with all credits.
- Any payable individual contributions that were unpaid by an individual under section 273 on the transfer day may be collected by the new registered provider.

While section 263 will provide for certain matters to be prescribed in the Rules for the transfer of an approved residential care home, it will depend on the drafting of the Rules under section 149 regarding starting and ceasing the delivery of funded aged care services and continuity of those services as to what is remaining to be included here. Regardless, it is the intent that transfer requirements under the 1997 Act be included in the Rules to support continuity of service to individuals and also that subsidy can be paid to the correct organisation.

Division 7—Grants

Section 268 of the Bill authorises the Rules to make provision for a new Grantee Code of Conduct. A similar arrangement can be found in subsection 20(1) of the *Disability Services and Inclusion Act 2023*.

Complying with the Grantee Code of Conduct is a condition on all grantees who receive a grant of financial assistance under section 265 of the Bill (i.e. general grants). The Grantee Code of Conduct is intended to set out broad, base level expectations on how grantees (or their workers or anyone else who is employed or otherwise engaged by the grantee) should conduct themselves when acting in accordance with the grant agreement.

For example, it is intended that the Grantee Code of Conduct will include requirements such as the grantee must provide activities in a safe and competent manner; act with integrity, honesty and transparency; and treat everyone with respect and courtesy.

This Grantee Code of Conduct is intended to operate alongside other obligations and duties that may apply to grantees, such as the Aged Care Code of Conduct and other conditions on registered providers in the Bill.

Part 3—Individual fees and contributions

The Bill provides for a lifetime cap on the total amount people will be expected to contribute to the cost of their aged care services through an individual contribution and a non-clinical care contribution (both defined in this Part). The lifetime cap will be prescribed in the Rules under section 7 as $130,000.

Division 1—Fees and contributions payable in a home or community setting

This Division provides for the calculation of individual contributions for the Support at Home program and the AT-HM Scheme.

This Division is closely linked to Part 5 regarding means testing (discussed below).

For Step 3(b) of the method statement, the table below includes the circumstances and the amount to be prescribed in the Rules.

For the following circumstances …	the amount is …
(a) the funded aged care service is any of the following (which involve the provision of products listed in the AT-HM List to the individual): (i) managing body functions; (ii) self-care products; (iii) mobility products; (iv) domestic life products; (v) communication and information management products; (vi) home modification products; and (b) the individual has an access approval in effect for, and the service is delivered to the individual through, the classification type ongoing or short-term for the service group assistive technology or home modifications	the amount of the cost of the product or service provided to the individual that is not a wraparound service.
(a) a classification decision establishing the classification level HM High in a classification type for the service group home modifications is in effect for the individual; and (b) the service is delivered to the individual through that classification type for the service group; and (c) the individual resides at a street address, or in a suburb or locality, that is in the MM category known as MM 6 or 7	the amount that is 66.6% of the cost of the service

The requirements for pricing to be included in the Rules (subsection 273(4)) are:

- that the provider must not charge above the final efficient price; and
- if the funded aged care service is delivered by a subcontracted organisation by request of the individual (i.e. they chose the subcontracted organisation and requested that the service be delivered by them specifically, rather than by the registered provider), the registered provider must not charge more than 10% of the actual cost of service as part of the price charged to the individual.

The second requirement listed is to protect self-managed clients from being charged high administration costs.

Division 2—Fees and contributions payable in an approved residential care home

The Rules for this Division largely replicate the existing provisions of the *Fees and Payments Principles 2014 (No. 2)* (Cth) (Fees and Payment Principles) and Part 1A, Chapter 5 of the Determination that relate to fees and contributions payable in residential care homes.

No Rules will be prescribed for sections 276 and 277 of the Bill. The Basic Daily Fee and the Respite Fee remain at 85% of the basic age pension amount.

The Rules will also incorporate Taskforce measures such that individuals will be required to make a hotelling contribution and non-clinical care contribution, subject to their daily means tested amount (Part 5 of this Chapter).

- The Bill establishes that the maximum hotelling contribution is equal to the maximum hotelling supplement, currently $12.55.
- The Rules (subsection 279(3) will prescribe the maximum amount of Non-Clinical Care Contribution as $101.16 per day.

