

# **EXPLANATORY STATEMENT**

## ***Aged Care Act 1997***

## ***Aged Care (Transitional Provisions) Act 1997***

## ***Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2025***

### **Purpose and operation**

The *Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2025* (Amending Instrument) amends subordinate legislation to provide for changes to:

- how the responsibility of approved providers of residential care to deliver a staff average amount of direct care ('care minutes') each quarter is calculated
- the amount of residential care hotelling supplement
- implement the Modified Monash Model 2023 for the purposes of residential care and flexible care subsidy
- repeal the residential care outbreak management support supplement
- insert a new residential care 'care minutes supplement', including eligibility and the method for calculating the amount of the new supplement
- the method for calculating and other matters determining the amount of residential care basic subsidy
- the amount of residential care registered nurse supplement (RN supplement)
- the amount of the home care basic subsidy, home care oxygen supplement, the home care enteral feeding supplement, the home care viability supplement and the home care top-up supplement
- the method for calculating and the amount of the flexible care subsidy, where care is provided through a multi-purpose service or as transition care or as short-term restorative care
- the maximum daily price which can be charged by approved providers of home care for home care 'care management' and 'package management'.

Consequent to repeal of the residential care outbreak management support supplement and related flexible care outbreak management support supplement equivalent amounts, increases to residential care basic subsidy and certain components of the flexible care subsidy provided through multi-purpose services and as transition care include cover for outbreak management costs.

All changes are applicable in respect of aged care provided to care recipients (who are subject to the *Aged Care Act 1997* (Aged Care Act) and its legislative instruments) and continuing care recipients (who are subject to the *Aged Care (Transitional Provisions) Act 1997* (Transitional Provisions Act) and its legislative instruments). The only exception to this is that changes to the home care top-up supplement are applicable to continuing home care recipients only.

The Amending Instrument amends the following subordinate legislation:

- *Aged Care (Transitional Provisions) Principles 2014* (Transitional Provisions Principles)
- *Quality of Care Principles 2014* (Quality of Care Principles)
- *Subsidy Principles 2014* (Subsidy Principles)
- *User Rights Principles 2014* (User Rights Principles)
- *Aged Care (Subsidy, Fees and Payments) Determination 2014* (Subsidy Determination)
- *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014* (Transitional Provisions Determination).

## Background

The Aged Care Act, the Transitional Provisions Act and the *Aged Care Quality and Safety Commission Act 2018* (the ACQSC Act) provide for the funding and regulation of aged care services.

Providers who are approved under the ACQSC Act to provide aged care (approved providers) may be eligible to receive subsidy payments in respect of the care they provide to a person who has been approved under the Aged Care Act as a recipient of aged care (approved care recipient) and as a continuing care recipient under the Transitional Provisions Act. The Aged Care Act and the Transitional Provisions Act provide that, for each type of aged care, the Minister may determine the amount of subsidy payable to an approved provider for the provision of that type of aged care.

The Aged Care Act and Transitional Provisions Act also provides that approved providers have responsibilities in relation to the aged care they provide. These responsibilities relate to matters that include the quality of care, fees and payments, and accountability for the care that is provided and for the suitability of key personnel. Sanctions may be imposed under Part 7B of the ACQSC Act on approved providers who do not meet their responsibilities.

### *Residential care changes*

#### Staff average amount of direct care ('care minutes')

**Schedule 1** of the Amending Instrument amends the Quality of Care Principles from 15 September 2025 to change the method for calculating the responsibilities to provide a combined staff average amount of direct care per care recipient per day and a registered nurse average amount of direct care per care recipient per day in respect of a residential care service for a quarter of a financial year for the approved provider of the service.

The Government accepted and implemented recommendation 86 of the Final Report of the Royal Commission into Aged Care Quality and Safety (Final Report), which recommended, amongst other matters, that Government should require approved providers of residential care to meet a minimum staff time quality and safety standard.

Recommendation 86 of the Final Report also recommended that the minimum staff time standard should be linked to what is now known as the classification amount element of basic subsidy for residential care, so that approved providers with a higher-than-average proportion of high needs care recipients should be required to engage additional staff, and vice versa. Accordingly, the method to calculate the care minutes responsibility places relative weights (through varying direct care per care recipient per day 'amounts') on care recipients' classification levels under Part 2.4A of the Aged Care Act.

Schedule 1 aligns the calculated care minutes responsibilities at specific residential care services with amended classification amounts of residential care basic subsidy (see **Part 2 of Schedule 3**).

#### Hotelling supplement amount

**Schedule 2** of the Amending Instrument amends the Subsidy Determination and the Transitional Provisions Determination from 20 September 2025 to change the amount of the hotelling supplement (a residential care 'primary supplement') for routine indexation and to take into account aged care costing and pricing advice to Government from the Independent Health and Aged Care Pricing Authority (IHACPA), consistent with IHACPA's function

to provide such advice under section 131A of the *National Health Reform Act 2011* (NHR Act). Government policy is to index the amount of the hotelling supplement annually on 20 September, taking into account changes in costs relevant to hotelling services as advised by IHACPA.

The amount of the hotelling supplement, together with other funding sources, is intended to sufficiently cover approved providers' costs of providing to care recipients the *hotel services* in Part 1 of Schedule 1 of the Quality of Care Principles. The hotelling supplement also assists with the costs of employing non-care staff for such services, which include catering, cleaning and laundry.

#### Modified Monash Model

**Part 1 of Schedule 3** of the Amending Instrument amends definitions in the Accountability Principles, Quality of Care Principles, Subsidy Determination and Transitional Provisions Determination from 1 October 2025 to implement the current (2023) iteration of the Modified Monash Model and its associated 2023 Modified Monash (MM) categories. The change implements the Modified Monash Model 2023 and the 2023 MM Categories for the purposes of determining amounts of residential care subsidy through the changes in **Part 2 of Schedule 3** and amounts of flexible care subsidy through the changes in **Part 4 of Schedule 3**.

#### Outbreak management support supplement

**Part 2 of Schedule 3** of the Amending Instrument amends the Subsidy Principles, Subsidy Determination, Transitional Provisions Principles and Transitional Provisions Determination to repeal the outbreak management support supplement (a residential care 'other supplement'), consistent with a previously announced 2024 MYEFO decision of Government. Related amendments in Part 4 of Schedule 3 of the Amending Instrument repeal outbreak management support supplement equivalent amounts in certain components of flexible care subsidy for multi-purpose service and transition care.

Ongoing funding for outbreak management costs continues instead through incorporation of an amount for costs associated with outbreak management in residential care basic subsidy (see **Part 2 of Schedule 3**) or alternatively through changes to flexible care subsidy (see **Part 4 of Schedule 3**).

#### Care minutes supplement

**Part 2 of Schedule 3** of the Amending Instrument also amends the Subsidy Principles, Subsidy Determination, Transitional Provisions Principles and Transitional Provisions Determination to insert a new 'care minutes supplement'.

The new supplement implements the Government's 'Linking care minutes to care' measure, announced at MYEFO 2024, to link residential care funding to the delivery of care minutes in all non-specialised residential care services in metropolitan areas (that is, with a street address in the 2023 MM 1 category). The measure will not apply to residential care services with specialised Aboriginal and Torres Strait Islander status or homeless status (as defined in Part 2 of Chapter 2A of the Subsidy Determination) and in regional centres and large rural towns, medium and small rural towns, and remote and very remote communities (that is, with a street address in the 2023 MM 2, 3, 4, 5, 6 or 7 categories).

The change aims to lift compliance by approved providers of residential care services in metropolitan areas with their existing direct care (or care minutes) responsibilities,

established by sections 9 and 10 of the Quality of Care Principles. Compliance with care minutes responsibilities is particularly low in metropolitan areas, where workforce shortages do not explain the level of non-compliance. This change will ensure the Government's substantial investment in residential care leads to more care time for residents, as intended.

The new supplement will be established as a residential care 'other supplement' with an amount per care recipient per day at a residential care service for a payment period that depends on a performance comparison with respect to a specified prior quarter between:

- the average amount of direct care actually provided through the service by the direct care staff members of the approved provider per counted care recipient per day and by the registered nurse and enrolled nurse staff members of the approved provider per counted care recipient per day, and
- the legislated responsibilities of the approved provider for that quarter and that residential care service to provide direct care by direct care staff members and direct care by registered nurse and enrolled nurse staff members.

The first specified quarter for purposes of calculation of the amount of the supplement will be the October to December 2025 quarter. Due to availability of care minutes data with respect to that quarter, the resulting supplement amount itself will not become payable until the April 2026 payment period.

For the payment periods April 2026, May 2026 and June 2026 calculation of the amount of the supplement will compare care minutes performance against care minutes responsibilities for the October to December 2025 quarter. For the payment periods July 2026, August 2026 September 2026 calculation of the amount of the supplement will compare care minutes performance against care minutes responsibilities for the January to March 2026 quarter, and so on as later quarters follow.

#### Residential care basic subsidy amount and method for calculation of amount

**Part 2 of Schedule 3** of the Amending Instrument also amends the Subsidy Determination and the Transitional Provisions Determination from 1 October 2025 to change the following elements of residential care basic subsidy:

- the amount of the national efficient price (NEP)
- the amount of national weighted activity units (NWAUs) associated with 'classification amounts'
- the amount of NWAUs associated with 'service amounts'
- the version of the Modified Monash Model (MMM) used for the purposes of calculating service amounts.

Residential care *basic subsidy* consists of a *classification amount*, linked to a care recipient's classification level under Part 2.4A of the Aged Care Act, and a *service amount*, linked to specified characteristics of the residential care service where a care recipient receives care. The dollar value of a given classification amount and a given service amount is calculated by reference to how many NWAUs are associated with the amount and the NEP (with the NEP being the dollar value of one NWAU).

Government policy is to change residential care basic subsidy each year on 1 October, taking into account aged care costing and pricing advice from IHACPA, consistent with IHACPA's function to provide such advice under section 131A of the NHR Act.

Change to the NEP reflects IHACPA's advice that the overall cost of providing residential care has increased since the NEP was last legislated. It also incorporates an additional amount for ongoing costs associated with outbreak management given the repeal of the outbreak management support supplement.

Change to the NWAUs associated with classification amounts and the service amounts reflect IHACPA's advice that the relative costs of providing residential care between care recipients with different residential care classification levels and between different types of residential care services have changed since the classification amounts and service amounts were last legislated.

Change to NWAUs associated with service amounts will have the effect of better recognising the significant differences in the average 'fixed' costs of delivering care on a day to care recipients in metropolitan areas, regional centres and large rural towns, medium and small rural towns, and remote and very remote communities (per the relevant 2023 MM categories).

#### RN supplement amount

**Part 2 of Schedule 3** of the Amending Instrument also amends the Subsidy Determination and the Transitional Provisions Determination from 1 October 2025 to change the dollar value of facility amounts for qualifying facilities with a street address in the 2023 MM 1 category (that is, metropolitan areas).

The RN supplement is an 'other supplement' that provides additional subsidy to eligible approved providers of residential care for RNs providing, or directing the provision of, care to residential care recipients to meet an approved provider responsibility under subsection 54-1A(2) of the Aged Care Act. The responsibility is to ensure, at all times on and after 1 July 2023, there is at least one registered nurse (within the meaning of the *Health Insurance Act 1973*) on site, and on duty, at each residential facility through which the approved provider provides residential care (the 24/7 RN responsibility).

The RN supplement recognises that meeting the 24/7 RN responsibility may be more difficult for an approved provider who is operating a residential facility that, on average, hosts few care recipients. These residential facilities receive smaller amounts of basic subsidy that can be used to employ sufficient RNs to meet the 24/7 RN responsibility. Working out the amount of RN supplement payable includes working out whether a residential facility is either a *group A qualifying facility* or *group B qualifying facility*. The appropriate *facility amount* is then calculated depending on whether it is a group A or group B qualifying facility.

The change will ensure facility amounts at qualifying facilities will be set from 1 October 2025 so that, between basic subsidy and the new facility amounts of RN supplement, approved providers operating residential facilities with relatively few care recipients are sufficiently funded to meet the 24/7 RN responsibility.

#### *Home care subsidy changes*

From 1 October 2025, national award wages will increase for many non-residential aged care workers as a result of the Fair Work Commission's Aged Care Work Value Case (ACWVC) determinations. Home care changes in the Amending Instrument give effect to the Government's commitment to fund the impact of the determinations by increasing funding in recognition of ongoing increased wage costs.

**Part 3 of Schedule 3** of the Amending Instrument amends the Subsidy Determination and the Transitional Provisions Principles to increase in respect of a day from 1 October 2025 the amount of home care basic subsidy payable to approved providers of home care services.

The part also amends the Subsidy Determination to increase in respect of a day from 1 October 2025 the following amounts payable to approved providers of home care services:

- home care oxygen supplement amount (a ‘primary supplement’)
- home care enteral feeding supplement amount (a ‘primary supplement’)
- ARIA value viability supplement amount (an ‘other supplement’)
- MMM value viability supplement amount (an ‘other supplement’).

The part also amends the Transitional Provisions Principles to increase in respect of a day from 1 October 2025 the amount of home care top-up supplement amount (a ‘primary supplement’).

#### *Flexible care changes*

From 1 October 2025, award wages will increase for many aged care workers as a result of the Fair Work Commission’s ACWVC determinations. Many of the flexible care changes in the Amending Instrument give effect to the Government’s commitment to fund the impact of the determinations by increasing funding in recognition of ongoing increased wage costs. This is identified case-by-case in following sections on specific flexible care subsidies.

#### Flexible care subsidy amount for care provided through a multi-purpose service

**Part 4 of Schedule 3** of the Amending Instrument amends the Subsidy Determination from 1 October 2025 to implement the Modified Monash Model 2023 and its associated revised 2023 MM categories for the Multi-Purpose Service Program (MPSP). This change impacts the calculation of location-based elements for the flexible care subsidy where care is provided through a multi-purpose service. In practice, it impacts the funding to be paid to approved providers for service delivery at only two multi-purpose services, increasing the amount of subsidy they will be paid from 1 October 2025. Transitional provisions are, however, also incorporated to ensure no other provider experiences a reduction in funding due to the application of the 2023 MM categories to the MPSP.

The Amending Instrument also amends the Subsidy Determination to reflect that the ‘Outbreak management support supplement amount’ (or ‘OMSA’) will no longer apply to the MPSP from 1 October 2025, consistent with the repeal of the outbreak management support supplement (see Schedule 5). Equivalent increases have, however, been made to the applicable amount for a residential care place. They ensure there is no decrease to the subsidies paid to MPSP providers and to continue to cater for costs associated with outbreak management.

Part 4 of Schedule 3 also amends the Subsidy Determination to increase the aged care wage supplement amounts allocated to 3 approved providers of flexible care through a multi-purpose service from 1 October 2025. The increased amounts will support providers to pay increased award wages for aged care workers from 1 October 2025 for the impact of the Fair Work Commission’s ACWVC determinations.

#### Flexible care subsidy amount for care provided as transition care

**Part 4 of Schedule 3** of the Amending Instrument also amends the Subsidy Determination from 1 October 2025 to remove all references to ‘Outbreak management support supplement amount’ (or ‘OMSA’) in the method for calculating flexible care subsidy for care provided

as transition care. This change is consequential to repeal of the outbreak management support supplement (see **Part 2 of Schedule 3**).

The part also amends the Subsidy Determination from 1 October 2025 to increase the basic subsidy amount for flexible care provided as transition care. The increase is both to take account of the impact from 1 October 2025 of the Fair Work Commission's ACWVC determinations and to incorporate an additional amount for costs associated with outbreak management given the repeal of the OMSA amount in the method for calculating flexible care subsidy for care provided as transition care.

The part also amends the Subsidy Determination from 1 October 2025 to increase the transition care dementia and veterans' supplement equivalent amount. The increase is to take account of the impact from 1 October 2025 of the Fair Work Commission's ACWVC determinations.

#### Flexible care subsidy amount for care provided as short-term restorative care

**Part 4 of Schedule 3** of the Amending Instrument amends the Subsidy Determination from 1 October 2025 to increase the basic subsidy amount for flexible care subsidy provided as short-term transition care. The increase is to take account of the impact from 1 October 2025 of the Fair Work Commission's ACWVC determinations.

The part also amends the Subsidy Determination from 1 October 2025 to increase the short-term restorative care dementia and veterans' supplement equivalent amount. The increase is to take account of impact from 1 October 2025 of the Fair Work Commission's ACWVC determinations.

#### *Home care maximum daily prices for care management and package management*

**Part 5 of Schedule 3** of the Amending Instrument amends the User Rights Principles to increase the maximum daily prices for care management and package management which can be charged by approved providers of home care in respect of a day from 1 October 2025, in line with home care subsidy increases.

#### **Authority**

Section 96-1 of the Aged Care Act provides that the Minister may, by legislative instrument, make Principles specified in the second column of the table in that section providing for matters required or permitted, or necessary or convenient, to give effect to the corresponding part or section of the Act specified in the third column of the table. This includes the Accountability Principles, Quality of Care Principles, Subsidy Principles and User Rights Principles.

The Aged Care Act also provides that for each type of aged care the Minister may, by legislative instrument, determine the amount of subsidy and supplement payable to an approved provider for the provision of that type of aged care.

Specifically, the authority provisions in the Aged Care Act for making specific determinations in the Amending Instrument are set out in the following table:

Type of Care	Aged Care Act section
<b>Residential care</b>	
Basic subsidy amount and method	subsection 44-3(3)
Other supplement and method and amount	subsection 44-27(3)
Direct care responsibility	paragraph 54(1)(h)
<b>Home care</b>	
Basic subsidy amount	subsection 48-2(2)
Primary supplement amount	subsection 48-3(3)
Other supplement amount	subsection 48-9(3)
Maximum prices for home care packages care management and package management	paragraph 56-2(1)
<b>Flexible care</b>	
Flexible care subsidy amount	subsection 52-1(2)

Section 96-1 of the Transitional Provisions Act provides that the Minister may, by legislative instrument, make Transitional Provisions Principles for matters required or permitted by the Transitional Provisions Act to be provided or necessary or convenient to be provided to carry out or give effect to the Transitional Provisions Act.

The Transitional Provisions Act also provides that for residential care and flexible care the Minister may determine, by legislative instrument, the amount of subsidy and supplement payable to an approved provider for the provision of that type of aged care. In relation to home care, the Transitional Provisions Act provides that the amount of home care subsidy payable to an approved provider in respect of a care recipient is the amount specified in the Transitional Provisions Principles.

Specifically, the authority provisions in the Transitional Provisions Act for making specific determinations in the Amending Instrument are set out in the following table:

Type of Care	Transitional Provisions Act section
<b>Residential Care</b>	
Basic subsidy method and amount	subsection 44-3(3)
Other supplement and method and amount	subsection 44-27(3)
<b>Home Care</b>	
Home care subsidy amount	subsection 48-1(2)
<b>Flexible Care</b>	
Flexible care subsidy amount	subsection 52-1(2)

### **Reliance on subsection 33(3) of the *Acts Interpretation Act 1901***

Under subsection 33(3) of the *Acts Interpretation Act 1901*, where an Act confers a power to make, grant or issue any instrument of a legislative or administrative character (including rules, regulations or by-laws), the power shall be construed as including a power exercisable in the like manner and subject to the like conditions (if any) to repeal, rescind, revoke, amend, or vary any such instrument.



## Commencement

The Schedules to the Amending Instrument commence as follows:

- Schedule 1 – 15 September 2025
- Schedule 2 – 20 September 2025
- Schedule 3 – 1 October 2025.

## Consultation

Providers and jurisdictions have been consulted about the general intention and nature of these changes. There has, however, been no consultation with the aged care sector on any of the specific amounts of subsidy increases for residential care basic subsidy and supplements, home care basic subsidy and supplements or flexible care subsidy.

Information about the specific amounts of aged care subsidies and supplements legislated in this Amending Instrument was communicated to approved providers through electronic media channels in early September 2025. Residential care measures will also be discussed by officials of the Department of Health, Disability and Ageing (Department) at a meeting of the Residential Care Funding Reform Working Group on 15 September 2025.

Changes to hotelling supplement (**Schedule 2**) and residential care basic subsidy (**Part 2 of Schedule 3**), including to the NEP, the classification amounts and the service amounts, reflect the Government's consideration of advice from IHACPA. Since August 2022, IHACPA has had the function of providing advice to Government (through relevant Commonwealth ministers) on aged care costing and pricing matters (see section 131A of the NHR Act).

IHACPA's advice reflects collection and analysis of data from the residential aged care facilities that participated in the Residential Aged Care Cost Collection 2024 and analysis of data in approved provider Aged Care Financial Reports (submitted annually under sections 31 to 41 of the *Accountability Principles 2014*).

The Department consulted with representatives of the residential aged care sector on design of the care minutes supplement (**Part 2 of Schedule 3**). Details are in section 5 of the Impact Analysis at **Attachment C**.

Increases to home care subsidy and prices and to supplements and flexible care subsidy (**Parts 3, 4 and 5 of Schedule 3**) continue implementation of the Government's commitment to fund the outcomes of the Fair Work Commission's ACWVC determinations. This commitment has been welcomed by aged care sector representatives.

Other changes to the flexible care subsidy for MPSP providers have been communicated in advance through existing communications mechanisms including monthly working group meetings with State and Territory health representatives, and webinars with providers.

## Impact Analysis

The Office of Impact Analysis has advised that a detailed impact analysis is not required for the changes in **Schedule 1**, **Schedule 2** and **Parts 1 and 2 of Schedule 3** (except inserting the new care minutes supplement) (OIA25-09845 and OIA25-09839), for **Parts 3 and 5 of Schedule 3** (OIA25-08831) and for **Part 4 of Schedule 3** (OIA25-08845).

In September 2025 the Department completed a detailed impact analysis for the care minutes supplement (see relevant components of **Part 2 of Schedule 3**), OIA24-08087, included at **Attachment C**.

### **General**

The Amending Instrument is a legislative instrument for the purposes of the *Legislation Act 2003*.

Details of the Amending Instrument are set out in **Attachment A**.

The Amending Instrument is compatible with the human rights and freedoms recognised or declared under section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*. A full statement of compatibility is set out in **Attachment B**.

**Details of the *Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2025***

**Section 1 – Name**

Section 1 provides that the name of the instrument is the *Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2025* (Amending Instrument).

**Section 2 – Commencement**

Section 2 provides that Schedule 1 of the instrument commences on 15 September 2025, Schedule 2 of the instrument commences on 20 September 2025 and Schedule 3 of the instrument commences on 1 October 2025.

**Section 3 – Authority**

Section 3 provides that the authority for making the instrument is the *Aged Care Act 1997* (Aged Care Act) and the *Aged Care (Transitional Provisions) Act 1997* (Transitional Provisions Act).

**Section 4 – Schedules**

Section 4 provides that each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.

## Schedule 1—Amendments commencing 15 September 2025—required amounts of direct care

### *Quality of Care Principles 2014*

#### **Item 1 – Subsection 9(3) (table)**

This item repeals and substitutes the table in subsection 9(3), which provides identification of the relevant daily amount used in working out the required combined staff average amount of direct care (see subsection 9(1) of the Quality of Care Principles) and the required registered nurse staff average amount of direct care (see subsection 9(2) of the Quality of Care Principles).

The substituted daily amounts (with effect from 15 September 2025) are as follows:

<b>Daily amounts</b>			
<b>Item</b>	<b>Column 1 For a care recipient classified as ...</b>	<b>Column 2 the combined staff daily amount is ... (minutes)</b>	<b>Column 3 and the registered nurse daily amount is ... (minutes)</b>
1	Class 1	268	51
2	Class 2	128	27
3	Class 3	178	36
4	Class 4	150	32
5	Class 5	185	41
6	Class 6	176	37
7	Class 7	215	46
8	Class 8	232	47
9	Class 9	214	44
10	Class 10	229	44
11	Class 11	253	48
12	Class 12	247	47
13	Class 13	268	51
14	Respite Class 1	176	37
15	Respite Class 2	223	48
16	Respite Class 3	262	51

The combined staff daily amount and registered nurse daily amount for a day in the reference period for a care recipient are identified by reference to the classification level under Part 2.4A of the Aged Care Act of the care recipient on that day.

For clarity, for purposes of subsection 9(3) care recipients includes continuing care recipients.

Continuing residential care recipient means a person who:

- entered a residential care service before 1 July 2014, and
- has not:
  - ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

## **Schedule 2—Amendments commencing 20 September 2025—residential care subsidy**

### ***Aged Care (Subsidy, Fees and Payments) Determination 2014***

#### **Item 1 – Section 64ZT**

This item amends section 64ZT to provide that the amount of the hotelling supplement for a day for a care recipient is increased from \$15.60 to \$22.15.

### ***Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014***

#### **Item 2—Section 91R**

This item amends section 91R to provide that the amount of the hotelling supplement for a day for a continuing residential care recipient is \$22.15.

Continuing residential care recipient means a person who:

- entered a residential care service before 1 July 2014, and
- has not:
  - ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

## Schedule 3—Amendments commencing 1 October 2025

### Part 1—Modified Monash Model

#### *Accountability Principles 2014*

##### **Item 1 – Section 4 and item 2 – section 4 (definition of MM category)**

These items repeal and replace the definition of MM category to give it the same meaning as in the *Aged Care (Subsidy, Fees and Payments) Determination 2014*. This is consequential to the amendments in item 4 of Part 1 of Schedule 3 of the Amending Instrument.

##### **Item 3 – Paragraph 27B(2)(b)**

This item amends paragraph 27B(2)(b), which deals with responsibilities of approved providers of residential care to provide information about allocated places in respect of which approved provider is, or will be, unable to provide residential care, to refer to 2023 MM categories. This is consequential to the amendments in item 4 of Part 1 of Schedule 3 of the Amending Instrument.