Division 3—Fees and contributions for specialist aged care programs

There are no proposed changes to policy from current arrangements, whether included in the 1997 Act or in program guidelines. The Rules will align the current policy settings with the new legislative framework, replacing Chapter 4 of the Subsidy Principles and Chapter 4 of the Determination.

Part 4—Accommodation payments and accommodation contributions

The Rules for Part 4, Chapter 4 will largely replicate Part 4 of the Fees and Payments Principles and Parts 2 and 3 of Chapter 5 of the Determination, with adjustments to address changes in terminology and incorporate the below Taskforce measures related to Refundable Accommodation Deposit (RAD) retentions and Daily Accommodation Payment (DAP) indexation. These two taskforce measures are designed to improve viability of residential aged care accommodation funding arrangements.

RAD retentions

As recommended by the Taskforce, section 308 of the Bill requires providers to keep a small proportion of an individual's RAD each month that the individual remains in residential aged care. The rate of RAD retention will be set in the Rules at 2% per annum of the RAD or Refundable Accommodation Contribution (RAC) balance, calculated daily. RAD retention is limited to five years to protect individuals that remain in aged care for a long time. This change also applies to RACs which are used by individuals that receive support for some but not all of their accommodation deposits.

DAP Indexation

Under section 302 of the Bill, providers will be required to index the DAP that residents pay, ensuring that the cost of accommodation remains constant in real terms. Indexation will be set in the Rules, in line with the Consumer Price Index and will occur twice per year at the same time as the Accommodation Supplement is indexed (20 March and 20 September). DAP indexation arrangements will not impact Daily Accommodation Contributions (DACs) as they are calculated with reference to relevant means testing thresholds and the accommodation supplement.

Division 2—Maximum accommodation payment amounts and publication of certain amounts by the System Governor

The Rules for this Division, will replicate Division 3, Part 4, of the Fees and Payments Principles and Part 2, Chapter 5 of the Determination with minor changes, as outlined below, and to address changes in terminology.

Maximum accommodation payment amount

The Rules will set the maximum accommodation payment amount at $750,000, enabling providers to agree accommodation payment amounts up to this value for rooms in approved residential care homes without further approval from the Pricing Authority. This amount is currently $550,000 (section 110 of the Determination) and has not changed since 2014 despite significant increases in accommodation costs over the past decade. This change will also be made to the current Determination ahead of 1 July 2025.

Pause in Pricing Authority approval period pending provision of requested information

In addition to replicating the provisions in Division 3, Part 4 of the Fees and Payments Principles, the Rules will allow for the 28-day period currently provided at subsection 26(4) of the Fees and Payments Principles to be paused if the Pricing Authority requests further information from the provider. This period is for the Pricing Authority to review a submission from a provider confirming they have met the terms of a prior conditional approval to exceed the maximum accommodation payment amount.

Division 3—Accommodation agreements

The Rules for this Division will replicate section 17 of the Fees and Payments Principles, with minor changes. It provides information that must be included in an accommodation agreement.

The Rules will replicate the formula provided at sections 20, 22, 31, and 32 of the Fees and Payments Principles to enable:

- a RAD amount to be expressed as a daily accommodation payment amount,

- a daily accommodation contribution to be expressed as a refundable accommodation contribution, and
- the amounts of refundable deposit and daily payments to be worked out if an individual is to make a combination of payment types for their accommodation payment or contribution.

There will be minor adjustments to these formula to account for the indexation of daily accommodation payments.

Divisions 4, 5 and 6 —Charging of accommodation payments, accommodation contributions and daily payments

There will not be any Rules prescribed for Division 4 or 5. The formula for equivalence between deposit amounts and daily amounts are described in the Rules for the accommodation agreement.

The Rules for Division 6 will largely replicate the existing provisions in the Fees and Payments Principles and Determination. The method for determining the maximum permissible interest rate (MPIR) for subsection 301(3) will replicate the formula at section 6 of the Fees and Payments Principles and section 113 of the Determination.

The Rules for paragraph 302 will address:

- Frequency of payments – replicate section 34 of the Fees and Payment Principles, i.e. payment frequency must be agreed between the individual and the provider.
- When daily payments are to be indexed – twice per year, in line with the accommodation supplement (20 March and 20 September).
- How to index the daily accommodation payments – a formula to index the DAP and considers the refundable deposit balance (when paying by combination of payment types) previous retention amounts and DAP indexation. This is a new requirement, and the draft methodology proposed for the Rules is below. The proposed methodology preserves the intention that the RAD retention does not cause the individual's DAP to increase or require them to make top-up payments. Note that steps 1-2 are sufficient for an individual that has paid entirely by DAP.

Step 1. Work out the value of the agreed accommodation payment amount (agreed room price) as a DAP on the individual's start day, by using the existing formula of $DAP = \frac{RAD \times MPIR}{365}$;

Step 2. Apply indexation calculated as $\frac{Indexation\ factor\ on\ the\ day}{Indexation\ factor\ at\ entry}$ to the amount determined at Step 1;

Step 3. Determine the adjusted Refundable Deposit Balance by adding any previous retention deductions to the Refundable Deposit Balance ;

Step 4. Determine the proportion of agreed price covered by the adjusted Refundable Deposit Balance;

Step 5. Determine the proportion to be paid as a DAP;

Step 6. Multiply the proportion worked out at step 5 by the amount at step 2

Case study

Item	Amount
Agreed Room Price	$500,000
Indexation factor at entry	1.015
Indexation factor on the day	1.0773
MPIR	8.38%

Refundable Deposit	$280,000
Retentions taken	$20,000

Step 1. To work out the value of the agreed room price as a DAP, the provider must use the formula.

$$\frac{\$500{,}000 \times 8.38\%}{365} = \$114.79$$

Step 2. Apply the indexation factor to the amount determined at Step 1

$$\frac{1.0773}{1.015} \times \$114.79 = \$121.84$$

Step 3. To determine the adjusted refundable deposit balance, add the retentions taken ($20,000) to the refundable deposit balance ($280,000).

$$\$20{,}000 + \$280{,}000 = \$300{,}000$$

Step 4. Determine the proportion of agreed price covered by the adjusted Refundable Deposit Balance, by dividing the amount at step 3 by the agreed room price

$$\frac{\$300{,}000}{\$500{,}000} = 0.6$$

Step 5. To determine the proportion to be paid as a DAP, take the whole (1.0) and reduce it by the amount in step 4, i.e.

$$1.0 - 0.6 = 0.4$$

Step 6. Multiply the proportion worked out at step 5 by the amount at step 2

$$\$121.84 \times 0.4 = \$48.74$$

Division 7—Refundable deposits

Rules for this Division will replicate Part 6, and Divisions 1 and 3 of Part 7 of the Fees and Payments Principles with minor changes to account for changes in language in the Bill.

Part 5—Means testing

Division 1—Means testing in a home or community setting

Individual contribution rates will be set as a percentage of the price of each service. This means an individual will pay an individual contribution equal to the individual contribution rate, and the Government will pay the remainder of the price as a subsidy to the provider.

The rate will be based on the type of service:

- There will be no contribution for services in the Clinical category, with assessed clinical care needs to be fully funded by Government.
- Contributions for services in the Independence category (e.g. personal care) will be moderate, recognising that many of the services in this group play an important role in keeping people out of hospital and residential aged care.
- Everyday living services (e.g. domestic assistance and gardening) will attract the highest contribution rates, recognising that the Government does not typically fund these services for people at other stages of life.

Which services fall into each category is included in the Service List.

The rate will also be based on the individual's pension status. In the event an individual's income and assets are known because they are receiving a relevant pension or payment under the *Social Security Act 1991* (Cth) (SS Act), this information will be used to identify the individual's pension status. Where an individual is not receiving any relevant pensions or payments under the SS Act, or the individual's income and assets are not known, the System Governor will need to work out the value of the individual's income and assets through a means assessment to identify the individual's means and equivalent pension status.