#### *Aged Care (Subsidy, Fees and Payments) Determination 2014*

##### **Item 4 – Section 4**

This item inserts the following new definitions in section 4:

**2023 MM category means** a category for an area provided for by the Modified Monash Model [see item 2 of Part 1 of Schedule 3 of the Amending Instrument], and known as MM 1, MM 2, MM 3, MM 4, MM 5, MM 6 or MM 7.

**Modified Monash Model** means the model known as the Modified Monash Model developed by the Department for categorising metropolitan, regional, rural and remote locations according to both geographical remoteness and population size, based on population data published by the Australian Bureau of Statistics, as the model existed on 13 April 2025.

A note clarifies that, in 2025, the Modified Monash Model categorisation for a location could be viewed on the Department’s website (<https://www.health.gov.au>).

The effect of these changes is that the most recent iteration of the Modified Monash Model, including 2023 MM categories inserted by item 2 of Part 1 of Schedule 3 of the Amending Instrument, is implemented for the purposes of determining residential care subsidy and flexible care subsidy for care recipients.

##### **Item 5 – Section 64H (definition of *has specialised ATSI status*)**

This item amends the definition of *has specialised ATSI status*, of a residential care service, to refer to section 64N of the Subsidy Determination as it is amended by item 7 of Part 2 of Schedule 3 of the Amending Instrument.

### **Item 6 – Section 64H**

This item repeals the definitions of MM category and Modified Monash Model.

This change is consequential to inserting new definitions of 2023 MM category and Modified Monash Model in section 4 of the Subsidy Determination through item 4 of Part 1 of Schedule 3 of the Amending Instrument.

### **Item 7 – Subsection 64N(1)**

This item repeals subsection 64N(1), as its effect was spent by 31 March 2023.

### **Item 8 – Paragraph 64Q(2)(a)**

This item omits references in paragraph 64Q(2)(a) to the MM category known as MM 6 or MM 7 and substitutes references to the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7.

This change is consequential to implementing the most recent iteration of the Modified Monash Model, including 2023 MM categories, for the purposes of determining residential care subsidy and flexible care subsidy (see item 4 of Part 1 of Schedule 3 of the Amending Instrument).

### ***Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014***

### **Item 9 – Section 5**

This item inserts a new definition in section 5 that **2023 MM category** has the same meaning as in the Subsidy Determination (see item 4 of Part 1 of Schedule 3 of the Amending Instrument).

The effect of this change is that the most recent iteration of the Modified Monash Model, including the related 2023 MM categories, is implemented for the purposes of determining residential care subsidy and flexible care subsidy for continuing care recipients.

Continuing residential care recipient means a person who:

- entered a residential care service before 1 July 2014, and
- has not:
  - ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

Other changes relating to the Modified Monash Model, including the 2023 MM categories, are in Parts 2 and 4 of this Schedule 3 of the Amending Instrument.

### **Item 10 – Section 81 (definition of *Modified Monash Model*)**

This item repeals the definitions of MM category and Modified Monash Model in section 81.

This change is consequential to inserting new definitions of 2023 MM category and Modified Monash Model in section 5 of the Transitional Provisions Determination through item 9 of Part 1 of Schedule 3 of the Amending Instrument.

### ***Quality of Care Principles 2014***

#### **Item 11 – Section 4**

This item inserts a definition of **2023 MM category** that has the same meaning as in the *Aged Care (Subsidy, Fees and Payments) Determination 2014*. This is consequential to the amendments in item 4 of Part 1 of Schedule 3 of the Amending Instrument.

#### **Item 12 – Section 4**

This item repeals the definitions of MM 5 area, MM 6 area, MM 7 area and MM category. This is consequential to the amendments in item 4 of Part 1 of Schedule 3 of the Amending Instrument.

#### **Item 13 – Paragraph 15S(1)(a)**

This item omits references in paragraph 15S(1)(a) to an MM 5 area, MM 6 area or MM 7 area and substitutes references to the 2023 MM categories known as MM 5, MM 6 or MM 7.

This change is consequential to implementing the amendments in item 4 and item 12 of Part 1 of Schedule 3 of the Amending Instrument.

### **Part 2—Residential care subsidy**

#### ***Subsidy Principles 2014***

#### **Item 14 – Subparagraph 20(e)(x)**

This item repeals and substitutes subparagraph 20(3)(x), to repeal a reference to the outbreak management support supplement and to substitute a reference to the care minutes supplement.

This change is consistent with separate 2024 MYEFO decisions of Government to cease the outbreak management support supplement from 1 October 2025 and to commence a new care minutes supplement from 1 October 2025.

For the purposes of Division 44 of the Aged Care Act, section 20 of the Subsidy Principles sets out matters in relation to the amount of residential care subsidy payable to an approved provider of a residential care service in respect of a care recipient who is being provided with residential care through the service.

#### **Item 15 – Subdivision L of Division 5 of Part 3 of Chapter 2**

This item repeals and substitutes Subdivision L of Division 5 of Part 3 of Chapter 2 (that is, section 70AN) of the Subsidy Principles, to repeal eligibility criteria for the outbreak management support supplement and to substitute eligibility criteria for a new care minutes supplement.

This change is consistent with separate 2024 MYEFO decisions of Government to cease the outbreak management support supplement from 1 October 2025 and to commence a new care minutes supplement from 1 October 2025.



The effect of substituted section 70AN is to provide that the care minutes supplement for a care recipient in respect of a payment period beginning on or after 1 October 2025 is the sum of all the care minutes supplements for the days during the period on which:

- the care recipient was provided with residential care through the residential care service in question; and
- the residential care service is not a specialised homeless service and is in a 2023 MM category 1 area (metropolitan area).

Specialised homeless status is defined in Part 2 of Chapter 2A of the Subsidy Determination.

The targeting of the supplement aims to lift compliance by approved providers of residential care services in metropolitan areas with their existing direct care (or ‘care minutes’) responsibilities, established by sections 9 and 10 of the Quality of Care Principles. Compliance with care minutes responsibilities is particularly low in metropolitan areas, where workforce shortages do not explain the level of non-compliance. This change is intended to ensure the Government’s substantial investment in residential care leads to more care time for residents.

### ***Aged Care (Subsidy, Fees and Payments) Determination 2014***

#### **Item 16 – Section 4**

This item inserts the following definitions, all used in calculating the amount of the new care minutes supplement (see item 15 of Part 2 of Schedule 3 of the Amending Instrument):

***counted care recipient*** has the same meaning as in the Quality of Care Principles.

Through this definition, a care recipient receiving care through a residential care service on a day is a counted care recipient on the day unless:

- the care recipient is on extended hospital leave on the day; and
- the day is on or after the 29th day of the recipient’s leave.

***direct care*** has the same meaning as in the Quality of Care Principles.

Through this definition, direct care means care provided to an individual care recipient that is of a kind described in item 1.11, 2.1, 2.3, 2.4, 2.5, 2.7, 2.8, 2.9 or 3.8 of Schedule 1 (other than the planning or delivery of activities to a group of care recipients).

***direct care staff member*** has the same meaning as in the Quality of Care Principles.

Through this definition, direct care staff member means a staff member of an approved provider who is a registered nurse, enrolled nurse, nursing assistant or personal care worker.

Registered nurse has the same meaning as in the *Health Insurance Act 1973*.

Enrolled nurse means a person who is registered under the National Law in the nursing profession as an enrolled nurse.

National Law has the same meaning as in the *Health Insurance Act 1973*.

Nursing assistant means a person:

- who is not a registered nurse or enrolled nurse; and

- who works under the direct control and supervision of a registered nurse; and
- whose work is solely to assist a registered nurse or enrolled nurse in the provision of nursing care.

Personal care worker takes its ordinary meaning.

***enrolled nurse staff member*** has the same meaning as in the Quality of Care Principles.

Through this definition, enrolled nurse staff member means a staff member of an approved provider who is an enrolled nurse.

Enrolled nurse means a person who is registered under the National Law in the nursing profession as an enrolled nurse.

***Quality of Care Principles*** means the *Quality of Care Principles 2014*.

***registered nurse staff member*** has the same meaning as in the Quality of Care Principles.

Through this definition, registered nurse staff member means a staff member of an approved provider who is a registered nurse.

Registered nurse has the same meaning as in the *Health Insurance Act 1973*.

**Item 17 – Section 64H (definition of *national efficient price*)**

This item amends section 64H to provide that the national efficient price for residential care activity is increased to \$295.64.

**Item 18 – Section 64K (table)**

This item amends section 64K to repeal and substitute the table (except for its existing note) with the effect of defining the non-respite classification amount for each class as the amount worked out by multiplying the national efficient price (\$295.64 from 1 October 2025, see item 17 of Part 2 of Schedule 3 of the Amending Instrument) by the specified NWAU attributable to each non-respite class as set out in the following table:

<b>Non-respite class</b>	<b>NWAU</b>
Class 1	0.73
Class 2	0.21
Class 3	0.40
Class 4	0.29
Class 5	0.43
Class 6	0.39
Class 7	0.54
Class 8	0.60
Class 9	0.53
Class 10	0.59
Class 11	0.68
Class 12	0.66
Class 13	0.73

NWAU (short for National Weighted Activity Unit) means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set (see section 64H of the Subsidy Determination).

#### **Item 19 – Section 64L (table)**

This item amends section 64L to repeal and substitute the table (except its existing note) with the effect of defining the respite classification amount for each class as the amount worked out by multiplying the national efficient price (\$295.64 from 1 October 2025, see item 17 of Part 2 of Schedule 3 of the Amending Instrument) by the specified NWAU attributable to each respite class as set out in the following table:

<b>Respite Class</b>	<b>NWAU</b>
Respite Class 1	0.405
Respite Class 2	0.574
Respite Class 3	0.714

NWAU (short for National Weighted Activity Unit) means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set (see section 64H of the Subsidy Determination).

#### **Item 20 – Subsection 64M(1) (table)**

This item amends subsection 64M(1) to repeal and substitute the table, to provide that the service amount for a care recipient for a day is the amount worked out in accordance with what is specified in column 2 of the relevant item in the substituted table, provided that:

- the care recipient is provided with residential care on a day through a residential care service, and
- on the day, the service also meets the requirements set out in column 1 of an item of the substituted table.

This change includes using 2023 MM categories inserted by item 4 of Part 1 of Schedule 3 in calculation of the service amount in the inserted table, in place of 2019 MM categories that were used in the repealed table.

The effect of this change is that, if eligibility criteria for payment of basic subsidy are met, different service amounts are payable based on relevant factors at the residential care service where a care recipient receives care, including whether the service has specialised Aboriginal and Torres Strait Islander status or specialised homeless status, the number of operational places at the service, and whether the street address at the service is in a metropolitan area, regional centre or large rural town, medium or small rural town, or remote or very remote community (per the 2023 MM categories).

Operational places is defined in subsection 64(2) of the Subsidy Determination.

Specialised Aboriginal and Torres Strait Islander status and specialised homeless status are defined in Part 2 of Chapter 2A of the Subsidy Determination.

#### **Item 21 – Subsections 64ZU(5) to (6C)**

This item repeals subsections 64ZU(5) to (6C) and substitutes new subsections 64ZU(5) to (6C).

New subsection 64ZU(5) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the 2023 MM category known as MM 1. The facility amount is set out in the table in subsection 64ZU(5), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(5) provides that the facility amount for group A qualifying facilities in the 2023 MM category MM 1 (that is, group A qualifying facilities in metropolitan areas), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is \$28,786 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is \$25,667 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is \$14,009 for the payment period.
- where the average daily care count is more than 30 but less than or equal to 35, the facility amount is \$11,370 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40, the facility amount is \$8,732 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45, the facility amount is \$6,093 for the payment period.
- Where the average daily care count is more than 45 but less than or equal to 50, the facility amount is \$3,454 for the payment period.

New subsection 64ZU(5A) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the 2023 MM category known as MM 2 or MM 3. The facility amount is set out in the table in subsection 64ZU(5A), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(5A) provides that the facility amount for group A qualifying facilities in the 2023 MM categories MM 2 and MM 3 (that is, group A qualifying facilities in regional centres and large rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is \$30,536 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is \$27,228 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is \$14,860 for the payment period.
- where the average daily care count is more than 30 but less than or equal to 35, the facility amount is \$12,062 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40, the facility amount is \$9,263 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45, the facility amount is \$6,464 for the payment period.
- Where the average daily care count is more than 45 but less than or equal to 50, the facility amount is \$3,664 for the payment period.

New subsection 64ZU(5B) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the 2023 MM category known

as MM 4 or MM 5. The facility amount is set out in the table in subsection 64ZU(5B), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(5B) provides that the facility amount for the period for group A qualifying facilities in the 2023 MM categories MM 4 and MM 5 (that is, group A qualifying facilities in medium and small rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is \$72,840 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is \$61,804 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is \$50,767 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is \$39,731 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is \$27,912 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is \$15,234 for the payment period.
- Where the average daily care count is more than 30 but less than or equal to 35 the facility amount is \$12,364 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40 the facility amount is \$9,495 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45 the facility amount is \$6,626 for the payment period.
- where the average daily care count is more than 45 but less than or equal to 50 the facility amount is \$3,756 for the payment period.

New subsection 64ZU(5C) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the 2023 MM category known as MM 6 or MM 7. The facility amount is set out in the table in subsection 64ZU(5C), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(5C) provides that the facility amount for the period for group A qualifying facilities in the 2023 MM categories MM 6 and MM 7 (that is, group A qualifying facilities in remote and very remote communities), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is \$86,378 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is \$73,290 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is \$60,203 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is \$47,115 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is \$33,099 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is \$18,065 for the payment period.

- Where the average daily care count is more than 30 but less than or equal to 35 the facility amount is \$14,663 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40 the facility amount is \$11,261 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45 the facility amount is \$7,857 for the payment period.
- where the average daily care count is more than 45 but less than or equal to 50 the facility amount is \$4,455 for the payment period.

New subsection 64ZU(6) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the 2023 MM category known as MM 1. The facility amount is set out in the table in subsection 64ZU(6), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(6) provides that the facility amount for group B qualifying facilities in the 2023 MM category MM 1 (that is, group B qualifying facilities in metropolitan areas), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is \$14,393 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is \$12,834 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is \$7,005 for the payment period.

New subsection 64ZU(6A) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the 2023 MM category known as MM 2 or MM 3. The facility amount is set out in the table in subsection 64ZU(6A), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(6A) provides that the facility amount for group B qualifying facilities in the 2023 MM categories MM 2 and MM 3 (that is, group B qualifying facilities in regional centres and large rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is \$15,268 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is \$13,614 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is \$7,431 for the payment period.

New subsection 64ZU(6B) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the 2023 MM category known as MM 4 or MM 5. The facility amount is set out in the table in subsection 64ZU(6B), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(6B) provides that the facility amount for the period for group B qualifying facilities in the MM categories MM 4 and MM 5 (that is, group B qualifying facilities in medium and small rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is \$36,421 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is \$30,902 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is \$25,384 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is \$19,866 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is \$13,956 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is \$7,618 for the payment period.

New subsection 64ZU(6C) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the 2023 MM category known as MM 6 or MM 7. The facility amount is set out in the table in subsection 64ZU(6C), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(6C) provides that the facility amount for the period for group B qualifying facilities in the 2023 MM categories MM 6 and MM 7 (that is, group B qualifying facilities in remote and very remote communities), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is \$43,190 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is \$36,646 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is \$30,102 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is \$23,558 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is \$16,550 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is \$9,033 for the payment period.

'Modified Monash Model' and 'MM category' have the same meanings as in section 4 of the Subsidy Determination, as amended by item 1 of Part 1 of Schedule 3 of the Amending Instrument.

The average daily care count is worked out in accordance with subsections 64ZU(7) and (8).

## **Item 22 – Division 7 of Part 7 of Chapter 2A**

This item repeals Division 7—Outbreak management support supplement of Part 7 of Chapter 2A and substitutes a new Division 7—Care minutes supplement of Part 7 of Chapter 2A.

The effect of this item is to repeal the amount of repealed outbreak management support supplement and substitute the amount of the new care minutes supplement (see item 15 of Part 2 of Schedule 3 of the Amending Instrument) through new section 64ZV Amount of care minutes supplement.

New subsection 64ZV(1) provides that section 64ZV, as amended, is made for the purposes of subsection 44-27(3) of the Aged Care Act (that is, is an ‘other supplement’).

New subsection 64ZV(2) provides that the care minutes supplement amount for a care recipient for a day before 1 April 2026 is nil.

New subsection 64ZV(3) provides that the care minutes supplement amount for a care recipient receiving residential care on a day in a quarter (the ‘supplement quarter’) that is on or after 1 April 2026 is the amount worked out by multiplying the national efficient price by the National Weighted Activity Unit (NWAU) specified in the appropriate cell of a matrix that measures (in percentage terms) care minutes delivery in the second most recent quarter (the ‘delivery quarter’) at the service where the care recipient is receiving care on the day against:

- the required combined staff average amount of direct care delivered (counting direct care delivered by all direct care staff members), and
- the required registered nurse average amount of direct care that applied at the residential care service for that second most recent quarter (counting direct care delivered by registered nurse staff members and enrolled nurse staff members).

The required combined staff average amount of direct is worked out under subsection 9(2) of the Quality of Care Principles, while the required registered nurse average amount of direct care is set out in subsection 9(3A) of the Quality of Care Principles.

As an example of a delivery quarter, for a day in the April 2026 payment period the delivery quarter is the October to December 2025 quarter and the supplement quarter is the April to June 2026 quarter.

Direct care staff member is defined in section 4 of the Quality of Care Principles and means a staff member of an approved provider who is a registered nurse, enrolled nurse, nursing assistant or personal care worker.

Enrolled nurse staff member is defined in section 4 of the Quality of Care Principles and means a staff member of an approved provider who is an enrolled nurse.

Enrolled nurse is defined in section 4 of the Quality of Care Principles and means a person who is registered under the National Law in the nursing profession as an enrolled nurse.

Registered nurse is defined in section 4 of the Quality of Care Principles and has the same meaning as in the Health Insurance Act 1973.

Registered nurse staff member is defined in section 4 of the Quality of Care Principles and means a staff member of an approved provider who is a registered nurse.

National Law is defined in section 4 of the Quality of Care Principles and has the same meaning as in the *Health Insurance Act 1973*.

The national efficient price for residential care activity will be \$295.64 from 1 October 2025 (see item 17 of Part 2 of Schedule 3 of the Amending Instrument as it will amend section 64H of the Subsidy Determination).



NWAU means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set (see section 64H of the Subsidy Determination).

The matrix provided for by new subsection 64ZV(3) is constructed so that if care minutes performance for the delivery quarter was less than 85% of both the ‘required amounts’ of direct care the amount of care minutes supplement for a day in a payment period in the supplement quarter is 0 NWAU multiplied by the national efficient price—that is, is substantively nil.

Conversely, the matrix also provides that if care minutes performance for the delivery quarter is greater than or equal to 85% of either required amount of direct care the amount of care minutes supplement for a day in a payment period in the supplement quarter is an amount greater than 0 NWAU multiplied by the national efficient price. That amount increases in steps as care minutes performance increases, until reaching a maximum of 0.113 NWAU multiplied by the national efficient price when care minutes performance for the delivery quarter is equal to greater than or equal to 100% of both required amounts of direct care.

The matrix is designed to encourage effort to achieve compliance with care minutes responsibilities by approved providers of residential care services in metropolitan areas, to ensure the Government’s substantial investment in residential care leads to more care for residents.

New subsection 64ZV(4) provides that, for the purposes of calculating the care minutes supplement, the average amount of direct care delivered through the service by registered nurse staff members and enrolled nurse staff members of the approved provider of the service per counted care recipient per day for the delivery quarter can include an amount of direct care delivered through the service by enrolled nurse staff members. This amount cannot exceed 10% of the required registered nurse average amount of direct care per care recipient per day calculated under subsection 9(2) of the Quality of Care Principles in respect of the service for the delivery quarter. This is consistent with design of the direct care (‘care minutes’) responsibility—compliance with which the new care minutes supplement is intended to encourage—which allows direct care provided by enrolled nurses to count toward meeting responsibilities of approved providers in relation to required amounts of direct care under section 10 of the Quality of Care Principles.

New subsection 64ZV(5) provides that calculated amounts of care minutes supplement are to be rounded to the nearest cent (that is, if 0.5 cent or above to be rounded up to the nearest cent and if less than 0.5 cent to be rounded down to the nearest cent).

A note clarifies that eligibility for the supplement is in Subdivision L of Division 5 of Part 3 of Chapter 2 of the Subsidy Principles.

### ***Aged Care (Transitional Provisions) Principles 2014***

#### **Item 23 – Subparagraph 17(h)(ix)**

This item repeals and substitutes subparagraph 17(h)(ix), to repeal a reference to the outbreak management support supplement and to substitute a reference to the care minutes supplement.

This change is consistent with separate 2024 MYEFO decisions of Government to cease the outbreak management support supplement from 1 October 2025 and to commence a new care minutes supplement from 1 October 2025.

For the purposes of paragraph 44-27(1)(e) of the Transitional Provisions Act, section 17 of the Transitional Provisions Principles sets out matters in relation to the amount of residential care subsidy payable to an approved provider of a residential care service in respect of a continuing care recipient who is being provided with residential care through the service.

Continuing residential care recipient means a person who:

- entered a residential care service before 1 July 2014, and
- has not:
  - ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

#### **Item 24 – Subdivision K of Division 8 of Part 3 of Chapter 2**

This item repeals and substitutes Subdivision K of Division 8 of Part 3 of Chapter 2 (that is, section 64H) of the Transitional Provisions Principles to repeal eligibility criteria for the outbreak management support supplement and to substitute eligibility criteria for a new care minutes supplement.

This change is consistent with separate 2024 MYEFO decisions of Government to cease the outbreak management support supplement from 1 October 2025 and to commence a new care minutes supplement from 1 October 2025.

The effect of substituted section 64H is to provide that the care minutes supplement for a continuing care recipient in respect of a payment period beginning on or after 1 October 2025 is the sum of all the care minutes supplements for the days during the period on which:

- the continuing care recipient was provided with residential care through the residential care service in question; and
- the residential care service is not a specialised homeless service and is in a 2023 MM category 1 area (metropolitan area).

Continuing residential care recipient means a person who:

- entered a residential care service before 1 July 2014, and
- has not:
  - ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

Specialised homeless status is defined in Part 2 of Chapter 2A of the Subsidy Determination.

The targeting of the supplement aims to lift compliance by approved providers of residential care services in metropolitan areas with their existing direct care (or ‘care minutes’) responsibilities, established by sections 9 and 10 of the Quality of Care Principles. Compliance

with care minutes responsibilities is particularly low in metropolitan areas, where workforce shortages do not explain the level of non-compliance. This change is intended to ensure the Government's substantial investment in residential care leads to more care for residents.

### ***Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014***

#### **Item 25 – Section 5**

This item inserts the following definitions, all used in calculating the amount of the new care minutes supplement (see item 22 of Part 2 of Schedule 3 of the Amending Instrument):

***counted care recipient*** has the same meaning as in the Quality of Care Principles (which includes application to continuing care recipients).

Through this definition, a continuing care recipient receiving care through a residential care service on a day is a counted care recipient on the day unless:

- the continuing care recipient is on extended hospital leave on the day; and
- the day is on or after the 29th day of the recipient's leave.

***direct care*** has the same meaning as in the Quality of Care Principles.

Through this definition, direct care means care provided to an individual care recipient [*including a continuing care recipient*] that is of a kind described in item 1.11, 2.1, 2.3, 2.4, 2.5, 2.7, 2.8, 2.9 or 3.8 of Schedule 1 (other than the planning or delivery of activities to a group of care recipients [*including continuing care recipients*]).

***direct care staff member*** has the same meaning as in the Quality of Care Principles.

Through this definition, direct care staff member means a staff member of an approved provider who is a registered nurse, enrolled nurse, nursing assistant or personal care worker.

Registered nurse has the same meaning as in the *Health Insurance Act 1973*.

Enrolled nurse means a person who is registered under the National Law in the nursing profession as an enrolled nurse.

National Law has the same meaning as in the *Health Insurance Act 1973*.

Nursing assistant means a person:

- who is not a registered nurse or enrolled nurse; and
- who works under the direct control and supervision of a registered nurse; and
- whose work is solely to assist a registered nurse or enrolled nurse in the provision of nursing care.

Personal care worker takes its ordinary meaning.

***enrolled nurse staff member*** has the same meaning as in the Quality of Care Principles.

Through this definition, enrolled nurse staff member means a staff member of an approved provider who is an enrolled nurse.

Enrolled nurse means a person who is registered under the National Law in the nursing profession as an enrolled nurse.

***Quality of Care Principles*** means the *Quality of Care Principles 2014*

***registered nurse staff member*** has the same meaning as in the Quality of Care Principles.

Through this definition, registered nurse staff member means a staff member of an approved provider who is a registered nurse.

Registered nurse has the same meaning as in the *Health Insurance Act 1973*.

**Item 26 – Section 81 (definition of *national efficient price*)**

This item amends section 81 to provide that the national efficient price for residential care activity is increased to \$295.64.

**Item 27 – Section 83 (table)**

This item amends section 83 to repeal and substitute the table (excluding the existing note) with the effect of defining the non-respite classification amount for each class as the amount worked out by multiplying the national efficient price (\$295.64 from 1 October 2025, see item 26 of Part 2 of Schedule 3 of the Amending Instrument) by the specified NWAU attributable to each non-respite class as set out in the following table:

<b>Non-respite class</b>	<b>NWAU</b>
Class 1	0.73
Class 2	0.21
Class 3	0.40
Class 4	0.29
Class 5	0.43
Class 6	0.39
Class 7	0.54
Class 8	0.60
Class 9	0.53
Class 10	0.59
Class 11	0.68
Class 12	0.66
Class 13	0.73

NWAU (short for National Weighted Activity Unit) means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set (see section 81 of the Transitional Provisions Determination).

**Item 28 – Subsection 84(1) (table)**

This item amends subsection 84(1) to repeal and substitute the table, to provide that the service amount for a care recipient for a day is the amount worked out in accordance with what is specified in column 2 of the relevant item in the substituted table, provided that:

- the continuing care recipient is provided with residential care on a day through a residential care service, and
- on the day, the service also meets the requirements set out in column 1 of an item of the substituted table.

This change includes using 2023 MM categories inserted by item 9 of Part 1 of Schedule 3 in calculation of the service amount in the inserted table, in place of 2019 MM categories used in the repealed table.

The effect of this change is that, if eligibility criteria for payment of basic subsidy are met, different service amounts are payable based on relevant factors at the residential care service where a continuing care recipient receives care, including whether the service has specialised Aboriginal and Torres Strait Islander status or specialised homeless status, the number of operational places at the service, and whether the street address at the service is in a metropolitan area, regional centre or large rural town, medium or small rural town, or remote or very remote community (per the 2023 MM categories).

Operational places is defined in subsection 84(2) of the Transitional Provisions Determination.

Through section 81, specialised Aboriginal and Torres Strait Islander status and specialised homeless status have the same meaning as in Part 2 of Chapter 2A of the Subsidy Determination.

Continuing residential care recipient means a person who:

- entered a residential care service before 1 July 2014, and
- has not:
  - ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles 2014, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

#### **Item 29 – Subsections 91S(5) to (6C)**

This item repeals subsections 91S(5) to (6C) and substitutes new subsections 91S(5) to (6C).

New subsection 91S(5) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the 2023 MM category known as MM 1. The facility amount is set out in the table in subsection 91S(5), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(5) provides that the facility amount for group A qualifying facilities in the 2023 MM category MM 1 (that is, qualifying facilities in metropolitan areas), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is \$28,786 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is \$25,667 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is \$14,009 for the payment period.
- where the average daily care count is more than 30 but less than or equal to 35, the facility amount is \$11,370 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40, the facility amount is \$8,732 for the payment period.

- where the average daily care count is more than 40 but less than or equal to 45, the facility amount is \$6,093 for the payment period.
- Where the average daily care count is more than 45 but less than or equal to 50, the facility amount is \$3,454 for the payment period.

New subsection 91S(5A) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the 2023 MM category known as MM 2 or MM 3. The facility amount is set out in the table in subsection 91S(5A), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(5A) provides that the facility amount for group A qualifying facilities in the 2023 MM categories MM 2 or MM 3 (that is, qualifying facilities in regional centres and large rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is \$30,536 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is \$27,228 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is \$14,860 for the payment period.
- where the average daily care count is more than 30 but less than or equal to 35, the facility amount is \$12,062 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40, the facility amount is \$9,263 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45, the facility amount is \$6,494 for the payment period.
- Where the average daily care count is more than 45 but less than or equal to 50, the facility amount is \$3,664 for the payment period.

New subsection 91S(5B) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the 2023 MM categories known as MM 4 or MM 5. The facility amount is set out in the table in subsection 91S(5B), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(5B) provides that the facility amount for the period for group A qualifying facilities in the 2023 MM categories MM 4 and MM 5 (that is, facilities in medium and small rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is \$72,840 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is \$61,804 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is \$50,767 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is \$39,731 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is \$27,912 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is \$15,234 for the payment period.

- Where the average daily care count is more than 30 but less than or equal to 35 the facility amount is \$12,364 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40 the facility amount is \$9,495 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45 the facility amount is \$6,626 for the payment period.
- where the average daily care count is more than 45 but less than or equal to 50 the facility amount is \$3,756 for the payment period.

New subsection 91S(5C) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the 2023 MM category known as MM 6 or MM 7. The facility amount is set out in the table in subsection 91S(5C), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(5C) provides that the facility amount for the period for group A qualifying facilities in the 2023 MM categories MM 6 and MM 7 (that is, facilities in remote and very remote communities), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is \$86,378 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is \$73,290 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is \$60,203 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is \$47,115 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is \$33,099 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is \$18,065 for the payment period.
- Where the average daily care count is more than 30 but less than or equal to 35 the facility amount is \$14,663 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40 the facility amount is \$11,261 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45 the facility amount is \$7,857 for the payment period.
- where the average daily care count is more than 45 but less than or equal to 50 the facility amount is \$4,455 for the payment period.

New subsection 91S(6) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the 2023 MM category known as MM 1. The facility amount is set out in the table in subsection 91S(6), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(6) provides that the facility amount for group B qualifying facilities in the 2023 MM category MM 1 (that is, group B qualifying facilities in metropolitan areas), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is \$14,393 for the payment period.

- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is \$12,834 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is \$7,005 for the payment period.

New subsection 91S(6A) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the 2023 MM category known as MM 2 or MM 3. The facility amount is set out in the table in subsection 91S(6A), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(6A) provides that the facility amount for group B qualifying facilities in the MM categories MM 2 and MM 3 (that is, group B qualifying facilities in regional centres and large rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is \$15,268 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is \$13,614 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is \$7,431 for the payment period.

New subsection 91S(6B) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the 2023 MM category known as MM 4 or 5. The facility amount is set out in the table in subsection 91S(6B), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(6B) provides that the facility amount for the period for group B qualifying facilities in the 2023 MM categories MM 4 and MM 5 (that is, group B qualifying facilities in medium and small rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is \$36,421 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is \$30,902 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is \$25,384 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is \$19,866 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is \$13,956 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is \$7,618 for the payment period.

New subsection 91S(6C) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the 2023 MM category known as MM 6 or 7. The facility amount is set out in the table in subsection 91S(6C), with different amounts depending on the average daily care count for the facility for the period.



The table in subsection 91S(6C) provides that the facility amount for the period for group B qualifying facilities in the 2023 MM categories MM 6 and MM 7 (that is, group B qualifying facilities in remote and very remote communities), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is \$43,190 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is \$36,646 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is \$30,102 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is \$23,558 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is \$16,550 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is \$9,033 for the payment period.

'Modified Monash Model' and 'MM category' have the same meanings as in section 5 of the Transitional Provisions Determination, as amended by item 2 of Part 1 of Schedule 3 of the Amending Instrument.

The average daily care count is worked out in accordance with subsections 91S(7) and (8).

### **Item 30 – Division 7 of Part 5 of Chapter 3**

This item repeals Division 7—Outbreak management support supplement of Part 5 of Chapter 3 and substitutes a new Division 7—Care minutes supplement of Part 5 of Chapter 3.

The effect of this item is to repeal the amount of repealed outbreak management support supplement and substitute the amount of the new care minutes supplement (see item 24 of Part 2 of Schedule 3 of the Amending Instrument) for continuing residential care recipients through new section 91T Amount of care minutes supplement.

New subsection 91T(1) provides that section 91T is made for the purposes of subsection 44-27(3) of the Transitional Provisions Act (that is, is an 'other supplement').

New subsection 91T(2) provides that the care minutes supplement amount for a care recipient for a day before 1 April 2026 is nil.

New subsection 91T(3) provides that the care minutes supplement amount for a care recipient receiving residential care on a day in a quarter (the 'supplement quarter') that is on or after 1 April 2026 is the amount worked out by multiplying the national efficient price by the National Weighted Activity Unit (NWAU) specified in the appropriate cell of a matrix that measures (in percentage terms) care minutes delivery in the second most recent quarter (the 'delivery quarter') at the service where the care recipient is receiving care on the day against:

- the required combined staff average amount of direct care delivered (counting direct care delivered by all direct care staff members), and
- the required registered nurse average amount of direct care that applied at the residential care service for that second most recent quarter (counting direct care delivered by registered nurse staff members and enrolled nurse staff members).

The required combined staff average amount of direct is worked out under subsection 9(2) of the Quality of Care Principles, while the required registered nurse average amount of direct care is set out in subsection 9(3A) of the Quality of Care Principles.

As an example of a delivery quarter, for a day in the April 2026 payment period the delivery quarter is the October to December 2025 quarter and the supplement quarter is the April to June 2026 quarter.

Direct care staff member is defined in section 4 of the Quality of Care Principles and means a staff member of an approved provider who is a registered nurse, enrolled nurse, nursing assistant or personal care worker.

Enrolled nurse staff member is defined in section 4 of the Quality of Care Principles and means a staff member of an approved provider who is an enrolled nurse.

Enrolled nurse is defined in section 4 of the Quality of Care Principles and means a person who is registered under the National Law in the nursing profession as an enrolled nurse.

Registered nurse is defined in section 4 of the Quality of Care Principles and has the same meaning as in the Health Insurance Act 1973.

Registered nurse staff member is defined in section 4 of the Quality of Care Principles and means a staff member of an approved provider who is a registered nurse.

National Law is defined in section 4 of the Quality of Care Principles and has the same meaning as in the *Health Insurance Act 1973*.

The national efficient price for residential care activity will be \$295.64 from 1 October 2025 (see item 22 of Part 2 of Schedule 3 of the Amending Instrument as it will amend section 81 of the Transitional Provisions Determination).

NWAU means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set (see section 81 of the Transitional Provisions Determination).

The matrix provided for by new subsection 64ZV(3) is constructed so that if care minutes performance for the delivery quarter was less than 85% of both the ‘required amounts’ of direct care the amount of care minutes supplement for a day in a payment period in the supplement quarter is 0 NWAU multiplied by the national efficient price—that is, is substantively nil.

Conversely, the matrix also provides that if care minutes performance for the delivery quarter is greater than or equal to 85% of either required amount of direct care the amount of care minutes supplement for a day in a payment period in the supplement quarter is an amount greater than 0 NWAU multiplied by the national efficient price. That amount increases in steps as care minutes performance increases, until reaching a maximum of 0.113 NWAU multiplied by the national efficient price when care minutes performance for the delivery quarter is equal to greater than or equal to 100% of both required amounts of direct care.

The matrix is designed to encourage effort to achieve compliance with care minutes responsibilities by approved providers of residential care services in metropolitan areas, to ensure the Government's substantial investment in residential care leads to more care for residents.

New subsection 91T(4) provides that, for the purposes of calculating the care minutes supplement, the average amount of direct care delivered through the service by registered nurse staff members and enrolled nurse staff members of the approved provider of the service per counted care recipient per day for the delivery quarter can include an amount of direct care delivered through the service by enrolled nurse staff members. This amount cannot exceed 10% of the required registered nurse average amount of direct care per care recipient per day calculated under subsection 9(2) of the Quality of Care Principles in respect of the service for the delivery quarter. This is consistent with design of the direct care ('care minutes') responsibility—compliance with which the new care minutes supplement is intended to encourage—which allows direct care provided by enrolled nurses to count toward meeting responsibilities of approved providers in relation to required amounts of direct care under section 10 of the Quality of Care Principles.

New subsection 91T(5) provides that calculated amounts of care minutes supplement are to be rounded to the nearest cent (that is, if 0.5 cent or above to be rounded up to the nearest cent and if less than 0.5 cent to be rounded down to the nearest cent).

Continuing residential care recipient means a person who:

- entered a residential care service before 1 July 2014, and
- has not:
  - ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

A Note clarifies that eligibility for the supplement is in Subdivision K of Division 8 of Part 3 of Chapter 2 of the Transitional Provisions Principles.

### **Part 3—Home care subsidy**

#### ***Aged Care (Subsidy, Fees and Payments) Determination 2014***

##### **Item 31 – Section 67 (table)**

This item repeals and substitutes the table in section 67 to provide for increased amounts in relation to the basic subsidy amount for home care as follows:

- Level 1 home care—\$30.10
- Level 2 home care—\$52.93
- Level 3 home care—\$115.22
- Level 4 home care—\$174.68.

**Item 32 – Subsection 70(1)**

This item amends subsection 70(1) to provide for an increased amount of home care oxygen supplement of \$14.66.

For clarity, paragraph 67D(1)(f) of the Transitional Provisions Principles ensures that the change applies to continuing home care recipients.

Continuing home care recipient means a person who:

- entered a home care service before 1 July 2014, and
- has not:
  - ceased to be provided with home care by a home care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another home care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

**Item 33 – Subsection 70(2)**

This item amends subsection 70(1) to provide for the amount that is equal to 125% of the home care oxygen supplement is \$18.33. This change is consequential to the amendment in item 25 of Part 3 of Schedule 3 of the Amending instrument.

For clarity, paragraph 67D(1)(f) of the Transitional Provisions Principles ensures that the change applies to continuing home care recipients.

Continuing home care recipient means a person who:

- entered a home care service before 1 July 2014, and
- has not:
  - ceased to be provided with home care by a home care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another home care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

**Item 34 – Paragraphs 72(1)(a) and (b)**

This item amends paragraphs 72(1)(a) and (b) to provide for an increased amount of enteral feeding supplement for bolus feeding of \$23.25 and for non-bolus feeding of \$26.11.

For clarity, paragraph 67D(1)(g) the Transitional Provisions Principles ensures that the change applies to continuing home care recipients.

Continuing home care recipient means a person who:

- entered a home care service before 1 July 2014, and
- has not:
  - ceased to be provided with home care by a home care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another home care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

### **Item 35 – Subsection 72(2)**

This item amends subsection 72(2) to omit reference to the dollar value of an amount that is equivalent to 125% of enteral feeding supplement for bolus feeding and for non-bolus feeding, as this is unnecessary.

For clarity, paragraph 67D(1)(g) the Transitional Provisions Principles ensures that the subsection applies to continuing home care recipients.

Continuing home care recipient means a person who:

- entered a home care service before 1 July 2014, and
- has not:
  - ceased to be provided with home care by a home care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another home care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

### **Item 36 – Section 84A (table to definition of *ARIA value viability supplement amount*)**

This item provides for changes to amounts in relation to the amount of viability supplement for home care by repealing the table to the definition of *ARIA value viability supplement amount* in section 84A and substituting a new table with the amounts following:

- ARIA value less than 3.52—\$0.00
- ARIA value at least 3.52 but less than 4.67—\$6.92
- ARIA value at least 4.67 but less than 5.81—\$8.29
- ARIA value at least 5.81 but less than 7.45—\$11.60
- ARIA value at least 7.45 but less than 9.09—\$13.91
- ARIA value at least 9.09 but less than 10.55—\$19.48
- ARIA value at least 10.55—\$23.40.

For clarity, paragraph 67D)(b) and section 67G of the Transitional Provisions Principles ensure that the changes apply to continuing home care recipients.

Continuing home care recipient means a person who:

- entered a home care service before 1 July 2014, and
- has not:
  - ceased to be provided with home care by a home care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another home care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

### **Item 37 – Section 84A (table to definition of *MMM classification viability supplement amount*)**

This item provides for changes to amounts in relation to the amount of viability supplement for home care by repealing the table to the definition of *MMM classification viability supplement amount* in section 84A and substituting a new table with the amounts following:

- MMM 1—\$0.00
- MMM 2—\$0.00
- MMM 3—\$0.00

- MMM 4—\$1.33
- MMM 5—\$2.94
- MMM 6—\$19.48
- MMM 7—\$23.40.

For clarity, paragraph 67D)(b) and section 67G of the Transitional Provisions Determination ensure that the changes apply to continuing home care recipients.

Continuing home care recipient means a person who:

- entered a home care service before 1 July 2014, and
- has not:
  - ceased to be provided with home care by a home care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another home care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

### ***Aged Care (Transitional Provisions) Principles 2014***

#### **Item 38 – Section 67E (table)**

This item provides for the increase of amounts in relation to the basic subsidy amount for home care for continuing home care recipients by repealing the table to section 67E and substituting a new table with the increased amounts following:

- Level 1 home care—\$30.10
- Level 2 home care—\$52.93
- Level 3 home care—\$115.22
- Level 4 home care—\$174.68.

Continuing home care recipient means a person who:

- entered a home care service before 1 July 2014, and
- has not:
  - ceased to be provided with home care by a home care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another home care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

#### **Item 39 – Section 67N**

This item amends section 67N to provide for an increased home care top-up supplement amount of \$3.45. Home care top-up supplement only applies to continuing home care recipients.

Continuing home care recipient means a person who:

- entered a home care service before 1 July 2014, and
- has not:
  - ceased to be provided with home care by a home care service for a continuous period of more than 28 days (other than because the person is on leave), or

- before moving to another home care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

#### **Part 4—Flexible care subsidy**

##### ***Aged Care (Subsidy, Fees and Payments) Determination 2014***

##### Flexible care subsidy for care provided through a multi-purpose service

##### **Item 40 – Section 87 (definitions), Item 41 – Section 87 (definition of *MMM classification additional amount*), Item 42 – Subsection 90A(2) (table item 1) and Item 43 – Subsection 90A(2) (note)**

These items amend the definitions that apply to Part 1 of Chapter 4 of the Subsidy Determination and impact the calculation of the Home Care Additional Amount (HMAA). This allowance is calculated under sections 91 and 96 of the Subsidy Determination and paid as part of the flexible care subsidy for care provided through a multi-purpose service. It is only applicable where a provider has allocated home care places that are in effect at the relevant multi-purpose service.

These changes, subject to specific transitional arrangements, implement the Modified Monash Model 2023 developed by the Department of Health, Disability and Ageing as it existed on 13 April 2025. The Modified Monash Model 2023 categorises areas according to geographical remoteness and population size.

This is achieved by amending the definition of MM category additional amount and inserting a new definition to cover a particular multi-purpose service (that is, Injune Multi-Purpose Service in Queensland).

These definitions ensure updated Modified Monash (MM) categories of remoteness, consistent with the Modified Monash Model 2023, will apply when calculating the HMAA from 1 October 2025, with one exception. The insertion of a specific definition of Injune ensures current HMAA funding is maintained for Injune (located in an MM 7 area based on the Modified Monash Model 2015), despite its decrease in remoteness under the Modified Monash Model 2023. This is consistent with the ‘no losers’ principle adopted by the Government when implementing the Modified Monash Model 2023. Equivalent changes are also made to section 90A.

##### **Item 44 – Section 91 (formula), item 45 – Section 91 (definition of *OMSA*) and item 46 – Section 91 (notes 3 and 4)**

This item amends section 91 to repeal references to ‘Outbreak management support supplement amount’ (or ‘OMSA’) in the method for calculating the amount of flexible care subsidy for care provided through an MPS. This is consequential to repeal of the outbreak management support supplement (see item 24 of Part 2 of Schedule 3).

Consequential changes are also made to the notes at the bottom of section 91.

**Item 47 – Section 92 (definition of B)**

This item increases the applicable amount for a residential care place by increasing the amount of the term ‘B’ in the formula used to work out the amount for a day for a residential care place for a multi-purpose service to \$153.35. This increase is equivalent to the decrease resulting from the removal of the OMSA for the subsidy calculation formula (see item 45 of Part 2 of Schedule 3). It ensures there is no decrease in funding overall for flexible care provided through a multi-purpose service.

**Item 48 – Subsection 93(1) and Item 49 – Paragraphs 96(1)(a) and (2)(b)**

This item, consistent with the changes outlined above for items 40 to 44 of Part 2 of Schedule 3, amends how the direct care supplement amount for a residential care place is calculated from 1 October 2025. It ensures the 2023 MM categories consistent with the MMM 2023 also apply to this calculation, with transitional arrangements again in place for Injune Multi-Purpose Service.

**Item 50 – section 96A (table)**

This item repeals the table at section 96A and substitutes it with a table that provides for the increase in the amount of flexible care subsidy for the aged care wage supplement amount. It amends the amount of the specific subsidies identified under the column titled ‘Amount (\$)’.

These amendments increase the amount of funding provided to the organisations specified in the table to pay salaries and on-costs paid for staff employed to provide aged care services at their multi-purpose service. The three providers listed are non-State and Territory government providers who employ their staff under the national Aged Care Award. They are eligible to receive the aged care wage supplement and benefit from this increase.

This supplement does not apply to the majority of providers who deliver services under the Multi-Purpose Service Program and pay their employees under respective State and Territory Health employment awards.

**Flexible care subsidy for care provided as transition care and short-term restorative care****Item 51 – Section 106**

This item repeals section 106 and substitutes a new section 106 to provide that the amount of flexible care subsidy for a day for a care recipient for care provided as transition care is the sum of:

- the basic subsidy amount for the day for the care recipient (and that this amount is \$257.46; and
- the dementia and veterans’ supplement equivalent amount for the day for the care recipient (and that this amount is \$5.16).

An effect of this item is to substitute increase amounts of the basic subsidy amount and the dementia and veterans’ supplement equivalent amount compared to amounts that existed under the repealed section. Another effect is to repeal from the method of calculating the amount of flexible care subsidy for a day for a care recipient for care provided as transition care an ‘outbreak management support supplement amount’ (or ‘OMSA’). This is consequential to repeal of the outbreak management support supplement through item 24 of Part 2 of Schedule 3 of the Amending Instrument. The new basic subsidy amount for a day is set to include an amount that compensates for the repeal of the OMSA.



**Item 52 – Subsection 106B(2)**

This item amends subsection 106B(2) to increase the basic subsidy amount of flexible care subsidy for a day for a care recipient for care provided as short-term restorative care to \$255.81.

**Item 53 – Subsection 106B(3)**

This item amends subsection 106B(3) to increase the dementia and veterans' supplement equivalent amount of flexible care subsidy for a day for a care recipient for care provided as short-term restorative care to \$5.16.

**Part 5—Home care—maximum daily prices for care management and package management*****User Rights Principles 2014*****Item 54 – Subsection 21KA(1) (table)**

This item provides for increases of maximum daily prices for care management and package management for home care services in line with the increases of home care basic subsidy by repealing the table to subsection 21KA(1) and substituting a new table with the increased maximum prices as follows:

- Level 1 home care—care management \$6.02 and package management \$4.52
- Level 2 home care—care management \$10.59 and package management \$7.94
- Level 3 home care—care management \$23.04 and package management \$17.28
- Level 4 home care—care management \$34.94 and package management \$26.20.

## Statement of Compatibility with Human Rights

*Prepared in accordance with Part 3 of the Human Rights (Parliament Scrutiny) Act 2011*

### ***Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2025***

The *Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2025* (the Amending Instrument) is compatible with human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

#### **Overview of the legislative instrument**

The *Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2024* (Amending Instrument) amends subordinate legislation to provide for changes to:

- how the responsibility of approved providers of residential care to deliver a staff average amount of direct care ('care minutes') each quarter is calculated
- the amount of residential care hotelling supplement
- implement the Modified Monash Model 2023 for the purposes of residential care and flexible care subsidy
- repeal the residential care outbreak management support supplement
- insert a new residential care 'care minutes supplement', including eligibility and the method for calculating the amount of the new supplement
- the method for calculating and other matters determining the amount of residential care basic subsidy
- the amount of residential care registered nurse supplement (RN supplement)
- the amount of the home care basic subsidy, home care oxygen supplement, the home care enteral feeding supplement, the home care viability supplement and the home care top-up supplement
- the method for calculating and the amount of the flexible care subsidy, where care is provided through a multi-purpose service or as transition care or as short-term restorative care
- the maximum daily price which can be charged by approved providers of home care for home care 'care management' and 'package management'.

Consequent to repeal of the residential care outbreak management support supplement and related flexible care outbreak management support supplement equivalent amounts, increases to residential care basic subsidy and certain components of the flexible care subsidy provided through multi-purpose services and as transition care include cover for outbreak management costs.

All changes are applicable in respect of aged care provided to care recipients (who are subject to the *Aged Care Act 1997* (Aged Care Act) and its legislative instruments) and continuing care recipients (who are subject to the *Aged Care (Transitional Provisions) Act 1997* (Transitional Provisions Act) and its legislative instruments). The only exception to this is that changes to the home care top-up supplement are applicable to continuing home care recipients only.

The Amending Instrument amends the following subordinate legislation:

- *Aged Care (Transitional Provisions) Principles 2014*
- *Quality of Care Principles 2014*
- *Subsidy Principles 2014*
- *User Rights Principles 2014*
- *Aged Care (Subsidy, Fees and Payments) Determination 2014*
- *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014.*

### **Human rights implications**

The Amending Instrument engages the following human rights contained in Articles 11(1) and 12(1) of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) and Articles 25 and 28(1) of the *Convention on the Rights of Persons with Disabilities* (CPRD):

- the right to an adequate standard of living, including with respect to food, clothing and housing, and the right to the continuous improvement of living conditions (Article 11(1) of ICESCR and Article 28(1) of CPRD)
- the right to the enjoyment of the highest attainable standard of physical and mental health (Article 12(1) of ICESCR and Article 25 of CPRD).

#### *Schedule 1 and Part 2 of Schedule 3—staff average amount of direct care responsibility and residential care subsidy amount and method for calculation of amount*

Schedule 1 engages the right to health by providing for amendments to the responsibility of approved providers of residential care to provide at each residential care service each quarter of a financial year at least an average amount of direct care per care recipient per day to align how the responsibility is calculated each quarter with changes in Part 2 of Schedule 3 to amounts and methods to calculate residential care subsidy. The schedules collectively engage the right to health by ensuring that approved providers of residential care are funded sufficiently to provide residential care recipients with an amount of clinical care each day that meets their needs.