The Rules (section 314) will prescribe the following pension statuses:

1. Full pensioner – an individual is a full pensioner if:
    a. they are a current means tested Income Support Payment (ISP) recipient under the SS Act (e.g., Age Pension, Disability Support Pensioner, etc) with a maximum payment rate of any means tested ISP; or
    b. The System Governor has worked out the individual's total assessable income and value of assets and has assessed the individual as having means that would make them eligible for the pension under the income and assets test under the SS Act.
2. Part-pensioner – an individual is a part-pensioner if:
    a. they are a current means tested ISP recipient under the SS Act (e.g., Age Pension, Disability Support Pensioner, etc) receiving less than (but greater than zero) the maximum payment rate of any means tested ISP.
    b. The System Governor has worked out the individual's total assessable income and value of assets and has assessed the individual as having means that would make them eligible for a part pension under the income and assets test under the SS Act.
3. Self-funded retiree (SFR) Commonwealth Seniors Health Card (CSHC) – an individual is a SFR CHSC holder if:
    a. The age pension is not payable to the individual for the relevant day and the individual is eligible to hold a CSHC as defined under the SS Act; or
    b. The System Governor has worked out the individual's total assessable income and has assessed the individual as having means that would make them eligible for the CSHC under the SS Act.
4. Self-funded non-CSHC holder – a self-funded non-CSHC holder is an individual for whom:

a. The age pension is not payable to the individual for the relevant day under section 1064 of the SS Act, and the individual is not a holder of a CSHC within the meaning of the SS Act; or

b. The System Governor has worked out the individual's total assessable income and has assessed the individual as having means that would make them not eligible for the pension or CSHC under the SS Act; or

c. Has a Mean Not Disclosed Status.

The individual will have a Means Not Disclosed status:

- If the individual is asked to provide specified information in relation to the assets and income within a specified period to assist the System Governor to determine the individual's individual contribution rate, and the individual fails to do so.
- If the individual makes an election to not disclose their assets and income.

Following the determination of an individual's person, the percentage contribution to the cost of services will be determined in line with the following table:

Means testing class	Means testing category – clinical supports	Means testing category – independence	Means testing category – everyday living
Full pensioner	0%	5%	17.5%
Part pensioner and Self-funded Commonwealth Seniors Health Card (CHSC) Holder	0%	Subject to independence rate means test (Between 5% and 50%)	Subject to everyday living rate means test (Between 17.5% and 80%)
Self-funded non-CSHC holder	0%	50%	80%

As noted in the above table, an 'independence rate means test' and the 'everyday living rate means test' will use an individual's assets and income to work out the individual contribution rate for their supports for independence and everyday living (as prescribed under section 314). The 'independence rate means test' and the 'everyday living rate means test' will be applied on a tapered rate between 5% and 50% for independence supports and between 17.5% and 80% for everyday living supports.

The calculation of the 'independence rate means test' and the 'everyday living rate means test' will be prescribed in the Rules as follows:

1. Step 1. Work out the income reduction amount.
2. Step 2. Work out the assets reduction amount.
3. Step 3. Work out the maximum reduction amount.
4. Step 4. Work out the input contribution rate.
5. Step 5. Work out the amount of the percentage:
    a. for the means testing category independence; and
    b. for the means testing category everyday living.

Step 1: Working out the income reduction amount

The method for working out the income reduction amount is as follows:

Step 1: Work out the amount that would be worked out as the individual's ordinary income for the purpose of applying Module E of Pension Rate Calculator A at the end of section 1064 of the Social Security Act.

Step 2: Work out the amount that would be worked out as the individual's ordinary income free area under point 1064-E4 of that Module.

Step 3: Subtract the amount under Step 2 from the amount under Step 1.

Step 4: Multiply the amount under Step 3 by 0.5 and round to the nearest dollar.

The result is the income reduction amount.

Step 2: Working out the assets reduction amount

The method for working out the assets reduction amount is as follows:

Step 1: Work out the value of the individual's assets in accordance with Division 1 of Part 3.12 of the Social Security Act, reduced by any amounts mentioned in section ^314BE of this instrument received by the individual.

Step 2: Work out the amount that would be worked out as the individual's assets value limit under point 1064-G3 of Module G of Pension Rate Calculator A at the end of section 1064 of the Social Security Act.

Step 3: Subtract the amount under Step 2 from the amount under Step 1.

Step 4: Multiply the amount under Step 3 by 0.078 and round to the nearest dollar.

The result is the assets reduction amount.