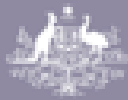
#### *Schedule 2 and Schedule 3—aged care subsidy and supplements*

Schedule 2 and Schedule 3 engage the right to an adequate standard of living and the right to health by amending the amounts of and methods for calculation of existing subsidy and supplements payable to approved providers of residential care, home care and flexible care for the provision of care and services to people receiving aged care, by creating a new residential care ‘care minutes supplement’, and by amending definitions, methods and amounts used to calculate residential care, home care and flexible care subsidy. The schedules separately and collectively engage the rights by ensuring approved providers of aged care are funded sufficiently to provide both non-clinical and clinical care to care recipients of all types of aged care to realise an adequate standard of living and the enjoyment of the highest attainable standard of physical and mental health.

### **Conclusion**

The Amending Instrument is compatible with human rights as it promotes the human right to an adequate standard of living and the highest attainable standard of physical and mental health.

**Sam Rae**  
**Minister for Aged Care and Seniors**



Australian Government  
Department of Health, Disability and Ageing



# Attachment C - Linking care funding to care minutes delivery in residential aged care Impact Analysis

## Executive summary

The 2021 Royal Commission into Aged Care Quality and Safety (Royal Commission) Final Report found that staffing levels across much of the residential aged care sector (sector) were inadequate to support quality care to older people living in residential aged care homes and recommended that government adopt minimum care time requirements to ensure consistent and adequate staffing across all approved residential aged care homes. The Australian Government (Government) accepted this recommendation and implemented mandatory care minutes requirements and provided substantial funding uplifts to fund the sector to deliver the additional required care time.

Despite this, compliance with the care minutes responsibility is low with only 37.4% of homes meeting their required care minute targets in the December quarter of 2024. This means that most residential aged care residents (residents) are not receiving the amount of care the Royal Commission considered necessary and that Government is providing substantial funding to registered residential aged care providers (providers) for care that is in many cases not being delivered.

The varying compliance rates between provider types, and across the different locations of their residential aged care homes, indicates that some providers could be making business decisions to not comply with care minutes targets. Analysis of care income and expense data from providers and residential aged care homes that met and did not meet their care minutes targets also show that those that did not meet their care minutes targets recorded substantially higher care profits than those that did. That is, those not meeting care minutes are benefitting financially from not doing so.

Without Government intervention, it is expected that compliance with care minutes targets will continue to be low. This means that a significant proportion of older people receiving residential aged care will continue to live in residential aged care homes with staffing levels lower than the Royal Commission considered necessary and that Government will continue to pay for a substantial amount of care that is not being delivered.

The objectives of any Government intervention to address this problem are to ensure residential aged care homes have adequate staffing to meet their residents' personal and clinical care needs (through meeting care minutes targets) and to ensure Government funding for residential aged care is cost-effective by minimising the extent to which funding is provided for care that is not delivered.

The levers Government has available to achieve these objectives are through transparency initiatives, strengthened regulation and/or changes to the way care minutes are funded. Further Government action around transparency is not expected to be effective given Government already publishes information about care minutes performance. Likewise, changes to the way care minutes are regulated are only expected to bring about incremental improvements. Funding is considered a viable lever to achieve these objectives given Government is the key funder of residential aged care, and has the legislative power to make funding changes, and the Information and Communication Technology (ICT) capability to make system changes to operationalise these.

This Impact Analysis considers the following policy options to address the policy problem of low care minutes compliance and the provision of Government funding for care not being delivered:

- Option 1 – Status quo
- Option 2 – Linking care minutes funding to care minutes performance for non-specialised residential aged care homes located in metropolitan areas (i.e. Modified Monash model [MM]1 areas) without additional assurance arrangements
- Option 3 – Linking care minutes funding to care minutes performance for non-specialised homes located in metropolitan areas (i.e. MM1 areas) with additional assurance

arrangements to manage the risk that providers may misreport their care minutes performance.

To identify the net benefit of each option, a cost benefit analysis of each option was undertaken. The cost benefit analysis covers a 4-year period from 2024-25 and is presented on a discounted cost basis. An estimate of regulatory burden of each of the 3 options was also completed.

The analysis shows that the net benefit is highest under Option 3, with residents in residential aged care homes that are not compliant with care minutes targets receiving more direct care and with a marginal benefit to Government through a reduction in subsidy payments for care that is not being delivered. Option 3 is the only option with additional regulatory burden with this small burden falling to providers.

The Department of Health, Disability and Ageing (department) has consulted directly with a range of stakeholders, including through the National Aged Care Advisory Council (NACAC), on the low levels of care minute compliance across the sector and options to address this issue. This consultation identified a general recognition of the need to do more to ensure providers are doing all they can to deliver the care minutes that they have been funded to deliver, particularly among residents and their family members, representatives of workers and also among some providers. Most stakeholders accepted that funding was the most effective lever available to Government to improve sector performance with their care minutes targets.

The Government has agreed to implement Option 3 - Linking care minutes funding to care minutes performance for non-specialised homes located in metropolitan areas (i.e. MM1 areas) with additional assurance arrangements to manage the risk that providers may misreport their care minutes performance, from October 2025. The department and Services Australia will jointly implement this option as a Tier 2 project under the governance of the Residential Aged Care Funding Reform Project Board.

This policy change will be incorporated into the department's existing care minutes and 24/7 registered nurse (RN) monitoring and evaluation plan. The success of the measure will be monitored quarterly through analysing the care minutes performance data collected through the Quarterly Financial Report (QFR). An evaluation of the care minutes and 24/7 RN responsibilities is planned to commence in early 2026 and will include early evaluation of the success of this policy change in achieving its objectives.

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# Background

The care minutes responsibility is a key Australian Government (Government) commitment to improve the quality of residential aged care. It responds to the findings from the Royal Commission into Aged Care Quality and Safety (Royal Commission) that the routine care of older people living in residential aged care homes often did not meet expectations for assistance with the activities of daily living, with many examples of substandard care in providing for the most basic of human needs.

In response, the Government introduced the care minutes responsibility on 1 October 2023, established by amendments to the Quality of Care Principles 2014<sup>1</sup> made through the Aged Care Legislation Amendment (Care Minutes Responsibilities) Principles 2023<sup>2</sup>.

Under the care minutes responsibility, registered residential aged care providers (providers)<sup>3</sup> are required to provide a minimum amount of direct care time to residents by registered nurses (RNs), enrolled nurses (ENs), and personal care workers (PCWs) and assistants in nursing (AINs) in their approved residential aged care homes (homes). This responsibility:

- commenced with a sector-wide average of 200 total care minutes, including a minimum of 40 minutes of RN time, per resident per day from 1 October 2023, and
- increased to a sector-wide average of 215 minutes per resident per day, including a minimum of 44 minutes of RN time per resident day, from 1 October 2024. From this time providers have been able to meet up to 10% of their required RN targets with the use of an EN.

The Government has been funding providers to deliver care minutes through the Australian National Aged Care Classification (AN-ACC) funding model since 1 October 2022, one year in advance of care minutes targets becoming mandatory.

## *Home level care minutes targets*

While the sector average care minute targets are set at 215 total minutes, including 44 RN minutes, each home has its own targets based on its residents' care needs.

These targets are calculated based on the assessed care needs of a home's residents. Under the AN-ACC<sup>4</sup> funding model, each resident receives an independent assessment of their care needs for funding purposes and is assigned an AN-ACC class or a respite class based on this assessment. Each class has a specific care minute allocation that reflects the care needs of residents in that class, which are matched to the level of funding for each class provided under the AN-ACC funding model (based on costing study data). Generally, a home with mainly higher needs residents will have higher care minutes targets than a home with mainly lower needs residents.

The targets are calculated on the 15th of the month prior to the start of the quarter based on the residents in care in the three prior calendar months. For example, for the 1 July to 30 September quarter of 2024, care minutes targets were calculated using AN-ACC classification data from 1 March to 31 May 2024.

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<sup>1</sup> Australian Government, 2014, Quality of Care Principles 2014 - Federal Register of Legislation, Accessed 4 July 2025.

<sup>2</sup> Australian Government, 2023, Aged Care Legislation Amendment (Care Minutes Responsibilities) Principles 2023 - Federal Register of Legislation, Accessed 4 July 2025.

<sup>3</sup>A provider is the organisation responsible for running approved residential aged care homes. There are currently around 750 providers than run around 2600 services.

<sup>4</sup> Department of Health, Disability and Ageing (DoHDA), 10 June 2025, The Australian National Aged Care Classification (AN-ACC) funding guide | Australian Government Department of Health, Disability and Ageing, Accessed 4 July 2025.



## Reporting

To monitor performance against care minutes targets, providers have been required to report care time delivered at the home level (i.e. for each of the homes in which they operate) in the Quarterly Financial Report (QFR) since 1 July 2022.

The department runs the care time reporting assessment program<sup>5</sup> to check the accuracy of provider reporting. This assessment program also helps ensure the accuracy of data used to inform Star Ratings, ensures the Aged Care Quality and Safety Commission (ACQSC) have accurate information for quality assurance and regulatory purposes, informs the Independent Health and Aged Care Pricing Authority's (IHACPA) costing and pricing studies, improves the quality of aged care data overall and informs policy decisions.

These assessments are undertaken on a sample of homes each quarter (using both a random and a targeted risk-based selection approach). Providers are notified of the information and documents required for assessment. The intention is that all homes will have their reporting checked at least once every 3 years.

Care time reporting assessments have been conducted since September 2023. When an assessment is being undertaken in a home, providers will need to provide payroll data, rosters and information about each workers role (e.g. a role description) to the department and respond to questions about any discrepancies in reporting and this source data. This administrative task is not normally completed by an RN, EN or PCW/AIN, instead it is completed by a business manager, accountant or administrative worker. Feedback from providers on the time taken to respond to reporting assessments varies, with reports of between 20-120 hours. As the process has been refined, providers have generally improved at responding to these requests.

The department publishes online support to assist with provider reporting, including information on activities eligible to be included as care minutes and the definition of workers that can be included<sup>6</sup>. The department also provides support for providers to comply with their care minute responsibility<sup>7</sup>.

## Regulation of care minutes

The Aged Care Quality and Safety Commission (ACQSC) is responsible for regulating the care minutes responsibility. Information on their approach to regulating care minutes is outlined in their regulatory bulletin<sup>8</sup>. The department provides data on care minutes compliance to the ACQSC quarterly to support its regulatory work.

## Care minutes transparency

Star Ratings<sup>9</sup> provides information on residential aged care homes to empower older people and their representatives with greater information to make choices about their aged care, incentivise provider engagement in continuous quality improvement and delivery of high-quality care to older people, and to support Government to provide transparent information about the quality of residential aged care at a system level.

The Staffing Rating is the key mechanism intended to support aged care residents and their family members, friends, and carers to see whether each home is meeting their care minutes targets and for older Australians to consider when selecting a residential aged care home. Each home's delivered care minutes are published alongside their targets.

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<sup>5</sup> DoHDA, 23 June 2025, Accessed 4 July 2025.

<sup>6</sup> DoHDA, 23 June 2025, Care minutes and 24/7 registered nurses in residential aged care | Australian Government Department of Health, Disability and Ageing, Accessed 4 July 2025.

<sup>7</sup> DoHDA, 2025, Support to comply with the care minutes responsibility | Australian Government Department of Health, Disability and Ageing, Accessed 4 July 2025

<sup>8</sup> Aged Care Quality and Safety Commission (ACQSC), 18 November 2024, RB 2023-19 Workforce-related responsibilities | Aged Care Quality and Safety Commission, Accessed 4 July 2025.

<sup>9</sup> DoHDA, 31 March 2025, Star Ratings for residential aged care | Australian Government Department of Health, Disability and Ageing, Accessed 4 July 2025.

Star Ratings are made up of an overall rating and 4 subcategory ratings, including staffing (based on care minutes). Staffing is displayed as a rating out of 5 stars. This provides a quick way to compare homes based on the amount of care they deliver. The Staffing Rating makes up 22% of the Overall Star Rating, meaning that non-compliance with care minutes targets, in isolation, may not significantly reduce a home's overall Star Rating.

Star Ratings, including the 4 subcategory ratings are published on the My Aged Care<sup>10</sup> website through the Find a Provider<sup>11</sup> tool.

Considerable effort has gone into ensuring that older people and their family members know about Star Ratings, including a national advertising campaign targeting older people and their support networks.

A 2024 Star Ratings evaluation report<sup>12</sup> commissioned by the department concluded that Star Ratings have promoted provider quality improvement and 'may have incentivised higher standards of care...[and]...driven improvements in both the timeliness and accuracy of reporting by providers' (Allen and Clarke Consulting, 2024, p. 10). The report highlights that Star Ratings has increased the availability of information to older people and their representatives to make choices regarding their aged care, including the selection of residential aged care homes. However, the report noted that care minutes is only one consideration for the selection of residential aged care homes with others being cost, location, models of care, facilities, etc. Consequently, care minutes performance has limited impact on the demand for residential aged care homes particularly as the demand for residential aged care is relatively high compared to the available beds in some locations.

The report also identified a lack of trust concerning how Star Ratings are determined and whether they reflect the care being provided.

In addition to information published through Star Ratings, home (or service) level care minutes performance has been published on the department's website<sup>13</sup> since the commencement of the care minutes responsibility and provider level care minutes metrics have also been published on the department's website<sup>14</sup> since October 2024. This allows the public to view and compare the collective performance of providers.

A sector-level care minutes dashboard is published on the department's website<sup>15</sup> and updated quarterly. The dashboard provides information on the residential aged care sector's performance in relation to care minutes delivered compared to the sector average targets and the percentage of homes that meet their targets. This dashboard also provides information on compliance in different regions and by providers of different ownership types.

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<sup>10</sup> myagedcare, n.d., Access Australian aged care information and services | My Aged Care, Accessed 4 July 2025.

<sup>11</sup> myagedcare, n.d., Find a provider | My Aged Care, Accessed 4 July 2025.

<sup>12</sup> Allen and Clarke Consulting, 2024, Star Ratings Evaluation – Summary report | Australian Government Department of Health, Disability and Ageing, Accessed 4 July 2025.

<sup>13</sup> DoHDA, 16 June 2025, Service-level care minutes performance in residential aged care (from October to December 2024) | Australian Government Department of Health, Disability and Ageing, Accessed 4 July 2025.

<sup>14</sup> DoHDA, 2 October 2024, Provider-level care minutes performance (from October 2023) | Australian Government Department of Health, Disability and Ageing, Accessed 4 July 2025.

<sup>15</sup> DoHDA, 3 July 2025, Care minutes in residential aged care dashboard | Australian Government Department of Health, Disability and Ageing, Accessed 4 July 2025.

# 1. Policy problem

The Royal Commission found that staffing levels across much of the residential aged care sector were inadequate to support high quality aged care and recommended that Government adopt minimum care time requirements to ensure consistent and adequate staffing across the sector. Government accepted this recommendation and implemented mandatory care minute requirements and provided substantial funding uplifts to fund the sector to deliver the additional required care time. Despite this, compliance with the care minutes targets is low with only 37.4% of approved residential aged care homes across the sector meeting their required care minute targets in the December quarter of 2024. This means that most residents are not receiving the amount of care the Royal Commission considered necessary to support quality care and that Government is providing substantial additional funding to providers for care that is in many cases not being delivered.

Compliance rates between different provider types (for-profit providers perform far worse than not-for-profit providers) and across different locations (metropolitan services perform worse than regional, rural and remote services) indicate that some providers appear to be making business decisions to not comply with care minutes requirements. Analysis of care income and expenses data from homes that met and did not meet their care minutes targets also show that those that did not meet their care minutes targets recorded substantially higher care profits than those that did. This means that those providers not meeting care minutes targets are in many cases benefitting financially from not doing so.

The Royal Commission's final report found that staffing levels within many residential aged care homes fell well short of good or even acceptable practice compromising the quality-of-care people living in these homes receive.

The Royal Commission identified that 'the introduction of the Aged Act in 1997 removed the obligation of providers to spend a dedicated portion of their Government funding on direct care staffing' (p.129) which meant that providers were free to determine for themselves what staffing numbers were adequate and what skill levels are appropriate (p.129). The Royal Commission also identified that this lack of regulation has resulted in 'providers replacing higher paid and skilled nurses with lower paid and semi-skilled personal care workers' who are required to care for residents with increasing levels of acuity (p.129)<sup>16</sup> which also increases pressure for staff.

The Royal Commission concluded that the 'status quo is unacceptable' (p. 129) and the evidence is compelling that overall staffing levels in aged care are linked to quality of care and that the number of RNs are particularly important<sup>17</sup>. This finding is also supported by academic evidence which concludes that higher RN staffing results in better quality of care<sup>18</sup>. As a result, the Royal Commission, in recommendation 86, recommended that Government require providers to meet minimum staffing standards for RNs, ENs and PCWs, and that these standards should be linked to a case-mix adjusted activity-based funding model (that is, the specific requirement for each home's care provision be linked to their residents' needs). The intention of this recommendation was to lift quality of care to a consistent and acceptable standard across the sector.

The Government accepted this recommendation, and implemented care minutes requirements over 3 stages:

1. From 1 October 2022 providers received additional funding to help them deliver an average of 200 total care minutes, including 40 RN minutes per resident per day. Each home also received a non-mandatory total and RN targets from this time and their

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<sup>16</sup> Australian Government Royal Commission into Aged Care Quality and Safety, 2021, Aged Care Quality and Safety final report, Executive Summary, p 129, Accessed 6 July 2025.

<sup>17</sup> Australian Government Royal Commission into Aged Care Quality and Safety, 2021, Aged Care Quality and Safety final report, Executive Summary, p 129, Accessed 6 July 2025.

<sup>18</sup> Dellefield, ME, Castle, NG, McGilton, KS, et al, 2015, The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review (2008-2014), *Nursing Economics*, 2015, 33 (2), p. 116, 95-108.

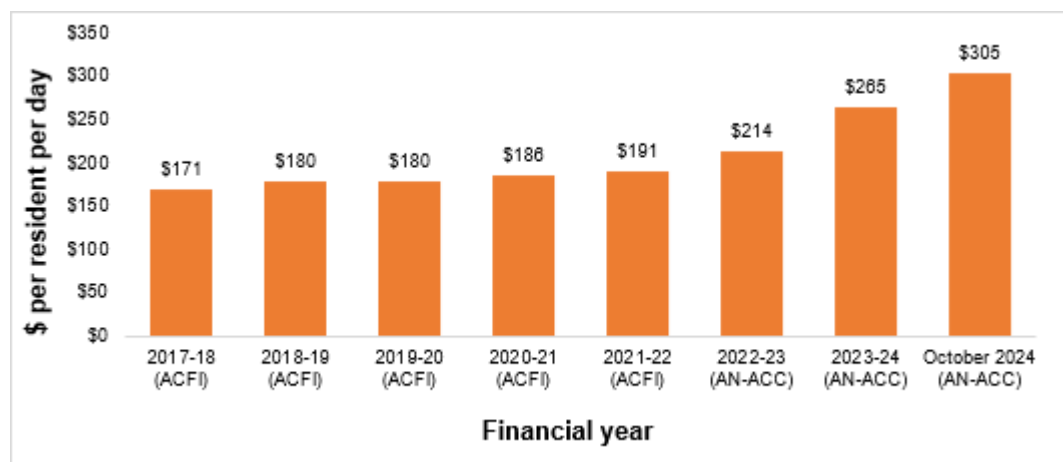
performance against their care minutes targets was measured and published as part of the Staffing Rating for Star Ratings.

2. From 1 October 2023 the care minute responsibility was legislated, with each home required by law to meet their specific care minutes targets. While these targets differ by home based on resident's needs (as determined by AN-ACC classifications) they were based on a sector average of 200 total care minutes, including 40 RN minutes per resident per day.
3. From October 2024 the legislated care minutes increased to a sector average of 215 total minutes including 44 RN minutes per resident per day (of which up to 10% can be met by an EN).

The Government also recognised the need to increase the wages of aged care workers to attract more workers to the sector and supported and funded the Fair Work Commission (FWC) Aged Care Work Value Case wage increases. RNs, ENs and PCWs/AINs were awarded a 15% wage increase from 1 July 2023, with further increases for PCWs/AINs on 1 January 2025 and 1 October 2025, and for RNs and ENs on 1 March 2025, 1 October 2025 and 1 August 2026.

The funding of wage rises and increases in care minutes requirements has led to substantial Government funding increases each year, with average per resident per day care funding now approximately 60% higher than it was in September 2022. Chart 1 below shows the progression of care funding in nominal dollars over recent years, with rapid funding increases commencing from 2022-23.

**Chart 1: Average per resident per day care funding**



Source: Department of Health, Disability and Aging (DoHDA).

Notes: Based on average Aged Care Funding Instrument (ACFI) funding until September 2022 and average AN-ACC funding from October 2022 onwards. October 2024 is an estimate based on projected average AN-ACC classifications of residents in care.

At the sector average level, care minutes increased to 212.90 total minutes including 45.88 RN minutes per resident per day by Q2 of 2024-25 compared to sector average targets of 215 total minutes and 44 RN minutes<sup>19</sup>.

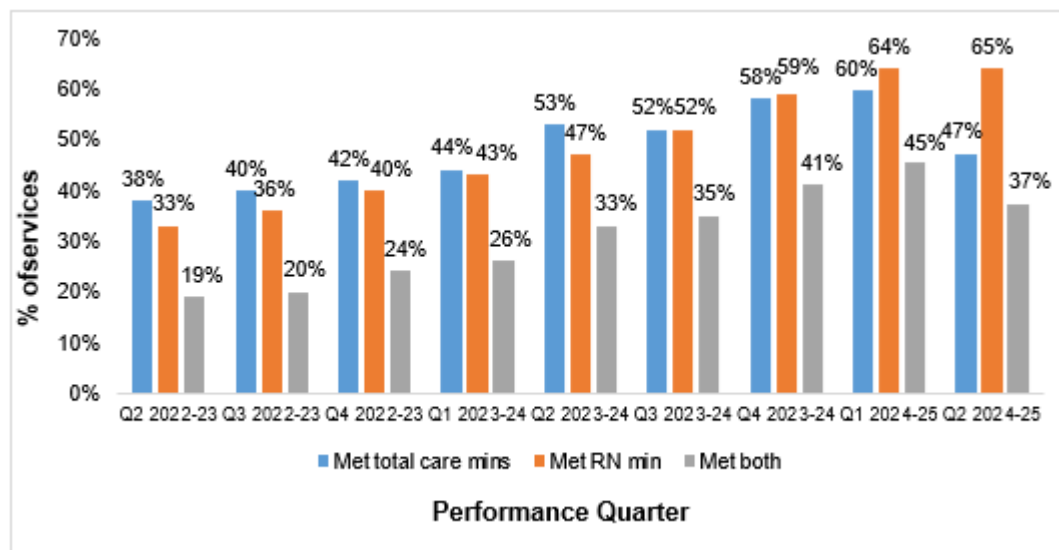
<sup>19</sup> Aged care providers report direct care hours delivered by RNs, ENs and PCWs/AINs together with occupied bed days in the Quarterly Financial Report (QFR). This data is checked for reasonableness by the department upon submission, and is either accepted, or the provider is contacted and asked to check if the data is correct and to explain any anomalies. A sample of this reporting is also checked in detail (including comparing to payroll records and role descriptions of workers) by the department through the reporting assessment program. Reporting assessments from the department generally support that the sector is mostly reporting accurately (with around 10% of reporting assessments over the last 10 months resulting in providers' data needing to be resubmitted to correct reporting errors).

However, the sector average performance masks low overall compliance with the care minutes responsibility at the home level. In Q2 of 2024-25 only 37.4% of homes met both their total care minutes and RN targets. Although these figures were impacted by the increased care minutes requirements introduced on 1 October 2024, the previous quarter's (Q1 of 2024-25) compliance levels were still unacceptably low with only 45% of homes meeting both their care minutes and RN targets (see chart 2). The size of this non-compliance is also quite significant with approximately 30% of homes being between 5 and 10 minutes per resident per day away from their total care minutes target and 22% of homes more than 10 minutes per resident per day away from achieving their total care minutes targets. In addition, approximately 12% of homes are more than 5 minutes per resident per day away from achieving their RN targets.

These figures mean that many aged care residents are not receiving the amount of care recommended by the Royal Commission and funded by the Government.

The large scale of non-compliance indicates that current regulatory levers, and the substantial increase in funding, are not providing the required incentives to ensure provider compliance with their care minutes responsibilities.

**Chart 2: Percentage of services that reported meeting their total, RN targets & both**



Source: DoHDA calculations based on QFR data, Services Australia claims, and AN-ACC assessment data

Notes: This is based on provider self-reported RN, EN & PCW/AIN worked hours and occupied bed days data from the QFR.

*Workforce shortages appear to be more significant outside of metropolitan areas but care minutes compliance is lowest in metropolitan areas*

Some of the non-compliance across the sector may be driven by workforce shortages outside the control of providers.

The Care Workforce Labour Market Study<sup>20</sup> found that currently there is limited evidence of a significant workforce shortage in the care and support sector at the national level, but that there are skill shortages and recruitment difficulties in some regions. The data analysed as part of this study indicates that workforce challenges are generally greater in the care and support economy in regional and remote areas (i.e. Modified Monash [MM] model area classifications 2-7) than in capital cities (i.e. MM area classification 1). This also aligns with the view of stakeholders consulted as part of the study, who noted greater difficulties in recruiting for care and support workers in regional and remote areas. It is also consistent with feedback that the department has received from providers prior to and following the implementation of mandatory care minutes targets, that it is generally harder to recruit and retain staff, particularly RNs, outside of metropolitan areas. The result is that providers incur more costs to achieve care minutes

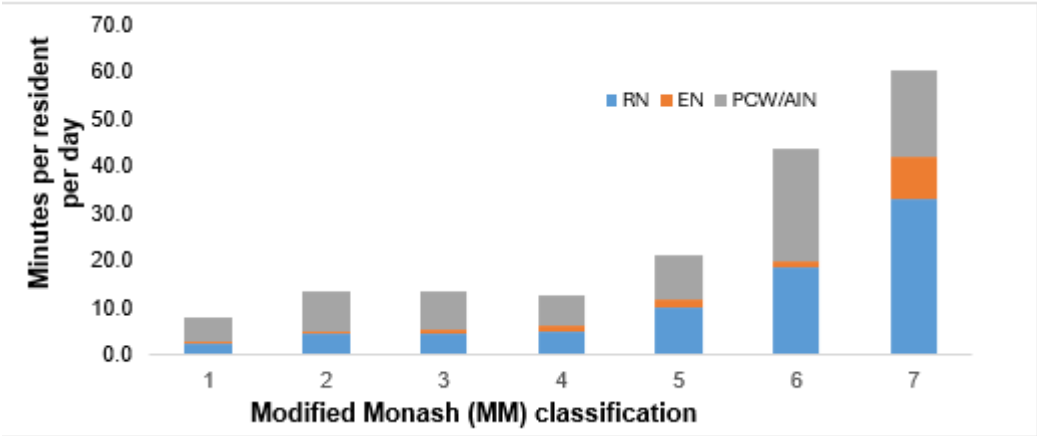
<sup>20</sup> National Skills Commission, 2021, Care Workforce Labour Market Study, Accessed 6 July 2025.

compliance in these regional and remote areas. For example, to make these areas more attractive to potential workers, many providers offer higher wages, housing for staff and their families and better working conditions such as increased holidays and additional travel benefits. Some providers elect to train local residents and/or use overseas staff including assisting them to integrate into the local community. Alternatively, they can use higher cost agency staff.

This is also supported by the department’s data the on use of agency staff by MM model<sup>21</sup> area classifications (noting that care minutes can be delivered, and count equally, whether they are delivered by directly engaged or agency staff, so long as staff are RNs, ENs or PCWs/AINs). As is shown in chart 3, the use of agency staff increases by remoteness. In MM1 (metropolitan areas) an average of 8 minutes of care is delivered by agency staff per resident per day, while usage in MM2-4 (regional centres and large and medium rural towns) is 12-13 minutes. Usage in MM5 (small rural towns) MM6 (remote areas) and MM7 (very remote areas) are significantly higher at 21, 44 and 60 minutes per resident per day respectively.

While agency staff usage is not a perfect measure of workforce shortage (because there are many reasons a provider might use agency staff) variation in usage between regions is a reasonable indicator of workforce shortages. Feedback from providers suggests that they generally try to employ staff directly wherever possible because agency staff costs are significantly higher (around 22% higher per hour in MM1 for an RN based on Q2 2024-25 QFR reporting) than directly employed staff. Although agency staff must have the required qualifications and experience, and can provide comparable quality care to permanent staff, they require onboarding and time to become familiar with residents, staff and working systems. They may also bring additional skills and knowledge to the care environment. Reasons to utilise agency staff include managing unexpected leave and absenteeism, dealing with infectious disease outbreaks, addressing short term increases in staffing needs and longer-term- staffing shortages.

**Chart 3: Agency RN, EN and PCW/AIN minutes by MM classification (per resident per day)**



Source: DoHDA, QFR Q2 2024-25

The table below shows the location and ownership type of residential aged care homes across the country to put the data provided in this section in perspective. Overall, 63% of homes are in MM1 areas, between 7-12% of homes are in each of MM2-5, while in MM6 and 7 there only a very small number of homes.

<sup>21</sup> The remoteness of aged care services are generally measured by the Modified Monash (MM) Model classification system. This system classifies locations into one of 7 categories ranging from metropolitan (MM1) to very remote communities (MM7). DoHDA, 10 April 2025, Modified Monash Model | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.

**Table 1: Breakdown of services by location and ownership type (Q2 2024-25)**

Modified Monash (MM) Model	Total	For-profit	Not-for-profit	Government
MM1: Metropolitan areas	1,543	712	809	22
MM2: Regional centres	194	59	111	24
MM3: Large rural towns	219	50	160	9
MM4: Medium rural towns	174	31	108	35
MM5: Small rural towns	297	27	162	108
MM6: Remote communities	25	0	19	6
MM7: Very remote communities	5	0	2	3
<b>Total</b>	<b>2,457</b>	<b>879</b>	<b>1371</b>	<b>207</b>

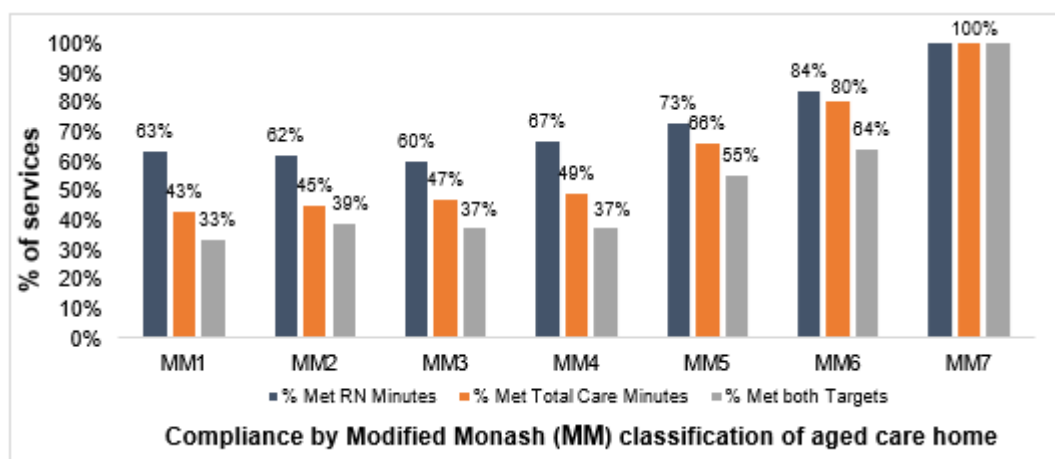
Source: DoHDA

Note: This table excludes a small number of services that did not have their QFR data accepted (or submitted) by the Q2 2024-25 care minutes dashboard cutoff date.

Chart 4 shows care minute's compliance rates by MM classification in the latest quarter of available data. Counterintuitively, care minutes compliance rates are higher outside of metropolitan areas (MM2-7) than they are in metropolitan areas (MM1). While 33% of MM1 homes met both their targets, compliance rates in MM2-7 areas were between 37% (for MM3-4) and 100% (for MM7). This is despite the data and feedback indicating that workforce shortages are more significant outside of metropolitan areas. This indicates that there are factors outside of workforce shortages impacting care minutes compliance across the sector.



**Chart 4: Care minute compliance by location (Q2 2024-25)**



Source: DoHDA, QFR data

Notes: This is based on provider self-reported RN, EN & PCW/AIN worked hours and occupied bed days data from the QFR.

### *For-profit providers generally perform far worse than other provider types*

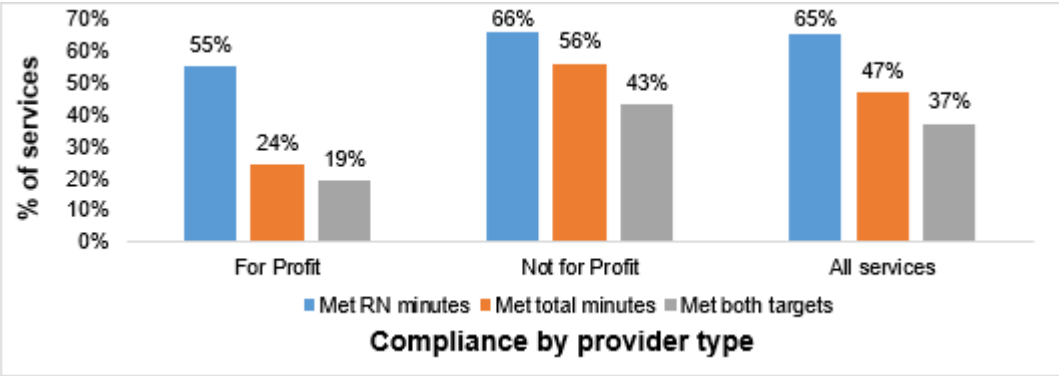
For-profit homes (comprising around 36% of all homes) are disproportionately located in metropolitan areas, with around 81% of for-profit homes located in MM1 regions, compared to around 59% of not-for-profit homes (not-for-profit homes comprise around 56% of all homes)<sup>22</sup>. Rural and remote homes are largely run by not-for-profit or state and local government owned providers.

As is evident in chart 5, for-profit homes have far lower compliance rates than not-for-profit homes. While 43% of not-for-profit homes met both their care minutes targets in the December quarter of 2024, only 19% of for-profit homes did. Looking only at total care minutes, 24% of for-profit homes met their targets compared to 56% of not-for-profit homes. The difference is less stark for RN targets, with 55% of for-profit homes meeting their targets compared to 66% of not-for-profit homes.

<sup>22</sup> State and local government owned homes make up the remaining 7% of homes. Care minutes delivered in government owned homes is generally much higher than across the rest of the sector. This is in part because some state governments have additional staffing regulations that need to be met by government run homes, and because many of these homes receive additional state government funding. We do not present the performance of government run homes throughout this analysis, but the government homes are included in the 'all homes' and sector average data.



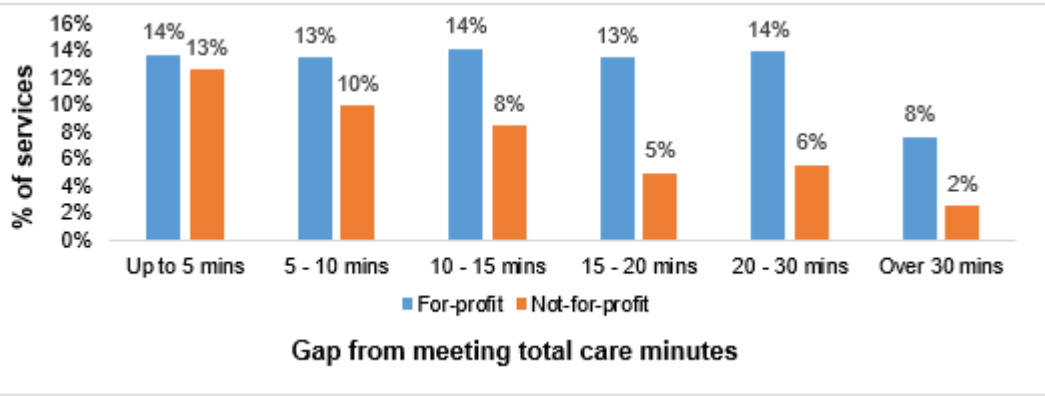
Chart 5: Percentage of homes that met their targets by provider type (Q2 2024-25)



Source: DoHDA, Care minutes dashboard - Quarter 2 2024-25<sup>23</sup>  
Notes: This is based on provider self-reported RN, EN & PCW/AIN worked hours and occupied bed days data from the QFR.

Of the for-profit homes not meeting their care minutes responsibilities, a large proportion have a significant gap between their targets and actual care time delivered, that is, they are not even close to being compliant (see chart 6). For example, 8% of all for-profit homes were more than 30 minutes off meeting their total care minute targets and a further 14% had a gap of 20 to 30 minutes. By comparison, only 2% of not-for-profit homes had a gap of more than 30 minutes and 6% had a gap of 20-30 minutes.

Chart 6: Gap from meeting total care minutes targets (Q2 2024-25)

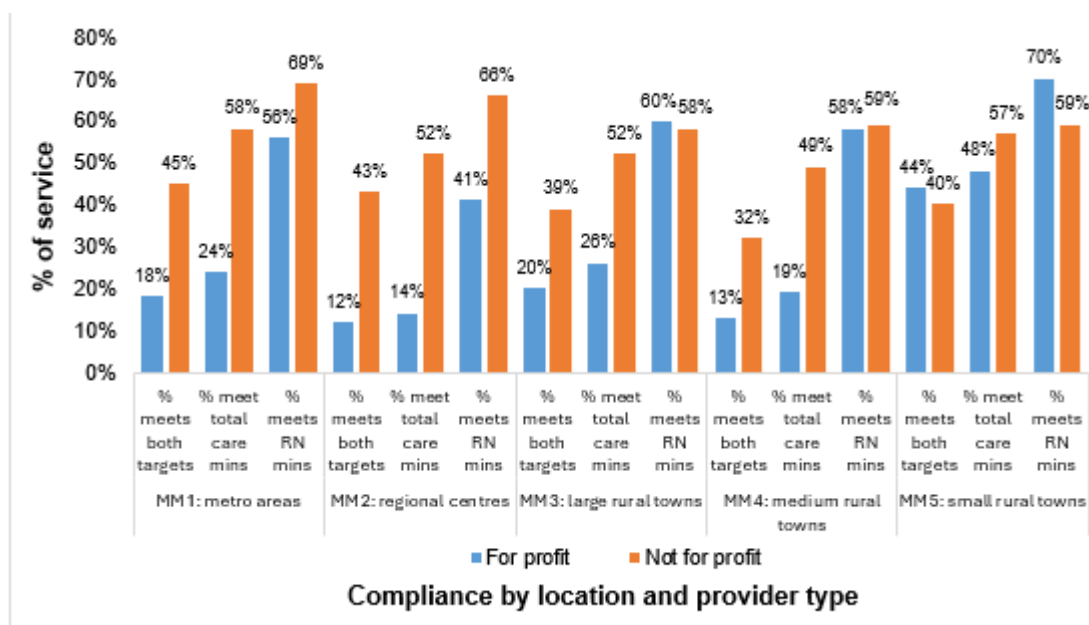


Source: DoHDA, QFR data  
Notes: This is based on provider self-reported RN, EN & PCW/AIN worked hours and occupied bed days data from the QFR.

When looking at the data split by location and ownership type in chart 9, for-profit services are performing far worse in terms of care minutes compliance across all regions except MM5 (noting that there are relatively few for-profit homes in MM5). For example, in MM1 only 18% of for-profit homes met both their care minutes and RN targets as compared to 45% of not-for-profit homes.

<sup>23</sup> DoHDA, 3 July 2025, Care minutes in residential aged care dashboard | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.

**Chart 7: Care minutes compliance by location and provider type (Q2 2024-25)**



Source: DoHDA, QFR data

Notes: This is based on provider self-reported RN, EN & PCW/AIN worked hours and occupied bed days data from the QFR. MM6-7 are not shown because there are no for-profit homes in MM6-7.

It is evident from chart 7, lower care minute compliance in metropolitan areas compared to regional and rural areas is largely driven by the distribution of homes by provider type across the regions, specifically the relatively high proportion of for-profit homes in MM1 regions compared to all other MM regions. For example, the compliance rates for not-for-profit homes generally decrease with remoteness between MM1 (where 45% meet both targets) and MM4 (where 32% of homes meet both targets).

The department has had discussions with various residential aged care advisory and consultation bodies to try and understand what kinds of legitimate reasons might be driving the differences in performance between for-profit and not-for-profit providers (noting that residential aged care funding arrangements are identical across the sector). Reasons identified include that not-for-profit providers may be using income from other parts of their organisation to support meeting their care minutes responsibilities, and that potentially, for-profit providers could not afford to meet their care minutes targets because they (unlike not-for-profit providers) are required to pay state-based payroll tax.

The department investigated these explanations using available financial reporting from the sector. When investigated for 2023-24, there was no evidence that a lack of care funding was driving the difference in care minutes performance between provider types. While for-profit providers are liable for state-based payroll tax, and not-for-profit providers are not, care profits by provider type are on average substantially higher for for-profit providers. For example, as is shown in chart 8, for-profit homes that met their total care minutes targets for each quarter recorded a \$20.23 per resident per day care profit on average, while not-for-profit homes recorded a care profit of \$6.80 per resident per day on average. This is explored further in the section below.

The fact that on average for-profit providers have systemically lower compliance rates than not-for-profit providers is further indication that some of the sector's non-compliance with care minutes is driven by business decisions rather than factors outside the providers control such as workforce shortages.

### *Not delivering care minutes is financially advantageous to providers*

Under current funding arrangements, the amount of care funding a provider receives depends on the number of residents they have in care and the AN-ACC classification of these residents. Providers are also not able to charge residents additional fees for care that they are required to provide under the *Aged Care Act 1997* (this remains the case once the *Aged Care Act 2024* commences).

Full funding is provided regardless of whether a provider meets their legislative obligations such as the care minutes responsibility. As a result, providers may benefit financially from not meeting their required care minute targets because of their lower wage cost. For example, assuming a care worker costs approximately \$60 per hour, a home with 100 residents, can save around \$0.73 million per year by delivering 20 less care minutes per resident per day than they are required to deliver. A provider with 50 homes like this would save \$36.5 million per year.

The department collects annual financial expense and revenue data from providers in respect of each of their services through the Aged Care Financial Report (ACFR)<sup>24</sup>. The latest ACFR data (from 2023-24) shows that on average care spending<sup>25</sup> was significantly lower than care costs, with the sector having a positive care result (or margin) of \$22.03 per resident per day.

StewartBrown, a significant provider of professional services to the aged care sector, also collects similar financial data from a sub-set of providers that subscribe to their benchmarking services<sup>26</sup>. StewartBrown's published data for the 2023-24 financial year shows a care surplus/profit of \$15.25 per resident per day and that this surplus is lower outside of MM1 areas (MM1 had a surplus of \$17.00 per resident per day, while average surpluses in MM2-5 were between \$5.62 and \$11.89 per resident per day)<sup>27</sup>.

Further analysis of care income and expense data by the department shows that that care profits are significantly higher for homes not meeting their care minutes targets than those meeting or exceeding their targets.

Chart 8 shows average care profits by provider type split by how many times a home met their care minutes targets in 2023-24. Average care margins are positive, even where homes meet their total target in every quarter, indicating that care funding is sufficient for providers to deliver their required residential aged care services (including care minutes delivery).

Further, chart 8 shows that care profits are far higher where providers have not met their total care minutes targets. For example, for-profit providers that met their total care minutes targets for every quarter recorded a \$20.23 per resident per day care profit on average, while those that did not meet it for any of the 4 quarters reported an average care profit of more than double this at \$46.72 per resident per day. This holds true when looking at not-for-profit providers as well, although the overall care profits are on average lower than for-profit providers as mentioned above.

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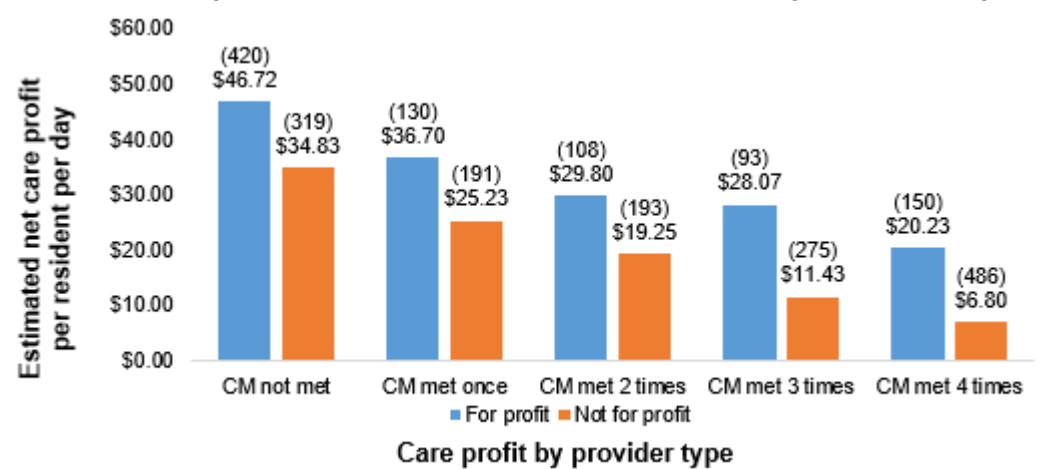
<sup>24</sup> ACFR income and expense data is self-reported by providers, and like QFR data, validation checks are applied by the department, with providers asked to resubmit or explain their data if it falls outside of expected boundaries.

<sup>25</sup> Care spending includes spending on care minutes, care management, allied health, lifestyle, care consumables, care related administration, payroll tax related to care staff and other care expenses.

<sup>26</sup> StewartBrown's survey covers around 46% of the residential aged care sector and includes relatively more of the not-for-profit part of the sector than the for-profit.

<sup>27</sup> StewartBrown, 2025, StewartBrown Aged Care Financial Performance Survey Report - 12 months ending 30 June 2024. p 8,11, Accessed 6 July 2025.

**Chart 8: Care profit of providers against their quarterly care minutes results per resident per day (number of providers in parentheses), by ownership type, 2023-24**



Source: DoHDA analysis based on QFR (Q1-4 of 2023-24) and ACFR (2023-24) data. This chart was also published in the Financial Report on the Australian Aged Care Sector 2023-24 on page 21.

Note: This excludes homes that did not have care minutes targets and reporting for all quarters of 2023-24, such as new homes, homes transferred between providers, and homes that went offline in 2023-24.

The department’s findings are also consistent with the University of Technology Sydney (UTS) Ageing Research Collaborative (UARC) report the Aged Care Sector Mid-Year Report 2023-24<sup>28</sup>. This report incorporated analysis of StewartBrown survey data from July to December 2023<sup>29</sup> that looks at operating result by quartile. UARC found that the most profitable homes (this is looking at overall profitability including labelling and accommodation in addition to just care, which is what is reflected in chart 9) are those that are furthest from meeting their care minute targets.

The UARC report summarised the problem in their report, noting:

*Even though care minute targets became a mandatory legal requirement on 1 October 2023, the mismatch between funding and spending on direct care staff has persisted. This mismatch occurs because AN-ACC funding – the primary mechanism the Government uses to fund additional staff or award wage increases – is tied to the number and acuity of residents (i.e. paid per occupied or operational bed day). Thus, a home’s direct care funding is not tied to its staffing levels. Put another way, since October 2022, most homes have received substantial increases in additional direct care funding to pay for staff they do not have.*

The UTS UARC Aged Care Sector Full Year Report 2023-24<sup>30</sup> notes that while they had predicted in their 2023-24 Mid-Year Report that staffing shortfalls would be a temporary issue and that the surpluses gained from direct care would reduce over the following months, this was not the case. These issues have persisted despite the Hon. Anika Wells MP, former Minister for Aged Care, reiterating expectations on providers in relation to care minutes delivery through an open letter to the sector<sup>31</sup> published 1 October 2024, the ACQSC updating its regulatory bulletin and

<sup>28</sup> University of Technology Sydney (UTS) Ageing Research Collaborative (UARC), 2024, Australia’s Aged Care Sector: Mid-Year Report 2023–24, UTS, Accessed 6 July 2025.

<sup>29</sup> StewartBrown’s July to December 2023 survey covers around 46% of the residential aged care sector, with data received for 1,203 aged care homes, of which 1187 were included. Unlike the Government, StewartBrown collects a full set of financial data quarterly from providers that subscribe to their service.

<sup>30</sup> UTS UARC, 2024, UTS UARC Aged Care Sector Full Year Report 2023-24, p 9, UTS, Accessed 6 July 2025.

<sup>31</sup> DoHDA, 2 October 2024, Letter to aged care providers from the Minister for Aged Care about care minutes – 1 October 2024, DoHDA, Accessed 6 July 2025.

hosting a webinar in November 2024, and providing an update through its 13 January 2025 media release<sup>32</sup> on the regulatory action that is being taken to address ongoing care minute non-compliance.

### *Who is impacted by providers not meeting their mandatory care minutes?*

The approximately 190,000 older people living in an approved residential aged care home are directly impacted by providers not meeting their mandatory care minute targets. In the December quarter of 2024-25 approximately 68% of these older people lived in homes that did not meet both their care minutes targets and therefore, have staffing levels below what the Royal Commission considered necessary to deliver appropriate care.

Older people living in residential aged care homes in metropolitan (MM1) areas are more likely than those outside of metropolitan areas to live in a home not meeting their care minutes targets than those living in regional, rural and remote areas (in line with the information in chart 4).

Workers are also impacted by providers not having sufficient staffing to meet their care minutes responsibilities. The Royal Commission identified that high workloads and time pressures are key factors behind job dissatisfaction and intentions to leave the aged care sector<sup>33</sup>. Where providers increase staffing to the level required to meet care minutes targets, there is likely to be a benefit to staff with these identified pressure points being eased. Based on the 2023 Aged Care Provider Workforce Survey there are around 217,000 direct care workers that work in a residential aged care setting<sup>34</sup>. The Government does not collect data on the proportion of these workers that work in homes that are not meeting their care minute targets, however, it is likely that it broadly reflects the percentage of residents in living homes not meeting their care minutes targets (i.e. in Q2 2024-25 62.6% of homes did not meet their care minute targets).

### *Data gaps*

Other data measures could be used to more clearly identify reasons for non-compliance with care minutes targets and to assess strategies used by providers to become compliant including collecting data on worker origin and/or nationality, or the number and progress of staff working towards further qualifications such as an aged care certification, or a formal nursing qualification.

Collecting this workforce data could help Government develop policy that supports staff training and builds on existing employment and workforce relocation programs (such as the Pacific Australia Labour Mobility [PALM] program) to import suitably qualified staff to work in the sector and/or support their training towards Australian aged care qualifications.

The department's existing reporting mechanisms such as the quarterly QFR, the monthly 24/7 RN report and the annual ACFR do not collect information relating to these workforce strategies and therefore cannot measure the benefits they offer in the short and long term, including how quickly they could improve minute compliance. Amending these reports to include this data could be problematic, expensive and increase the reporting burden for providers. In addition, these initiatives would take time to implement and positively impact care minutes compliance and therefore, were not included as a policy lever available to Government (outlined in Chapter 2) or in the policy proposals presented in Chapters 3, 4 and 6.