Step 3: Working out the maximum reduction amount

The method for working out the maximum reduction amount is as follows:

Step 1: Work out the individual's senior's health card income limit under point 1071-12 of the Seniors Health Card Income Test Calculator at the end of section 1071 of the Social Security Act.

Step 2: Subtract the individual's ordinary income free area (worked out under Step 2 of the method statement in section ^314DB) from the individual's senior's health card income limit.

Step 3: Multiply the amount under Step 3 by 0.5 and round to the nearest dollar.

The result is the maximum reduction amount.

Step 4: Working out the input contribution rate

The method for working out the input contribution rate is as follows:

Step 1: Divide the greater of the income reduction amount and the assets reduction amount by the maximum reduction amount.

Step 2: Express this figure as a percentage.

The result is the input contribution rate.

Step 5(a): Working out the percentage for the means testing category independence

The method for working out the percentage for the means testing category independence is as follows:

Step 1: Multiply the input contribution rate by 0.45.

Step 2: Add 5% to the Step 1 amount and round to 2 decimal places.

The result is the amount of the percentage for the means testing category independence.

Step 5(b): Working out the percentage for the means testing category everyday living

The method for working out the percentage for the means testing category everyday living is as follows:

Step 1: Multiply the input contribution rate by 0.625.

Step 2: Add 17.5% to the Step 1 amount and round to 2 decimal places.

The result is the amount of the percentage for the means testing category everyday living.

Example Step-by-Step Calculation

Step 1: Calculate the Income Reduction Amount

1. **Determine Brett's annual income:**
   - Brett is single and earns $26,000 annually from his income and receives a part-pension of $18,779.80 per annum.
   - Total annual assessable income: $26,000
2. **Subtract the income free area:**
   - The income free area is the amount of income that is not counted in the means test. This is $5,512 per annum.
   - Remaining income after free area: $26,000 - $5,512 = $20,488
3. **Apply the 50% reduction:**
   - The means test reduces the remaining income by 50% to calculate the income reduction amount.
   - Income Reduction Amount: $20,488 × 0.50 = $10,244 annually

Step 2: Calculate the Assets Reduction Amount

1. **Determine Brett's total assessable assets:**
   - Brett has assessable assets worth $350,000.
2. **Subtract the asset free area:**

- The asset free area is the amount of assets that are not counted in the means test. This is $314,000.
- Remaining assets after free area: $350,000 - $314,000= $36,000

3. **Apply the 7.8% reduction:**
   - Multiply the remaining assets after free area by 7.8% to calculate the assets reduction amount.
   - Assets Reduction Amount: $36,000 × 0.078 = $2,808

Step 3: Determine the Maximum Reduction Amount

1. **Maximum income limit:**
   - The annual maximum income limit for Brett is $95,400.
2. **Calculate the maximum reduction amount:**
   - The formula for the maximum reduction amount is: Maximum Reduction Amount = ($95,400 - $5,512) × 0.50
   - Maximum Reduction Amount: $44,944

Step 4: Calculate the Input Contribution Rate

1. **Compare the income reduction amount and the assets reduction amount:**
   - Income reduction amount: $10,244
   - Asset reduction amount: $2,808
2. **Calculate the input contribution rate:**
   - Divide the greater of the income reduction amount and the assets reduction amount by the maximum reduction amount.
   - $10,244 / $44,944 = 0.2279280882876468
   - Express this figure as a percentage: = 22.79280882876468% (input contribution rate)
   - No rounding occurs at this step.

Step 5: Calculate the Means Tested Percentage Contribution

1. **Calculate the final contributions rounded to 2 decimal places:**
   - Independence: (22.79280882876468% (input contribution rate) × 0.45) + 5% = 15.26%
   - Everyday Living: (22.79280882876468% (input contribution rate) × 0.625) + 17.5% = 31.75%

Varying or revoking individual contribution rate determination – Assistive Technology or Home Modifications

If an individual has home modifications that are yet to be completed or assistive technology that has yet to be delivered and installed, and a social security decision or change of circumstances results in an increase in the individual contribution rate – the new determination will apply for that funded aged care service on the day after the home modification works are completed or the assistive technology is delivered and installed (as prescribed under subsections 317(5) and 318(6)). This ensures equity for the individual so that they are not paying a higher individual contribution rate for the same assistive technology or home modifications funded aged care services that have yet to be completed or delivered.