Collecting this type of information may be better suited to a more qualitative or mixed method study that targets a sample of aged care providers before proposing further reporting changes beyond those proposed later in this impact analysis.

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<sup>32</sup> ACQSC, Commission cracks down on aged care providers failing to meet care minutes, 13 January 2025

<sup>33</sup> Australian Government Royal Commission into Aged Care Quality and Safety, 2021, Aged Care Quality and Safety final report, Volume 2, 2021, p 129, Accessed 6 July 2025.

<sup>34</sup> Australian Institute of Health and Welfare (AIHW), 27 August 2024, 2023 Aged Care Provider Workforce Survey: Summary report - AIHW Gen, p 5, Accessed 6 July 2025.

### *Policy Problem*

This chapter showed that the Royal Commission identified that providers were not delivering the required amount of quality care to aged care residents and recommended the introduction of mandatory care minutes targets including prescribing the amount of care minutes that should be delivered to each resident per day.

In response to the Royal Commission's recommendations, the Government introduced care minutes targets for providers and increased AN-ACC funding for providers to deliver care minutes. However, many providers are not engaging sufficient nurses and carers to comply with their care minute targets regardless of receiving Government funding to do so. As a result, aged care residents are not receiving the required amount of quality care and Government funding to deliver care is not being used as intended.

Consequently, the policy problem is:

A significant number of providers are not delivering the required amount of care minutes that Government funds them to deliver, which results in the misallocation of Government funding and residents not receiving the recommended amount of quality care to meet their personal and clinical care needs.

The next chapter will identify the objectives of Government action to address this policy problem and the government interventions available to achieve these objectives.



## 2. Need for Government action

Government intervention is needed because without it, it is expected that compliance with care minutes targets will continue to be low. This means that a significant proportion of older people living in residential aged care will continue to live in homes with staffing levels lower than the Royal Commission considered necessary to deliver quality care and that Government will continue to pay for a substantial amount of care that is not being delivered.

The objectives of Government action are to ensure residential aged care homes have adequate staffing levels to meet their residents' personal and clinical care needs (through meeting care minutes requirements) and to ensure Government funding for residential aged care is cost-effective by minimising the extent to which funding is provided for care that is not delivered.

The levers Government has available to achieve these objectives are through transparency initiatives, strengthened regulation and/or changes to the way care minutes are funded. Further Government action around transparency is not expected to be effective given the Government already publishes information about care minutes performance. Likewise, changes to the way care minutes are regulated are only expected to bring about incremental improvements. Funding changes are a viable lever that falls within the Government's control as the funder of residential aged care.

### *Objectives of Government action*

The objectives of Government action are:

1. For all residential aged care homes to have adequate staffing levels to meet their residents' personal and clinical care needs. As was outlined in the previous section, adequate staffing levels were established by the Royal Commission to be a case-mix adjusted (based on the care needs of residents) average of 215 minutes of total care time including 44 minutes of RN time per resident per day. This objective is therefore measured in practice by compliance with service level care minutes targets.
2. To ensure that Government funding for residential aged care is cost-effective and sustainable by minimising the extent to which funding is provided for care minutes that are not delivered.

### *What levers does Government have to achieve these objectives?*

Government has 3 key levers available to achieve the objectives. These are:

1. Transparency measures aimed at highlighting providers' performance with their care minutes targets to incentivise better performance.
2. The way in which care minutes are regulated by the ACQSC. This includes the response of the ACQSC to non-compliance (for example, whether not meeting care minutes leads to further monitoring, formal action such as enforceable undertakings or non-compliance notices or sanctions), the factors that the ACQSC consider when determining their regulatory response and the resources of the ACQSC available to respond to widespread sector non-compliance with care minutes targets.
3. The way in which providers are funded to deliver their care minutes targets.

### **Transparency measures**

As noted earlier in this report, there is already considerable transparency around care minutes delivery with care minutes performance published on the My Aged Care 'Find a Provider' webpage as part of the Staffing Rating and forming a component of each home's Overall Star Rating each quarter. This care minutes and Staffing Rating information published on My Aged Care is specifically targeted at older people and their family members and was designed using target audience user testing. Also noted earlier in this report was the considerable effort that has gone into ensuring that older people and their family members know about Star Ratings, including a national advertising campaign targeting older people and their support networks. An evaluation

survey undertaken as part of the recent Star Ratings evaluation found that approximately 60% of prospective consumer survey respondents indicated they had accessed the Find a Provider tool to learn about the Star Ratings of a home (of which the Staffing Rating, which is based on care minutes is a component).

In addition, tabulated data showing home and provider level care minutes performance is readily available on the department's website<sup>35</sup>. This is published in spreadsheet form, allowing stakeholders to easily compare performance across the sector. While it is available to all, it is not designed to be readily accessible to older people, who are directed to the accessible information published through Star Ratings on My Aged Care. Instead, it is aimed at groups such as sector peaks, media, academics, unions and individuals with some ability to navigate a spreadsheet who want to do a deeper dive into care minutes delivery across particular homes and providers. These spreadsheets have been accessed on 889 occasions from 31 July to 30 November 2024.

The department also publishes sector level performance through the care minutes dashboard which was accessed on 5,774 occasions from 11 April to 30 November 2024. It is not clear which stakeholders accessed this information.

Given the already high degree of transparency around care minutes performance and promotion of Star Ratings, it is unlikely that further transparency measures will significantly improve compliance with care minutes targets. The department will continue to use its resources to ensure this level of transparency continues.

### **The way in which care minutes are regulated by the ACQSC**

It is expected that incremental improvements to care minutes performance will continue to be driven by the ACQSC's risk-based regulatory response to care minutes non-compliance. This approach is outlined in the ACQSC's regulatory strategy<sup>36</sup> and regulatory bulletin concerning workforce-related responsibilities<sup>37</sup> and continually refined based on insights from monitoring and evaluation strategies.

ACQSC's initial regulatory response to provider non-compliance with care minutes targets (as reported for the Q2 2023-24 period) was to engage with the worst performing providers to understand barriers to compliance and encourage them to take action towards achieving compliance. The ACQSC sent a letter to the providers of all other non-compliant homes which set out their expectation that providers are required to remedy non-compliance in a timely manner. These letters also included information about department supports available to them.

Acting on concerns from residential aged care sector stakeholders about care minutes non-compliance, on the 1 October 2024 the Hon. Anika Wells, the then Minister for Aged Care, published a letter to the residential aged care sector noting her 'disappointment' with the failure of some providers, mainly for-profit providers, to meet care minute targets despite increased funding over the past 2 years, and warning providers that the ASQSC would take increased action against non-compliance<sup>38</sup>.

With additional data providing insights into trends of non-compliance, in December 2024, the ASCQC commenced regulatory action against providers with the persistently highest rates of non-compliance (i.e. over 3 consecutive quarters). It accepted enforceable undertakings from the worst performing providers for 36 homes. The ACQSC's acceptance of the undertakings enables the ACQSC to monitor the provider's progress to remedy non-compliance and improve their

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<sup>35</sup> DoHDA, 3 July 2025, Care minutes in residential aged care dashboard | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.

<sup>36</sup> ACQSC, 28 August 2024, Regulatory Strategy 2024–25 | Aged Care Quality and Safety Commission, Accessed 6 July 2025.

<sup>37</sup> ACQSC, 18 November 2024, RB 2023-19 Workforce-related responsibilities | Aged Care Quality and Safety Commission, Accessed 6 July 2025.

<sup>38</sup> Wells, A, 2 October 2024, Letter to aged care providers from the Minister for Aged Care about care minutes – 1 October 2024 | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.



performance with their care minute targets. For those providers that continue to have high levels of non-compliance with their care minute targets, the ACQSC may take further action including:

- Commence proceeding in court to enforce an undertaking
- impose sanctions on a provider that restricts receipt of Australian Government subsidy for new residents at a home
- revoke a provider's approval to deliver aged care.

ACQSC's regulatory response and the application of these measures are outlined in Section 3 of this report which shows that the measures have had some success in improving care minute compliance. However, given the scale of the non-compliance across the sector (1156 of 2457 homes did not meet their care minutes target in the October – December 2024 quarter) and the resources required to thoroughly investigate the reasons for non-compliance in each home and to take regulatory action, it is not expected that altering ACQSC's regulatory stance or approach will bring about a substantial and swift improvement in care minute compliance without applying further policy levers.

### **The way in which providers are funded to deliver their care minutes targets**

Funding is a viable lever to generate both improvements in care minutes compliance (Objective 1) and to minimise the extent to which funding is provided for care minutes that are not delivered (Objective 2). Government has clear capacity to intervene with funding changes as the funder of the care component of residential aged care (through the AN-ACC funding model) and administrator of the aged care payment system (through Services Australia).

As has been outlined in Section 2, care minutes are funded through the AN-ACC funding model. AN-ACC funding is not currently based on services delivered and is instead based solely on the number of residents in care, and their AN-ACC funding classification (which represents their care needs). Government has capacity to make the amount of funding conditional on meeting certain conditions (like delivering care minutes in a particular period).

A recent example of Government using funding as a lever to support outcomes in residential aged care, which demonstrates that Government has capacity to intervene, and that linking funding to outcomes can have positive results, is the relatively recent introduction of the 24/7 RN supplement. This supplement was introduced in July 2023 to provide additional funding to small residential aged care homes to support the provision of 24/7 RN care and is only provided where a home has an RN on-site and on duty for at least 87.5% of the hours in the month. Overall compliance with the 24/7 RN responsibility has been high with around 94% of homes that meet the 50 residents or fewer size criteria for the supplement also meeting the 87.5% RN coverage threshold criteria in May 2025. Overall compliance with the 24/7 RN responsibility is relatively high at around 95% of all homes<sup>39</sup>.

### ***Why is Government intervention necessary?***

Government intervention is needed because without it, it is expected that compliance with care minutes will continue to be low. It will remain low as existing Government initiatives and alternatives to Government interventions are inadequately addressing the policy problem and are not increasing care minute compliance quickly enough and ensuring Government funding for care is being used for that purpose. This means that a significant proportion of older people living in residential aged care will continue to live in homes with staffing levels lower than the Royal Commission considered necessary to deliver quality care and that Government funding for care is not being used to deliver care.

### **Alternatives to Government intervention**

Alternatives to Government intervention could include education and advertising campaigns, however these have already been undertaken through the Star Ratings promotion work, as have

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<sup>39</sup> DoHDA, 30 May 2025, Registered nurse coverage in residential aged care dashboard | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.

attempts to drive up compliance through raising the profile of the issue through the release of the publication and distribution of an open letter to providers from the Minister for Aged Care<sup>40</sup>.

Like care minutes requirements, Star Ratings<sup>41</sup> were introduced as a recommendation of the Royal Commission and are designed to inform consumer choice by providing transparency about care quality, safety and services of residential care homes. As mentioned earlier in this Impact Analysis, Star Ratings help people to compare homes with an Overall Star Rating and across 4 subcategories (including resident experience, compliance, staffing, quality measures) and help providers to monitor, compare and improve the quality of their aged care service. Although this information is transparent and easily accessible it has not resulted in high levels of provider compliance with their care minutes targets regardless of the Staffing Rating making up 22% of the Overall Staff Rating. Consequently, the department considers that Star Ratings are effective in supporting the proposed options presented in this Impact Analysis rather than being likely to solve the policy problem of low care minutes compliance.

The open letter from the Minister to the aged care sector reinforces Government's expectation that providers comply with their care minutes requirements and highlights the level of non-compliance and the amount of Government funding given to providers to achieve care minutes compliance. The letter also highlights the ASQSC's regulatory power to take action against providers who are non-compliant with their care minutes responsibilities. However, unacceptably high levels of non-compliance remain. Consequently, in isolation this letter insufficiently addresses non-compliance and the misallocation of Government care funding particularly as the ACQSC does not have the resources to take regulatory action against all non-compliant providers nor would this be a proportionate response to providers that are close to achieving their targets.

Other alternatives to Government action such as seeking to get providers to voluntarily sign up to an agreement to deliver care minutes are not appropriate for what is already a legislated obligation on providers. Additionally, it is unlikely that providers would agree to or adhere to such standards (especially those not adhering to the legally required care minutes) which would take time to establish, garner industry support and implement.

As such there are not any clear unexplored alternatives to Government intervention to address the problem of low compliance with care minutes beyond relying on market forces to gradually drive increased care minutes performance, supported by the transparency measures described earlier in this section (and in the background section of this report).

It is unlikely that relying on external market forces would provide the required incentives for providers to significantly improve their compliance with their care minute targets. Increasing occupancy across the sector (noting StewartBrown reported occupancy at 94.0% in their latest report, higher than pre-COVID 2020 levels<sup>42</sup>, and the department also reporting a trend of increasing occupancy in the Quarterly Financial Snapshots<sup>43</sup>) reduces the ability of older Australians entering residential aged care to select a home on factors like care minutes performance and quality ratings. These factors also need to be considered alongside other factors such as location, building design, and room price.

Providers are also unlikely to increase their care minutes compliance without Government intervention because the policy settings and regulatory oversight, for many providers, compete

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<sup>40</sup> Wells, A, 2 October 2024, Letter to aged care providers from the Minister for Aged Care about care minutes – 1 October 2024 | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.

<sup>41</sup> DoHDA, 2025, About Star Ratings | Star Ratings for residential aged care | Australian Government Department of Health, Disability and Ageing, Accessed 7 August 2025

<sup>42</sup> Stewart Brown, 2025, 2025 03 StewartBrown Aged Care Financial Performance Survey Analysis Report (December 2024), Accessed 16 July 2025.

<sup>43</sup> DoHDA, 2025, Quarterly Financial Snapshot for the Aged Care Sector – Quarter 2 2023–24, Australian Government Department of Health Disability and Ageing, Accessed 16 July 2025.

directly with the desire to avoid a competitive disadvantage by incurring increased workforce costs of complying with their care minutes targets.

With the ACQSC targeting providers with high levels of non-compliance with their care minutes targets for further regulatory action (e.g. enforceable undertaking, sanctions), there is a reduced need for providers with low to medium levels of non-compliance to act. This has resulted in a culture across some parts of the sector of acceptable levels of non-compliance with care minutes targets.

The ACQSC regulates this provider responsibility at the provider level. It targeted providers of homes with the largest levels of care minutes non-compliance (the worst performers) while at the same time engaging with these providers about all their homes that have failed to meet targets, regardless of the extent of the shortfall. These engagements demonstrate that for most providers, the actions they need to take to improve performance against their care minutes targets takes time, and some providers lack the capability to make rapid changes to their workforce in order to comply.

The option of not intervening further to improve care minutes compliance is further explored in the next section under the status quo option.

### **Why Government intervention is appropriate**

Government intervention is required to ensure homes have adequate staffing to meet their residents' personal and clinical care needs and to ensure that Government funding for residential aged care is cost-effective and sustainable by minimising the extent to which funding is provided for care minutes that are not delivered.

Government is the primary source of care funding for residential aged care delivery which is the main source of income for providers. Under arrangements set out in the *Aged Care Act 1997* (and from November 2025 the *Aged Care Act 2024*), the Government distributes this funding based on the AN-ACC funding model. Consequently, Government has the legislative ability to alter how Government funding is distributed including it being based on compliance with care minutes targets. In doing so, Government can also take advantage of the commercial priorities of providers to ensure they deliver their care minutes targets.

Government can also use its legislative powers to ensure providers are responsible for providing accurate reporting of their care minute performance and has the resources to undertake reporting assurance activities.

In conclusion, without Government intervention, not only will some residents miss out on the quality-of-care benefits of increased staffing, but the Government will also continue to fund all aged care homes in full regardless of whether they are compliant with their care minutes targets or not. That means that the Government will spend a considerable amount of money paying providers to deliver care that is not being delivered. Additionally, providers who are compliant with their care minutes targets may be unfairly operating at a competitive and commercial disadvantage as compared to providers who are not compliant and who may have lower wage costs and are allocating care funding to other areas of their business and/or profiteering.

### ***How will success be measured?***

Success of Government intervention at meeting Objective 1 will be determined by observing the quarterly care time data reported by providers through the QFR and specifically, the following metrics:

- Increase in the percentage of homes that meet their total care minute targets by 5 percentage points or more each quarter in the first year following Government intervention.
- Increase in the percentage of homes that meet their RN care minutes targets by an average of 5 percentage points or more each quarter in the first year following Government intervention.

- Increase in the percentage of homes that meet both their targets by an average of 5 percentage points or more each quarter in the first year following Government intervention.
- Reduction in the percentage of homes that were more than 10 minutes per resident per day from meeting their RN targets to below 1% of all homes in the first year following Government intervention.
- Reduction in the percentage of homes that were more than 20 minutes per resident per day from their total care minute targets to below 5% of all homes in the first year following Government intervention.

Success against Objective 2 will be measured by looking at the monetary value of funded but undelivered care minutes each quarter across the sector (the care underspend). Specifically, for each home their undelivered care minutes will be multiplied by average RN, and PCW/AIN expenses in their MM cohort, then the results from all homes will be summed together to establish a residential aged care sector level measure. Success would be a 50% reduction in the quarterly dollar value of this care underspend within a year of Government intervention.

Due to the current high rates of non-compliance across the sector, these figures are considered achievable.

In addition to the metrics above, the department will evaluate the policy of linking funding to care minutes compliance (refer to chapter 7 Evaluation). This program will include engagement with providers and other industry stakeholders to collect qualitative data to give context and deeper meaning to the metrics outlined above. For example, evaluation will identify and examine factors that are impacting care minutes compliance and the impact of care minutes compliance on care quality.

### *Barriers to achieving objectives*

Barriers to increasing care minutes compliance and minimising the extent to which funding is provided for care minutes that are not delivered primarily relates to providers as they are responsible for:

- recruiting, retaining and managing their workforce to be compliant with their care minutes targets and the Aged Care Quality Standards, and
- accurately reporting their levels care minutes compliance.

The key risks associated with meeting the objectives are:

- Ongoing workforce shortages, which may mean that in some regions providers are genuinely unable to meet their care minutes targets with the funding available to them. For example, the viability of homes may be at risk if they need to pay excessively high wages to attract and retain workers. As has been identified in the previous section of this report, this risk is more likely to be an issue in regional, rural and remote areas than in metropolitan areas. Some providers are successfully overcoming this risk by adopting more efficient and effective computerised rostering technology (to align rostering and care minutes requirements and to reduce the use of agency staff) and innovative workforce recruitment and retention strategies such as training local community members and recruiting international workers. This shows provider willingness and ability to improve their business processes to more effectively and efficiently deliver care within an evolving regulatory context.
- Providers may misreport the amount of care minutes they deliver rather than increase the amount of care minutes they deliver. Currently around 10% of reporting that is checked by the department through reporting assurance assessments is required to be re-reported because it is inaccurate<sup>44</sup>. The department does not currently disclose which providers have submitted incorrect data. Any Government intervention that increases the onus on

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<sup>44</sup> This is internal departmental data.

providers to improve their care minutes performance will also increase the likelihood of providers over-reporting care minutes delivered. The proposed policy Option 3 outlined later in this impact analysis considers strengthened data assurance processes to ensure care minute reporting is accurate.

- Providers having financial difficulties in reaching their care minutes targets. This risk is mitigated through annual funding adjustments to the AN-ACC funding model and funding weights which are determined by Government following consideration of pricing advice from the Independent Health and Aged Care Pricing Authority (IHACPA). IHACPA through their pricing methodology, recommend a price based on ensuring providers are funded to meet mandatory care minutes targets, plus other required care and services.
- Providers may intentionally resist Government efforts to increase care minutes compliance. Several providers disagree with the concept of Government prescribing how to deliver quality care particularly when they are compliant with the Aged Care Quality Standards. These providers advocate that prescribed care minutes targets involving care delivered by RNs, ENs and PCWs does not align with their care models that may include a higher proportion of care delivered by allied health professionals and recreational staff that are excluded from being counted as care minutes for compliance purposes. These providers advocate that care minutes requirements stifle innovation in care delivery resulting in poorer care outcomes for residents. These views contrast with the findings and recommendations of the Royal Commission.

These risks have been considered further in the design of the policy options outlined in the next section of this Impact Analysis.

### 3. Policy options considered

This Impact Analysis considers the following policy options to address the policy problems of low care minutes compliance and Government funding for care not being used for the provision of care:

- Option 1 – Status quo
- Option 2 - Linking care minutes funding to care minutes performance for non-specialised residential aged care homes located in metropolitan areas (i.e. MM1 areas) without additional assurance arrangements.
- Option 3 – Linking care minutes funding to care minutes performance for non-specialised residential aged care homes located in metropolitan areas (i.e. MM1 areas) with additional assurance arrangements to manage the risk that providers may miss-report their care minutes delivered.

This section considers the 3 policy options proposed to address policy problem of low care minutes compliance and Government funding for care not being used for the provision of care.

#### *Option 1: Status quo*

Under this option Government would make no changes to improve providers compliance with the care minutes responsibility. There would be no changes to funding for providers not meeting their care minutes responsibility.

Under this option, the ACQSC would continue to regulate provider compliance with their care minute responsibility in line with the approach outlined in their regulatory bulletin<sup>45</sup> and in the previous section of this report. In short, the ACQSC may act against providers that are:

- are not complying with their care minutes targets principally because of their workforce strategy or business decisions; and
- have not taken reasonable steps to mitigate risk for people receiving an insufficient amount of care caused by provider non-compliance with their workforce responsibilities, including their care minutes responsibility.

The high levels of non-compliance across the sector means that the ACQSC has been primarily focused on homes with a gap of 30 minutes or more in total care minutes, and/or 15 minutes or more in RN minutes (around 15% all non-compliant homes in Q2 of 2024-25). This is because the ASQSC is a risk-based regulator and directs its finite resources towards the highest and most direct risks. Furthermore, assessing the specific arrangements and circumstances in each home, and why they are not meeting their care minutes targets (e.g. is it because of factors outside of their control, or because of a business decision or workforce strategy that is within their control) is very resource intensive, particularly with the large amount of non-compliance across the sector.

In December 2024, the ACQSC commenced taking formal regulatory action in the form of enforceable undertakings or non-compliance notices for providers who failed to meet either care minutes targets (by 30 minutes or more in total care minutes and/or 15 minutes or more in RN minutes) over 3 consecutive quarters. To date the ACQSC has entered into 28 enforceable undertakings with providers covering 36 homes and issued 7 non-compliance notices to providers that have fallen well short of delivering their individual care minutes targets across successive quarters.

The ACQSC's compliance action has to date successfully supported providers on a pathway to compliance, with most of the enforceable undertakings and non-compliance notices now closed and many of the remainder expected to be closed in the coming months. The ACQSC's approach has incentivised providers to uplift their performance and the number of homes meeting their

<sup>45</sup> ACQSC, 14 November 2024, Regulatory Bulletin 2023-19, ACQSC, Accessed 6 July 2025.

targets has increased, However, as this regulatory action has focussed on only a small number of providers, it has not substantially improved compliance rates at the sector level.

More extreme regulatory enforcement action may not be the optimum use of limited Government resources and may not align with the ACQSC's risk-based approach noting that some providers may have persistent low levels of non-compliance with their care minutes targets but comply with the Aged Care Quality Standards. In addition, taking-action against providers who are making efforts to achieve compliance may be perceived as counterproductive by some industry stakeholders.

The ACQSC will continue to monitor and target sub-groups of providers and homes as part of a rolling regulatory strategy designed to sustain regulatory pressure on providers with homes with large gaps and appear to have no reasonable excuse for not meeting their care minute targets. The methodology used to target these providers will continue evolving as patterns and trends emerge and as insights into the barriers to compliance develop. As a risk-based regulator, the ACQSC directs its finite resources to where they matter most in responding to provider non-compliance and in communicating their expectations that providers met all their obligations including those related to workforce.

In addition to the ACQSC's regulatory action, the Government will continue to transparently publish home-level care minutes performance on the My Aged Care 'Find a Provider'<sup>46</sup> website as part of Star Ratings to support current and future residents and their advocates to understand the care provided in each residential aged care home. This information will also continue to be published in a spreadsheet<sup>47</sup> (viewed on 889 occasions from 31 July to 30 November 2024) on the department's website alongside the care minutes dashboard<sup>48</sup> of sector level performance (viewed on 5,774 occasions from 11 April to 30 November 2024). Regardless of not being able to determine who accesses this information, it is a valuable source of information (along with the other care minutes guidance documents) to increase the transparency of residential aged care delivery.

An evaluation survey undertaken as part of the recent Star Ratings evaluation found that approximately 60% of prospective consumer survey respondents indicated they had accessed the Find a Provider tool to learn about the Star Ratings of a home (of which the staffing rating, which is based on care minutes is a component). The focus groups for this evaluation also highlighted that many prospective residents formed their views on an aged care home's quality and staffing based on their direct observations (e.g. building layout, fittings etc.) and location of the home and service costs rather than through their published ratings<sup>49</sup>. This is an indication that, while these transparency measures are helpful for prospective residents in choosing their aged care home, they are not a key driver.

In terms of improving the quality of care, over 80% of the sector survey respondents (of which only 56 of the 381 respondents were residential aged care residents) believed that Star Ratings had either no impact or only a 'limited impact' on improving care quality and 13% felt that Star Ratings had, 'to some extent' or 'to a great extent', prompted improvements in care quality.

Consequently, Star Ratings and increased transparency are limited in how much of an incentive they place on providers to improve their care minutes performance.

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<sup>46</sup> My Aged Care, n.d., Find a provider | My Aged Care, Accessed 6 July 2025.

<sup>47</sup> DoHDA, 16 June 2025, Service-level care minutes performance in residential aged care October to December 2024 (2024-25 Financial Year Quarter 2) | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.

<sup>48</sup> DoHDA, 3 July 2025, Care minutes in residential aged care dashboard | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.

<sup>49</sup> DoHDA, n.d., [Star Ratings Evaluation – Summary report](#), Accessed 6 July 2025.



## *Option 2: Linking care minutes funding to care minutes performance for non-specialised services located in metropolitan areas without additional assurance arrangements*

Option 2 would see funding for care minutes linked to a home's performance for non-specialised services located in MM1 areas only. This option is intended to lift care minutes performance through there being financial implications of not delivering on required staffing levels required to comply with care minutes targets. It is also intended to reduce the extent that Government is funding providers for care time that is not being delivered.

Linking funding to care minutes performance would be achieved by establishing a 'care minutes supplement' by setting aside a small proportion (equivalent to 0.113 of the national weighted activity unit or NWAU<sup>50</sup> or \$33.41 based on the proposed AN-ACC price from 1 October 2025 of \$295.64) of the provider's AN-ACC funding (i.e. per resident per day) which will be paid at different rates based on a home's care minutes performance.

The AN-ACC funding withheld would be drawn from the base care tariff<sup>51</sup> (BCT) component as this allows the funding change to be targeted at only MM1 non-specialised services<sup>52</sup> without undertaking major aged care payment system changes.

Under this option, the care minute supplement would be linked to provider performance as measured by the percentage of total care and RN minutes targets delivered in the latest period of care minute reporting. A detailed supplement schedule for this option is outlined in table 2 below. This table is based on the proposed October 2025 AN-ACC price of \$295.64 per NWAU, noting that any change in the AN-ACC price would see the dollar amounts in this rates table updated.

The supplement is tapered so that 100% compliance gets providers their full care minute funding, and then the funding reduces for each compliance bracket. Providers delivering less than 85% of both their targets would not get any care minute supplement funding (but they still receive around 85% of their care minutes funding through their remaining AN-ACC funding). 85% was selected as the threshold for the supplement because only a relatively small number of homes are delivering less than 85% of their targets. Specifically, in Q1 of 2024-25, there were approximately 2% of homes delivering less than 85% of their total care minutes targets, and around 9% of homes delivering less than 85% of their RN targets.

Under this option, the ACQSC would remain responsible for regulating care minutes, and would be particularly focused on the worst performing homes, including those delivering less than 85% of both their targets (ensuring that providers cannot maximise their relative funding versus costs by delivering below 85% of their targets).

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<sup>50</sup> The AN-ACC funding model works by applying weightings, or NWAUs, to the AN-ACC price. NWAU's are a unit of activity/cost. The NWAU associated with each component of the AN-ACC funding model reflects variations in the cost of providing care, based on the characteristics of a service and its individual residents. DoHDA, n.d., The Australian National Aged Care Classification (AN-ACC) funding guide, p 13.

<sup>51</sup> AN-ACC base care tariff (BCT) funding is set based on the characteristics of the home rather than the residents. The AN-ACC BCTs are outlined in section 3 of the AN-ACC funding guide.

<sup>52</sup> Specialised services are considered those eligible for additional BCT funding under the AN-ACC funding model because of their specialised status, that is those in receipt of the specialised homeless BCT status funding supplement (which can apply to a home in any location) and specialised First Nations services funding supplement in rural and remote areas (MM 6-7)



**Table 2: Proposed care minute supplement rates per resident per day\***

% RN care minutes								
% total care minutes	<85%	≥85% - <87.5%	≥87.5% - <90%	≥90% - <92.5%	≥92.5% - <95%	≥95% - <97.5%	≥97.5% - <100%	≥100%
<85%	0.00	0.59	1.18	1.77	2.37	2.66	2.96	2.96
≥85% - <87.5%	5.62	6.21	6.80	7.10	7.69	8.28	8.28	8.57
≥87.5% - <90%	10.94	11.53	12.12	12.71	13.30	13.90	13.90	14.19
≥90% - <92.5%	16.56	17.15	17.74	18.33	18.92	19.51	19.51	19.81
≥92.5% - <95%	22.17	22.76	23.36	23.95	24.24	24.83	24.83	25.13
≥95% - <97.5%	27.79	28.09	28.68	29.27	29.86	30.45	30.45	30.75
≥97.5% - <100%	28.38	28.97	29.56	29.86	30.45	30.75	31.04	31.34
≥100%	30.45	31.04	31.63	32.22	32.52	32.82	33.11	33.41

\*Rate applicable until care minute performance is first assessed

This table is based a proposed 1 October 2025 AN-ACC price of \$295.64 per NWAU.

The supplement funding rates (in table 2) are designed to fund homes for the care minutes they delivered and provide funding to enable them to reach the next bracket of compliance. That is, under the design of the supplement table, a home is generally funded for one compliance (or funding bracket) higher than they perform. For example, if a home was delivering care minutes at 85-87.5% of their targets, the supplement table is designed to fund them as though they were delivering 87.5-90%. In effect, this provides a funding ladder for homes to increase their care minutes delivered to achieve full compliance.

If providers elect for their homes to remain in a low compliance funding bracket through a lack of action to improve their care minute compliance, they may become subject to ACQSC's regulatory action. Low compliance would also result in low Staffing Ratings for the provider and the home and ultimately lower Overall Star Ratings. Furthermore, the provider would not get the additional funding from being in a higher compliance bracket.

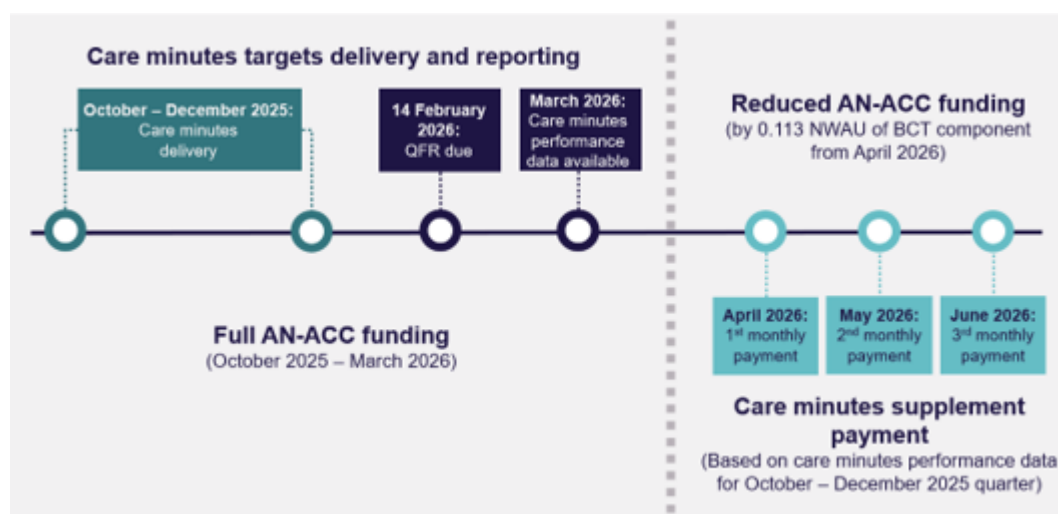
While the supplement generally provides funding to support a 2.5 percentage point improvement in care minutes compliance, once compliance gets close to 100% (above 95%) the additional funding is wound back or the financial impact of not meeting the care minutes target is reduced. For example, moving from just above 100% to just above 97.5% compliance would see a provider's funding reduce by \$2.37 per resident per day (\$33.41 to \$31.04), while moving from 92.5% to 90.0% compliance would see funding reduce by around \$5.91 per resident per day (\$24.24-\$18.33). This recognises the efforts of providers with homes who are close to their care minutes targets and may for one reason or another fall just short, possibly due to a time-limited event. Conversely, it also gives a greater financial incentive to those that are far away from meeting their targets. In addition, it ensures that the same amount of funding removed from the MM1 areas BCT is provided for 100% compliance (that is, any home that meets both their target will not experience any funding change under this option).

The size of the funding brackets in table 2 is a balance between ensuring there is sufficient funding for providers to continue to deliver more care minutes (creating the funding ladder mentioned above), and the size of the financial impact for not delivering their targets and usability of each bracket. For example, a smaller funding bracket of 1% would not create a sufficient funding ladder to support providers to deliver more care minutes each quarter while also complicating the policy, and a funding bracket of 5% would impose a significant financial impact of falling just short. The funding bracket of 2.5% aims to strike an appropriate balance in this respect.

The care minutes supplement would be payable monthly, based on the latest available care minute quarterly performance data. For example, the April, May and June 2026 supplement payments would be based on care minute performance in October-December 2025 (in line with Figure 1 below). In effect, providers will continue to receive their AN-ACC funding in full until March 2024, ensuring that there are no funding gaps.

The delay between the delivery of care minutes and the impacts on funding described above, and shown in Figure 1 below, is necessary because of the current quarterly care minutes reporting timeframes, with reporting not submitted until around 6 weeks after the end of the quarter. Shifting to monthly care minute reporting was considered but it was determined to place too much additional administrative burden on providers. Monthly reporting is something that could be considered in the future when business to government reporting solutions are further developed.

**Figure 1: Timing of linking funding to care minutes**



### Restricting care funding to care compliance to metropolitan areas

Option 2 proposes to link funding to care minutes compliance in homes operating in metropolitan areas (MM1) which is the majority (around 64%) of all aged care homes. As was shown in Chart 4, homes in MM1 areas also have the lowest compliance rate with their care minutes target.

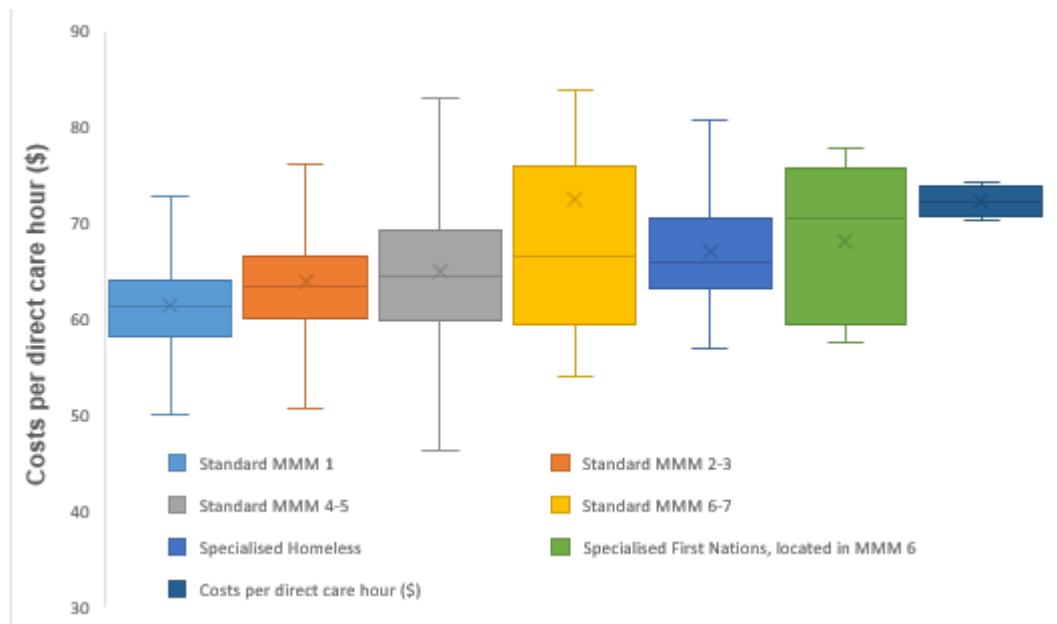
By targeting homes operating in MM1, this option will impact the largest number of homes (by geographical grouping) and those that have the highest levels of non-compliance with their care minutes targets. Furthermore, homes operating in MM1 also include the highest proportion of for-profit homes which have higher levels of care minute non-compliance as compared to homes with other ownership types.

Consideration was given to also linking funding to homes outside of MM1. This was ruled out because of sector feedback around workforce shortages in these locations and viability concerns (refer section 5 of this report) if they were subject to reduced funding due to non-compliance with care minutes targets. This concern is supported by QFR data showing relatively higher labour cost variability outside of metropolitan areas. This variability in costs means that there is a risk that some providers are not currently meeting their care minutes targets because they have significantly higher labour costs than their BCT average, driven by factors unique to the location of their homes, such as local workforce availability, housing costs, travel costs, etc. that are outside of their control. In this context, reducing funding because a provider did not meet their care minutes targets will further limit the provider's ability to meet their targets, and potentially impact their financial viability.

Chart 9 highlights labour cost variability across the sector and shows that it is generally higher outside of MM1 areas. For example, the middle 50% of services in MM1 have an average cost for

each hour of direct care of between \$58 and \$64 (a variance of \$6/hour), compared to a variance of \$10/hour in MM4-5 and a variance of around \$17/hour in MM6-7. The variance is even greater when considering the outer quartiles of labour expenses from all homes (shown by the length of the 'whiskers' in the chart 9 below).

**Chart 9: Labour costs per direct care hour by BCT categories**



Source: DoHDA using calculations based on Q2 2024-25 QFR data.

Notes: This is based on provider self-reported RN, EN & PCW/AIN worked hours, labour expenses and occupied bed days data from the QFR. Restricting the linking of care funding to care minutes to homes operating in MM1 means that residents in metropolitan areas will directly benefit from this option whilst those living in homes operating in regional and remote areas (MM2-7) will not. Although residents in regional and remote areas will not initially benefit from linking care minute compliance to funding, the ACQSC will have greater capability to target non-compliant homes operating outside metropolitan areas as homes in metropolitan areas become more compliant under this option.

Women will not be unfairly disadvantaged by linking care funding to care minute compliance as the ratio of women to men across MM locations is constant. Similarly, there is no significant variation of ages and AN-ACC classifications for residents across different geographical locations. Residents with CALD backgrounds and homes that provide aged care to these residents are more commonly located in metropolitan rather than regional and remote areas and therefore will benefit directly under this option.

### Excluding specialised homeless services

It is also not proposed that homes providing specialised homeless services are included in this option because of the ongoing work being undertaken by Government on whether an alternative skills mix should be incorporated into care minutes requirements in these homes to better meet the distinct needs of their residents.

This funding change proposed in Option 2 is broadly consistent with recommendations of the UTS UARC Aged Care Sector Full Year 2023-24 report which suggested that more explicit conditions that require homes to meet their mandatory direct care staffing obligations are needed, but that Government should be cautious of implementing any policy response to care minutes non-compliance that adopts a blunt approach (e.g. adjustment of the AN-ACC price, which would

simply result in less funding for the whole sector) that unfairly and unintentionally penalises homes that are meeting or exceeding their staffing obligations<sup>53</sup>.

Under this option, the risk that providers over report their care minutes (to gain access to higher levels of funding) rather than deliver increased minutes would be managed by the department's existing reporting assessment program, which aims to check the accuracy of one quarter of the care minute reporting from around one third of all homes each year.

### *Option 3: Linking care minutes funding to care minutes performance for non-specialised services located in metropolitan areas with additional assurance arrangements*

Under this option, funding for care minutes would be linked to care minutes delivery in all non-specialised metropolitan aged care homes consistent with the approach described under Option 2, but with additional assurance arrangements.

Linking funding to the delivery of care minutes increases incentives for providers to over report their care minutes delivery. While this incentive already exists because care minutes reporting is used for Star Ratings and to support the ACQSC's regulation of care minutes, this option substantially increases the incentive on providers to over report because they can directly benefit financially from doing so.

To manage this risk, this option includes new assurance and fraud control arrangements. These include:

- Introducing a new requirement for providers to submit a Care Minutes Performance Statement annually as part of their ACFR. Through this statement, providers would be required to resubmit their care time and expense reporting for each quarter over the financial year. This allows providers to correct any errors in their reporting that are discovered through end-of-financial-year processes and consolidates 4 quarters of reporting for audit purposes (see next point).
- Introducing a requirement for providers to have their Care Minutes Performance Statement audited annually by an auditor under assurance standard ASAE 3000.
- Continuation of the department's existing reporting assessment program, which checks the accuracy of homes care minutes reporting. However, coverage will be reduced from around 33% to 10% of homes each year, recognising that this is appropriate given the annual audits being introduced. The continuation of this program is to manage the risk of poor-quality audits, and collusion between auditors and approved providers (consistent with functions the Australian Tax Office undertake to check audited tax returns). Where the external audit opinion, or the department's assurance checks lead to revised care minutes in previous quarters, funding for this period would be recalculated, and retrospectively adjusted as part of Services Australia's established monthly adjustment process.

These new assurance and fraud controls would apply to all homes, not just non-specialised homes in MM1 that are in-scope for the funding changes, to ensure reporting consistency across the sector (noting many providers operate homes across different MM locations), and because accuracy of reporting is also important across all homes for supporting the provision of accurate care minute reporting to the ACQSC, for Star Ratings and for the department's performance statement audits. It also enables the Government to consider an expansion of the policy to include MM2-7 in future.

There are some expected limitations of Option 3 based on the requirement for additional assurance and reporting requirements.

Providers are required to complete additional reporting on their care minutes compliance and procure an external auditor to complete an annual Care Minutes Performance Statement which comes at a cost to providers (explored in the next section of this Impact Analysis). This additional

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<sup>53</sup> UARC, 2024, UTS UARC Aged Care Sector Full Year Report 2023-24, p 58, UTS, Accessed 6 July 2025.

reporting is partially offset by the reduced frequency of reporting assessments checks by the department.

Reduced departmental oversight over provider reporting, through the reporting assessment program from 33% to 10% and with increased reliance on external auditors could also be considered a potential limitation of Option 3. However, maintaining 10% coverage will enable close monitoring of the effectiveness of the external audits in raising the standard and accuracy of provider reporting. If they do not prove effective Government could consider future increases to the coverage of the reporting assessment program to have more direct oversight over provider reporting.

### *Other options*

In addition to the 3 options outlined above, the department also considered options designed to further enhance care minutes performance transparency measures. This included the possibility of requiring all providers to display a poster with basic information about their care minutes performance (such as care minutes targets and care minutes delivered in the latest quarter) in a prominent position within their home(s) in a standard form and size.

This option could allow workers, prospective and existing residents and their family members and friends that do not use the My Aged Care 'Find a Provider' tool, to see how the service is performing against their mandatory care minutes targets as a mechanism to incentivise improved performance. This option was discarded as this information would only replicate the information already available online via the My Aged Care and the department's website (updated quarterly), so would only be expected to have a marginal impact in terms of incentivising improved care minute performance from providers.

Another option considered as part of the policy development process was to significantly increase the regulatory resources of the ACQSC to allow them to engage substantively with every service that is not meeting their care minutes targets to determine the cause of this non-compliance and where appropriate take regulatory action against these providers. This option was discarded because it was considered too resource intensive given the current scale of non-compliance across the sector.

As mentioned earlier in this chapter, Options 2 and 3 involves linking care funding to care minute compliance for homes in metropolitan areas (MM1) as these homes have the highest levels of non-compliance and for-profit homes (which have higher levels of non-compliance than not-for-profit homes) The department discounted expanding the scope of this reform to include homes operating in MM2-7 due to viability concerns in relation to homes that have significantly higher than average wage costs than other homes in their funding category. Expanding this policy beyond MM2 homes is something that could be explored in the future if compliance outside of MM1 areas increases.

The department undertook a net benefit analysis of each of the 3 proposed options which is outlined in the following section of this report.

## 4. Net benefit of each option

To identify the net benefit of each of the proposed 3 options to improve care minutes compliance and address care funding not used to provide care, a cost benefit analysis of each option was undertaken. The cost benefit analysis was undertaken over 4 years from 2024-25, with total discounted costs (using a 7% discount rate) over this timeframe presented. In addition, an estimate of regulatory burden of each of the options has been completed.

The analysis indicates that the regulatory burden is highest under Option 3 with this burden primarily falling to aged care providers. The overall net benefits are also highest under Option 3, with the benefits falling to residents in homes that are not compliant with care minutes targets, and to Government through a reduction in subsidy payments for care that is not being delivered. This section of this Impact Analysis presents the net benefits analysis for each of the 3 proposed policy options to improve care minutes compliance and address care funding not used to provide care that were presented in the previous section.

### *Option 1: Status quo*

Under this option the Australian Government would make no changes to improve providers compliance with the care minutes responsibility. There would be no changes to funding for providers not meeting their care minutes responsibility, and no changes to assurance arrangements. As such there would be no change in the regulatory burden placed on providers. This option represents the baseline that the net benefit of the other 2 options is measured against.

Based on the department's modelling, it is expected that under this option compliance with the care minutes responsibility will very incrementally improve over the coming years, as it has over the previous years, and eventually plateau at around 67% of providers meeting their care minute targets by mid-2028 (see Appendix A).

**Table 3: Regulatory impact (\$ millions, average annual impact) for Option 1**

Average annual regulatory costs				
Change in costs (\$ million)	Business	Community Organisations	Individuals	Total change in costs
Total, by sector	\$0	\$0	\$0	\$0

### *Option 2: Linking care minutes funding to care minutes performance for non-specialised services located in metropolitan areas without additional assurance arrangements*

Under this option, funding would be linked to care minutes delivered in metropolitan areas, and no changes to assurance arrangements would be made.

### *Net benefit for Option 2*

#### **Consumers**

Consumers will receive the largest benefit under this option through receiving an amount of care that is closer to the time considered necessary by the Royal Commission to support high quality care, where residents' basic personal and clinical care needs are met.

The approximately 160,000 consumers (which equates to approximately 70.6% of all aged care residents) who are living in the 1,543 homes in MM1 (which equates approximately 63% of all Australian residential aged care homes) will benefit from the adoption of Option 2.

The department's modelling (in Appendix A) indicates that providers will increase their care minutes delivered in homes where care minutes are not currently being met in response to linking funding to care minutes and the financial penalties for not meeting their care minutes targets. Under this option it is expected that around 72% of homes will meet their total care



minutes targets by mid-2028. This is 5 percentage points above the compliance rate under Option 1.

In total it is estimated that an additional 153.5 million care minutes would be delivered between 2024-25 and 2027-28 under this option compared to the status quo (Option 1). For the purposes of the cost benefit analysis these additional minutes have been valued with respect to the average cost of delivering these minutes in each financial year.

Care minutes delivered is lower under this option than in Option 3 because this option does not have any enhanced assurance arrangements to ensure that providers reported care minutes are correct. This means a provider's response to this policy could be to over-report their care minutes delivered rather than deliver additional care minutes.

The extent to which this may occur is subject to uncertainty. For the purposes of putting a value on this for the cost benefit analysis, it was assumed that 42% of homes will respond to this policy change by reporting increasing their care minutes delivery rather than genuinely delivering increased care minutes. This percentage is based on evidence from when providers undertook funding needs assessments of their residents under the discontinued Aged Care Funding Instrument (ACFI) arrangements. ACFI review data from near the end of this program in 2018-19 showed that when providers' funding assessments were externally reviewed, they were downgraded 42% of the time (resulting in reductions in subsidy of around \$75 million)<sup>54</sup>. That is, of all ACFI assessments checked by the department, 42% overstated the needs of residents to receive higher funding.

### **Providers**

Providers that do not meet their care minute responsibility in their metropolitan aged care services will receive less Government subsidy under this option. It is estimated that the discounted reduction in subsidy will be \$221 million from 2025-26 to 2027-28. Appendix B outlines how this estimated reduction in subsidy is calculated (noting that the figures in Appendix B are nominal dollars prior to the discount rate of 7% being applied).

Providers will also deliver more care time under this option (in line with the increases outlined as a benefit to consumers) as compared to Option 1. This additional care time will have a cost to providers; however, providers are funded to meet this cost under the AN-ACC funding model and are currently deriving an illegitimate financial benefit from not delivering these minutes (as was outlined in Section 2 of this Impact Analysis). As such, the costs of delivering these extra minutes are not included as a cost in the cost benefit analysis.

### **Government**

Government benefits from this proposal through not paying for as many care minutes where they are not delivered. As noted earlier under the consumer section, an additional 153.5 million care minutes (that Government already funds) are expected to be delivered.

Government is also expected to directly save \$221 million between 2025-26 and 2027-28 through reduced funding to providers that report not meeting their care minutes targets.

Under this option, Government will still pay for some care minutes not being delivered, including:

- where a provider reports increasing care minute delivery in their homes but does not actually increase their minutes delivered (i.e. they misreport increasing their care minutes)
- because the supplement has a tolerance built into it to fund providers to increase their care minutes delivered (providers are funded to deliver a 2.5% increase in their compliance)
- in homes outside of metropolitan areas where care minutes delivery will not be linked to funding under this option.

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<sup>54</sup> DoHDA, n.d., Residential aged care funding arrangements: Regulatory Impact Statement, p 7, Accessed 6 July 2025.

## Total net benefit for Option 2

The expected net benefits of this option across consumers, providers and Government are summarised in table 4 below. Overall, this option has a positive net benefit of \$7,380.1 million from 2024-25 to 2027-28.

**Table 4: Net benefit of Option 2 from 2024-25 to 2027-28**

Impact	Total discounted net benefit (\$m)
<b>Consumers</b>	
Increased care minutes delivered to residents in non-compliant homes - Appendix A	\$7,390.7
<b>Providers</b>	
Decreased care funding for providers not meeting their care minutes (only impacts non-compliant providers) – Appendix B	-\$221.4
<b>Australian Government</b>	
The amount of subsidy paid is lower, as entitlement becomes contingent on performance – Appendix B	\$221.4
Cost of implementation of the funding change (from funding allocated at 2024-25 MYEFO)	\$10.6
<b>Total net benefit</b>	<b>\$7,380.1</b>

## Other unquantified impacts

While this is not quantified in this cost benefit analysis, it is likely that RNs, ENs and PCWs would also benefit from this option because of the increased staffing levels it is expected to deliver. Delivering care and nursing services in an environment where staffing levels are adequate, and workers have time to properly care for and engage with each resident likely increases workforce satisfaction and wellbeing, compared to working in an environment that is understaffed. This benefit is not quantified in the cost benefit analysis because the department does not have adequate information on which to place a dollar value on this benefit.