Division 2—Means testing in approved residential care home

The Rules for this Division address means testing in Residential Care. The Rules incorporate Taskforce recommendations, as well as provisions from Subdivisions C to D of Division 4 of Part 3 of Chapter 2 the Subsidy Principles.

Subdivision A—Daily means tested amounts

The method for calculating an individual’s daily means tested amount is set out in the Bill. In simple terms it stipulates that where an individual's assessable income and assets exceeds the income and asset free areas, their daily means tested amount is equal to a proportion of that excess, depending on whether the value is

income or assets and the specific value of the excess. The method for determining the value of the individual's assessable income and assets, and how to determine an individual's income and asset free areas are set out in the Bill, as are the specific proportions of income or asset value that contributes to the daily means tested amount as the value exceeds certain thresholds. The thresholds are provided for in the rules as these amounts change over time with inflation. Indexation is also needed to ensure alignment with other rates in the aged care and/or age pension system.

The income and asset testing thresholds referred to in the methodology will be set out in the Rules. The amounts that will be included in the draft rules are below.

- First income threshold – $84,324
- Second income threshold - $95,400
- Third income threshold - $103,583
- Fourth income threshold - $131,279
- First asset threshold - $206,039
- Second asset threshold - $238,000
- Third asset threshold - $299,480
- Fourth asset threshold - $502,981

It is important to note that these thresholds are indexed twice annually on 20 March and 20 September each year, and this includes 20 March 2025 before the rules commence.

The third income and asset thresholds are also influenced by the level of the Hotelling Supplement, as the rate at which an individual is paying the full amount of the Hotelling Supplement. The government has announced a $1.89 uplift to the rate of the Hotelling Supplement from 1 July 2025, which will necessitate an increase in these rates.

The Rules for this Subdivision will also detail the process and timeframes the System Governor must follow before determining an individual has 'means not disclosed' status. This series of information requests and notifications must be followed when an individual does not disclose sufficient information to enable a means test to be completed.

This is not currently included in the 1997 Act, but is a process followed by Services Australia on behalf of the department.

Subdivision B—An individual's total assessable income

The Rules for this Subdivision will provide that:

- the income determination time (subsection 322(1)) is 28 days,
- the determination made in subsection 322(6) must not be for a day prior to the individual's start day,
- a notice to the individual must include summary of the individual's sources of income, and the assessed amounts (paragraph 322(9)(g)).

The Rules for section 323 regarding what types of amounts are to be included and excluded when determining an individual's assessable income will replicate Subdivision C and Subdivision CA of Division 4 of Part 3 of Chapter 2 of the Subsidy Principles (sections 42-46B).

The Rules for sections 324 to 328 formalise existing operational timeframes within which the System Governor must make decisions or provide notifications. These timeframes will be included in the Rules in response to stakeholder feedback that the Government should be accountable for making decisions in a timely manner. The timeframes will be 28 days.

Subdivision C—The value of an individual's assets

The Rules for this Subdivision will provide that:

- the time the System Governor has to determine the individual's assets is 28 days (subsection 329(1)),
- the determination made in subsection 329(6) must not be for a day prior to the individual's start day,
- a notice to the individual must include a summary of the individual's sources of income, and the assessed amounts (paragraph 329(9)(g)).

The Rules for subsection 330(7) will set the value above which the value of a homeowner's home is to be disregarded at $206,039.20. The Rules will also provide a clearer definition of principal home in situations where an individual owns more than one property.

Additionally, in determining an individual's assets, this section will prescribe that payments made under the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* must be excluded (note: these are not excluded for an individual's income as this payment is already excluded under the SS Act).

As per Subdivision B, the Rules will provide that the System Governor has 28 days in which to make decisions about varying or revoking a determination regarding the value of an individual's assets.

Subdivision D—Notifying of event or change in circumstances

The Rules for this Subdivision will require an individual to notify the System Governor of changes in circumstances within 14 days using an approved form and that providers must notify the System Governor of changes in circumstances via the claim at the end of the payment period.