## Regulatory burden of Option 2

As this option only changes funding arrangements, without any additional assurance arrangements, this option does not have any additional regulatory costs than the status quo (Option 1).

**Table 5: Regulatory impact (\$ millions, average annual impact) for Option 2**

Average annual regulatory costs				
Change in costs (\$ million)	Business	Community Organisations	Individuals	Total change in costs
Total, by sector	\$0	\$0	\$0	\$0

## Option 3: Linking care minutes funding to care minutes performance for non-specialised services located in metropolitan areas with additional assurance arrangements

Under this option, funding would be linked to care minutes delivered in metropolitan areas and includes additional assurance arrangements to manage the risk that providers over-report their care minutes, rather than increase their care minutes delivered.

## Net benefit of Option 3

### Consumers

As with Option 2, consumers will receive the largest benefit under this option through receiving an amount of care that is closer to the time considered necessary by the Royal Commission to support high quality care, where residents' basic personal and clinical care needs are met.



Under this option, it is expected that around 76% of homes will be compliant with care minutes targets by mid-2028 (see Appendix A). This is 9 percentage points above the compliance rate under the status quo, and 4 percentage points above the compliance rate under Option 2.

In total, it is estimated that an additional 264.6 million care minutes would be delivered between 2024-25 and mid-2028 under this option compared to the status quo (Option 1).

Care minutes are higher under this option than under Option 2 because the additional assurance arrangements limit the ability of providers to report increased care minutes performance (to gain financial benefit through receiving a higher care minute supplement rate without delivering these care minutes).

### **Providers**

The cost to providers under this option is the same as with Option 2, except for the additional costs associated with preparing an annual Care Minutes Performance Statement and obtaining a reasonable assurance audit over this statement, and decreased costs from a reduction in coverage of the department's reporting assessment program.

The average annual discounted cost of preparing the Care Minutes Performance Statement and obtaining the audit is expected to be \$18.6 million per year across the sector (see Appendix C for detailed information on how this cost is derived). This is partially offset by the reduced cost of participating in reporting assessments. With reporting assessment coverage reducing from 33% to 10% of all homes, providers are expected to save \$3.5 million per annum.

The detailed assumptions behind the costs of the changed assurance arrangements are outlined in Appendix C.

### **Government**

As with Option 2, Government benefits from this proposal through not paying for as many care minutes where they are not delivered. As noted earlier in this impact analysis, an additional 264.6 million care minutes (that Government already funds) are expected to be delivered under this option compared to the status quo (Option 1), and an additional 111.1 million minutes are expected to be delivered than under Option 2 (because the assurance arrangements mean providers are less able to report care minutes without delivering them). (See to Appendix A for detailed information on measuring the change in care minutes)

In addition, Government is expected to directly save \$221 million through reduced funding to the sector where care minutes are not delivered under this option.

### **Total net benefit of Option 3**

The expected net benefits of Option 3 across consumers, providers and Government are summarised in table 6 below. Overall, this option has a positive net benefit of \$12,716 million from 2024-25 to 2027-28.

**Table 6: Net benefit of Option 3 from 2024-25 to 2027-28**

Impact	Total discounted net benefit (\$m)
<b>Consumers</b>	
Increased care minutes delivered to residents in non-compliant homes – Appendix A	\$12,742.6
<b>Providers</b>	
Decreased care funding for providers not meeting their care minutes (only applies to non-compliant providers) – Appendix B	-\$221.4
Costs of preparing a Care Minute Performance Statement & obtaining audit over it – Appendix C	-\$18.6
Reduction in coverage of reporting assessments decreasing administrative burden on providers – Appendix C	\$3.5
<b>Australian Government</b>	
The amount of Aged Care Subsidy paid is lower, as entitlement becomes contingent on performance	\$221.4
Cost of implementation of the funding change and assurance changes (from funding allocated at 2024-25 MYEFO)	-\$11.3
<b>Total net benefit</b>	<b>\$12,716.2</b>

### *Regulatory burden of Option 3*

The average annual regulatory cost burden of this option is outlined in Table 7 below. These costs are the costs of submitting the new Care Minute Performance Statement and associated auditing requirements, as well as the reduced costs of the reduction in coverage of the reporting assessment program (see Appendix C for further information on how these are calculated).

The costs of government run aged care providers is excluded from the regulatory impact consistent with the Regulatory Burden Measurement Framework, although these are included in the cost benefit analysis.

The costs to community organisations represent the costs to not-for-profit providers and the costs to business represent the costs to for-profit providers. These costs are also average annual costs, with no discount or wage indexation applied and as such, differ slightly from those used for the cost benefit analysis above in Table 6.

**Table 7: Regulatory impact (\$ millions, average annual impact) for Option 3**

<b>Average annual regulatory costs</b>				
Change in costs (\$ million)	Business	Community Organisations	Individuals	Total change in costs
Total, by sector	\$1.78	\$3.16	\$0	\$4.93

## 5. Consultation

The department has consulted in detail with a range of stakeholders, including through the National Aged Care Advisory Committee on the low care minute compliance levels across the sector and options to address these.

This consultation identified a general recognition of the need to do more to ensure providers are doing all they can to deliver the additional care minutes that they have been funded to deliver, particularly among representatives of workers and residents and their family members, but also among some providers. It was accepted by many stakeholders that funding was the most effective lever available to Government to bring about improved sector performance.

Specific concerns were raised about the potential viability impact of linking funding to care minutes in more regional, rural and remote areas, as well as around the need to give the sector adequate notice before the commencement of any funding related policy, and the need to ensure the financial impact on providers falling just short of meeting their targets is minimal. This feedback led to refinement of the proposed policy options.

The department has consulted with a range of stakeholders on the low care minute compliance levels and the extent to which Government funding is provided for care minutes that are not delivered and options to address these.

The purpose of initial consultation was to better understand what may be driving providers to not deliver their care minutes, and to support the development of policy options that could be put to Government to address this issue. This included seeking views on whether linking funding to care minute delivery and/or further transparency measures (including increased reporting requirements) might be an appropriate policy response, and any unintended consequences of such a response.

Initial discussions did not include details about the proposed strengthened reporting and assurance requirements including the requirement for providers to procure an external auditor who is required to provide a Care Minutes Performance Statement under Option 3. This was not discussed as the department was still determining policy options for linking care funding to care minute compliance.

Further consultation included the implementation and on-going operation of the proposed policy options and included the requirement and responsibility for strengthened reporting and assurance requirements.

This consultation has been key to the departments work to develop the policy options outlined in the previous chapter of this report.

Key stakeholders the department consulted with included:

- Providers
- the Aged Care Quality and Safety Commission
- Aged care advisory bodies including the:
  - Council of Elders<sup>55</sup> which is a group of older people from diverse backgrounds with lived experience of ageing and aged care
  - Residential Aged Care Funding Reform Working Group (Working Group)<sup>56</sup> which is an advisory group of key residential aged care industry stakeholders who advise on aged care reform related activities. Members include key Government stakeholders. Industry advocates, providers, professional associations and academic groups to name just some.

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<sup>55</sup> See details and membership at: Aged Care Council of Elders | Australian Government Department of Health, Disability and Ageing

<sup>56</sup> See details and membership at: Residential Aged Care (RAC) Funding Reform Working Group | Australian Government Department of Health, Disability and Ageing

- National Aged Care Advisory Council (NACAC) <sup>57</sup> which provides advice to Government on key matters relating to aged care including on aged care reform. Members include people accessing aged care services, aged care workers, providers, health and allied health professionals, specialists in training and education and independent experts.
- Peak bodies representing aged care providers

### *Positive feedback*

Consultation with the aged care sector was initiated through discussions with the Working Group and NACAC in the September 2024 meeting. To support these discussions, the department prepared papers providing an overview of the current care minutes non-compliance across the sector, and possible policy options to address this, including linking funding to care minutes delivery, and enhanced transparency measures. Feedback provided during the meeting by members was generally supportive of the need to do more to ensure care minutes are being delivered given the large increase in funding the sector received from Government to increase their care staffing levels.

While efforts to support transparency around providers care minute delivery were supported and considered important by stakeholders, concerns were raised around whether any further measures would be a meaningful driver of improved provider performance given that data on care minutes performance at the home level is already publicly available. Many stakeholders considered that funding changes are likely to be the most effective mechanism available to Government to address care minutes under performance.

After the Minister for Aged Care released an open letter to the sector on 1 October 2024, which stressed the importance of care minutes and reiterated the Government's expectations on how its significant investment in residential aged care is to be used to increase care minutes delivery to improve the quality of care experienced by residents<sup>52</sup>, a number of small providers contacted the department wanting to discuss the contents of the letter. They also wanted to discuss potential policy options as the letter noted that the department has been asked to develop policy options to address low care minutes compliance rates.

The department met with these providers who were generally accepting of the notion that linking funding to care minute delivery may be an appropriate next step to improve care minute compliance and ensure funding is directed to care minutes delivery.

The department consulted with the Council of Elders in May 2025 on linking funding to care minutes delivery. This group was very supportive of linking care funding to the delivery of care minutes and considered that it was the obvious next step to increase compliance. This group did not support the idea that providers should get 100% of their funding where they do not deliver their care minute targets in full as they considered it likely that many providers would not aim for full delivery.

The department also discussed linking care funding with care delivery with NACAC on two more occasions in 2025. Attendees at these discussions were generally supportive of the announced measure to link funding to care minutes compliance, particularly the representatives of older people and workers.

### *Stakeholder concerns*

Regardless of the general agreement from stakeholders that linking care funding to care minutes delivery would help improve care minute compliance and reduce the extent to which Government funding is provided for care minutes that are not delivered, there were some stakeholder concerns. These concerns are outlined below.

### **Adversely impacting care innovation**

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<sup>57</sup> See details and membership at: National Aged Care Advisory Council | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.

As noted earlier in this Impact Analysis, some providers were concerned that prescribed care minutes targets involving care delivered by RNs, ENs and PCWs did not align with their care models which often include a higher proportion of care delivered by allied health professionals and recreational staff that are excluded from being counted as care minutes delivered. These providers advocate that care minutes requirements stifle innovation in care delivery resulting in poorer care outcomes for residents. These views contrast with the findings and recommendations of the Royal Commission.

### **Impact on regional providers**

Some provider stakeholders were concerned about the adverse impacts that linking care funding to care minutes delivery could have on providers with homes in regional, rural and remote areas. It was highlighted that in some regional, rural and remote locations, it may not be possible for homes to meet care minutes targets with the funding available (even with the higher AN-ACC BCT funding for their respective MM location) because of the provider needing to pay for staff relocation, fly in fly out travel and to provide staff housing to attract and retain workers. In response to this feedback, the department investigated labour expense variability across the sector and ruled out the option of linking care funding to care minutes outside of metropolitan areas.

### **Adversely affecting providers working towards or very close to compliance**

Some provider stakeholders expressed the view that so long as providers are making legitimate efforts to increase their workforce to meet their care minutes targets, they should not receive any funding reductions. Other members countered this concern on the basis that if providers do not have the workforce that they are funded to have, they will benefit financially through lower employee expenses.

Concerns were raised about providers that roster to meet 100% of their targets, but just under-deliver due to unexpected events, such as a worker falling sick very late in a quarter. Many stakeholders thought that there should be some tolerance around the funding for falling just short of 100% to address this. Other stakeholders, including members of the Council of Elders and worker representatives, had strong views that 100% of funding should not be provided for anything less than 100% performance, otherwise providers may aim to not comply.

### **More data and evidence needed**

A provider peak expressed concern that policy changes should not be considered without further data and understanding of what is driving the under delivery of care minutes. Other stakeholders (generally representing aged care participants and workers, as well as independent medical professionals/academics) expressed a strong counterview that as Government has invested billions of dollars to fund increases to care minutes to lift the standards of care in the residential aged care sector, that swift action should be taken to establish policy settings that better incentivise care minute delivery, including through linking funding to care minute delivery. Some stakeholders also noted that there is already a lot of data on care minute delivery, given care minutes data has been collected since July 2022, and the policy has been funded since October 2022.

Given the provider peak's view was countered by many other stakeholders, and the extensive available data on care minutes performance, AN-ACC funding, and the financial state of providers and their homes (through the QFRs and the ACFRs) outlined in section 1 of this report, the provider peak's feedback that more evidence is needed before any Government intervention is taken was noted. However, it was not considered appropriate to not change the options on the basis of this feedback.

### **Quality of provider reporting**

The importance of ensuring providers are reporting correctly and consistently across the sector was also raised by some stakeholders (including providers), noting that to date not every service or provider has had their reporting checked by the department's reporting assessment program, and that some of the variability in care minute performance could be driven by miss-reporting. It was noted that the department's reporting assessments are an important element in ensuring

reporting consistency. Following this feedback, the department developed the options to enhance assurance arrangements to ensure that all care minutes reporting is independently validated under Option 3.

### **Timing of reform**

The department received feedback from some providers who were concerned about the timing of introducing a policy linking care funding to care minutes delivery, noting that it is important that the sector is provided with sufficient time to allow them to prepare by recruiting additional staff. This concern was considered reasonable and led to the department agreeing that the sector would be given 6-9 months to prepare for the introduction of a policy linking funding to care minutes.

Following the release of the Minister's open letter to the sector concerning non-compliance with care minutes requirements, a provider peak body informed the department of their concerns to linking care funding to care minutes delivery, suggesting providers needed more time to meet their targets, that there should be a greater focus on the use of transparency measures to drive increased compliance and that any approach should be nuanced to the individual circumstances of each provider.

These concerns were considered by the department but as noted in earlier in this report, the department's analysis showed that transparency measures were not increasing care minutes compliance at the rate expected by Government. It also showed that the resources required to undertake a nuanced approach for each provider would be too resource intensive.

### **Funding contingency**

A provider also noted that the care minutes targets for some providers can change between quarters so it may be appropriate to consider building in a small level of contingency into the policy to account for these changes and support providers to continue to build their workforce and increase the number of care minutes they are delivering. This advice was considered in the development of options 2 and 3, with the care minutes supplement rates generally funding providers to get 2.5 percentage points closer to their care minutes targets than they are actually delivering. For example, if a service was delivering care minutes at 90-92.49% of their targets, they would be funded as though they were delivering 92.5-95%.

### **Assurance and reporting requirements**

While the department has not consulted the sector broadly on the new assurance arrangements, including the Care Minute Performance Statement and the annual audit arrangements, the department has consulted on its existing assurance arrangements over care time reporting. Some in the sector have provided feedback about the difficulty associated with participating in a care time reporting assessment because of the time taken to compile the necessary documentation and have asked whether alternative assurance arrangements can be explored. Other providers have noted that they have found the process useful and educative by helping them understand what can be reported as care minutes, including sometimes helping providers report care time that they had not understood could be reported as care minutes.

The department has discussed the increased assurance requirements associated with Option 3 with specific stakeholders of the Working Group. In doing so, the department has received (and continues to receive) some negative feedback from the sector (i.e. providers and their advocates) about the increased costs of procuring an external auditor to review their care minutes reporting and provide a Care Minutes Performance Statement to assure the department that care minutes reporting is accurate.

While providers will not explicitly receive additional funding for the purposes of engaging and external auditor AN-ACC funding (that is adjusted annually based on IHACPA's annual independent costing and pricing studies) covers care related reporting costs. Over time additional reporting and audit costs would be captured through IHACPA's costing studies and pricing advice and will be incorporated into the AN-ACC price (and therefore provider funding).

Although these stakeholder concerns were considered, they were weighed up against the benefits for residents receiving the required amount of quality care and that government funding for care should be used for that purpose ahead of provider concerns about a slight increase in reporting costs which will be covered under AN-ACC funding model.

### **Incorporating stakeholder feedback**

In summary, the department has considered all feedback received through the consultation and engagement processes in developing the 3 policy options outlined in this impact analysis.

Consultation showed that stakeholders generally supports the linking of care minutes funding to care minutes delivery and that Government funding for care should be used for care delivery. This feedback generally supports the notion that the status quo (Option 1) should not be adopted particularly as Option 1 does not incentivise providers to achieve their care minutes targets and unfairly rewards those providers with lower care minutes compliance due to their lower wage costs. Option 1 will also result in continued misallocation of Government funding for care. This positive stakeholder feedback also supports options 2 and 3 which involve linking care funding to care minute delivery.

Stakeholder concerns about the impact of care minutes compliance for homes operating in rural and remote regions were considered and these homes were ruled out, with the option of linking care funding to care minutes only proposed in metropolitan areas (MM1) under options 2 and 3.

The department also considered stakeholder concerns about the reporting burden for Option 3. However, the assurance changes were considered necessary to help mitigate over reporting and ensure that Government funding is used for the purposes of delivering quality care.

To address concerns relating to the timing of the reforms, Government has given providers a generous period (9 months) to prepare for the changes and made guidance materials are readily available.

Stakeholder engagement and consultation in relation to implementing the preferred options is outlined in Chapter 6 of this Impact Analysis.

## 6. Preferred option and implementation

The best option is Option 3: Linking care minutes funding to care minutes performance for non-specialised services located in metropolitan areas with additional assurance arrangements. As was outlined in part 4 of this Impact Analysis, Option 3 has the highest net benefit and best meets the objectives to increase compliance with the care minute responsibility and to minimise the extent to which Government funding is provided for care minutes that are not delivered.

This option will be implemented from October 2025 jointly by the Department of Health, Disability and Ageing and Services Australia as a Tier 2 project under the governance of the Residential Aged Care Funding Reform Project Board.

### *Preferred option*

The net benefit analysis in section 4 of this report shows that Option 3 best achieves the Government objectives which are:

1. For all residential aged care homes to have adequate staffing levels to meet their residents' personal and clinical care needs as established by the Royal Commission and measured in practice by compliance with home level care minutes targets.
2. To ensure that Government funding for residential aged care is cost-effective and sustainable by minimising the extent to which funding is provided for care minutes that are not delivered.

The following summarises how each of the 3 options addresses the objectives above.

### *Option 1: Status Quo*

Under Option 1, residential care homes will have limited reasons to increase the amount of care minutes delivered, particularly if they are close to their care minute targets. This is because any enforcement action by the ACQSC (with finite resources) is focused on those providers who have high rates of non-compliance with their care minutes targets.

The increased transparency of care minutes performance has not significantly improved the performance of providers to meet their care minutes targets particularly as demand for residential aged care services is predicted to remain high with other factors such as building facilities, price and location influencing consumer decisions when selecting a residential aged care home.

Under Option 1, many residents will not receive the personal and clinical care recommended by the Royal Commission particularly in the short term as the department's analysis shows that only 67% of homes are expected to meet their care minutes targets by 2028 which is lower than for both options 2 and 3.

Under Option 1, providers will continue to receive funding for care minutes that are not delivered which puts providers who are compliant with their care minutes requirements at a competitive disadvantage due to having higher workforce costs. Furthermore, the department's analysis indicates that providers who are non-compliant are allocating funding to other areas of their business and/or profiteering from unused Government funding provided for the provision of care. Although levels of non-compliance with care minutes targets are expected to reduce somewhat over time as the ACQSC's regulation and the transparency measures have cumulatively taken effect, the high rates of non-compliance are expected to continue. This means that funding provided by Government is not being used as intended which contrasts with its legislative obligations to take all reasonable measures to prevent, detect and respond to fraud and to ensure trust in public institutions.

In summary, Option 1 has less ability to fulfil objectives 1 and 2 as compared to both options 2 and 3.



### *Option 2: Linking care minutes funding to care minutes performance for non-specialised services located in metropolitan areas without additional assurance arrangements*

In combination with the ACQSC's regulatory action (being risk-based, proportionate and within the ACQSC's finite resources) and the increased transparency of care minutes performance (with limited effectiveness), Option 2 is more effective for achieving the Government's objective of ensuring adequate staffing levels to meet their residents' personal and clinical care needs (as measured by percentage of homes meeting their care minutes targets) as compared to Option 1. As the net benefit analysis in Section 4 of this report shows, around 72% of homes are expected to meet their total care minutes targets by mid-2028 if Option 2 is adopted. This is 5 percentage points above the compliance rate under Option 1. The net benefits analysis also shows that under Option 2, it is estimated that an additional 153.5 million care minutes would be delivered between 2024-25 and mid-2028 as compared to Option 1.

This improvement is due to the financial incentives on providers to meet their care minute targets. However, unlike Option 3, Option 2 does not include more stringent assurance arrangements than are currently used which limits the ability of the department to ensure that providers are accurately reporting their care minutes performance.

Although the use of existing reporting mechanisms would be less resource intensive for Government than the reporting assurance activities proposed in Option 3, they would be less effective in minimising the extent to which funding is provided for care minutes that are not delivered. Consequently, providers would have more ability to over-report their care minutes delivered which means that residents would continue to not receive the required amount of care, and the Government would continue to pay for care not delivered. As a result, Option 2 does not adequately address Government's objective of minimising the amount of Government funding for care delivery that is not being used for this purpose.

In summary, Option 2 would better fulfill objective 1 than Option 1, but would not achieve objective 2 as well as Option 3 and is projected to have a net benefit of \$7,380.1 million compared with a \$12,716.2 million for Option 3.

### *Option 3: Linking care minutes funding to care minutes performance for non-specialised services located in metropolitan areas with additional assurance arrangements*

Option 3 better achieves both government objectives.

Option 3 better achieves adequate staffing levels to meet residents' personal and clinical care needs as measured by compliance with home level care minutes targets. Option 3 does this due to the same reasons listed for Option 2. However, due to the reporting assurance processes involved in this option, providers will be required to provide more accurate care minutes reporting and as a result will be required to deliver the required care minutes to receive the Government funding for care. As the net benefit analysis in Section 4 shows, it is estimated that an additional 264.6 million care minutes would be delivered between 2024-25 and mid-2028 under Option 3 compared to Option 1 and an additional 111.1 million minutes are expected to be delivered than under Option 2.

Option 3 also better achieves the second Government objective of ensuring that Government funding for residential aged care is cost-effective and sustainable by minimising the extent to which funding is provided for care minutes that are not delivered. Although this option includes additional reporting and assurance processes for providers (through the completion of the externally audited Care Time Performance Statement), the reporting will be more reliable and, as shown in the net benefits analysis, this additional cost will be offset by the \$221 million saved through reduced Government funding to the sector where care minutes are not delivered. Also, as is shown in the net benefit analysis, the streamlining of reporting assessment processes are expected to partially offset these additional provider costs.

In summary, Option 3 is the preferred option, as it best meets the objectives of Government intervention and has the highest net benefit. The net benefit of Option 3 (compared to status quo) is expected to be \$12,716.2 million between 2024-25 and 2027-28 compared to \$7,380.1 million under Option 2. Under Option 3 around 76% of homes are expected to meet their total care minutes by mid-2028, compared to 72% under Option 2 and 67% under the status quo (Option 1).

The effectiveness of each of the 3 proposed options to achieve the 2 Government objectives is shown in the table below.

**Table 8: Degree to which the proposed policy options achieve Government's policy objectives**

	Option 1: Status Quo	Option 2:	Option 3:
Objective 1: For all residential aged care homes to have adequate staffing levels to meet their residents' personal and clinical care needs as established by the Royal Commission and measured in practice by compliance with home level care minutes targets.	Low	Medium	High
Objective 2: To ensure that Government funding for residential aged care is cost-effective and sustainable by minimising the extent to which funding is provided for care minutes that are not delivered.	Low	Low	Medium

An interim decision to implement Option 3, linking funding to care minute delivery in metropolitan non-specialised services, with increased assurance of care time reporting was made by Government, as part of the 2024-25 MYEFO process, with the final decision point being the point of introducing the enabling legislation prior to October 2025. The Australian Government Department of Finance Economic Review Committee (ERC) is expected to consider minor refinements to care minutes supplement rates provisionally announced in December 2024 in August 2025.

The status of the Impact Analysis at each major decision point is outlined in the below table.

**Table 9: Interim and final decision points**

Decision Point	Timeframe	Impact Analysis status
Interim policy decision and Government announcement	Interim decision made as part of 2024-25 Mid-Year Economic and Fiscal Outlook process and announced on 18 December 2024	Draft Impact Analysis provided to the ERC to support decision making
Final policy decision to be made with introduction of subordinate legislation to implement preferred option	Rules expected to be introduced for the funding changes in September 2025 and the assurance changes in October 2025.	Second pass Impact Analysis scheduled to be submitted to Office of Impact Analysis in August 2025

### *Commencement of policy changes*

The timeline of the commencement of the policy changes agreed by Government are as follows:

- The policy to link funding to care minutes delivery will commence in October 2025, with care minutes delivered in October to December 2025 impacting funding from April 2026. April 2026 is when the care minutes supplement will commence, with eligible providers receiving their April 2026 supplement payment in early May 2026, following submission

of their April claim (which can occur from 1 May). Likewise, the reduction in AN-ACC BCT for non-specialised MM1 services will also commence in April 2026, with providers receiving their first reduced BCT payment in early May, following submission of their April claim.

- Providers will submit their first Care Minutes Performance Statement and audit alongside their 2025-26 ACFR which will be due at the end of October 2026. There are a small number of overseas based providers that report based on a different financial year than the standard July to June financial years, for example January to December. These providers will submit their first Care Minutes Performance Statements and audit in their next ACFR due following October 2026. For these providers, this means their first statements will relate to January-December 2026. Reporting assessments will commence being scaled back to 10% service coverage each year from July 2025.

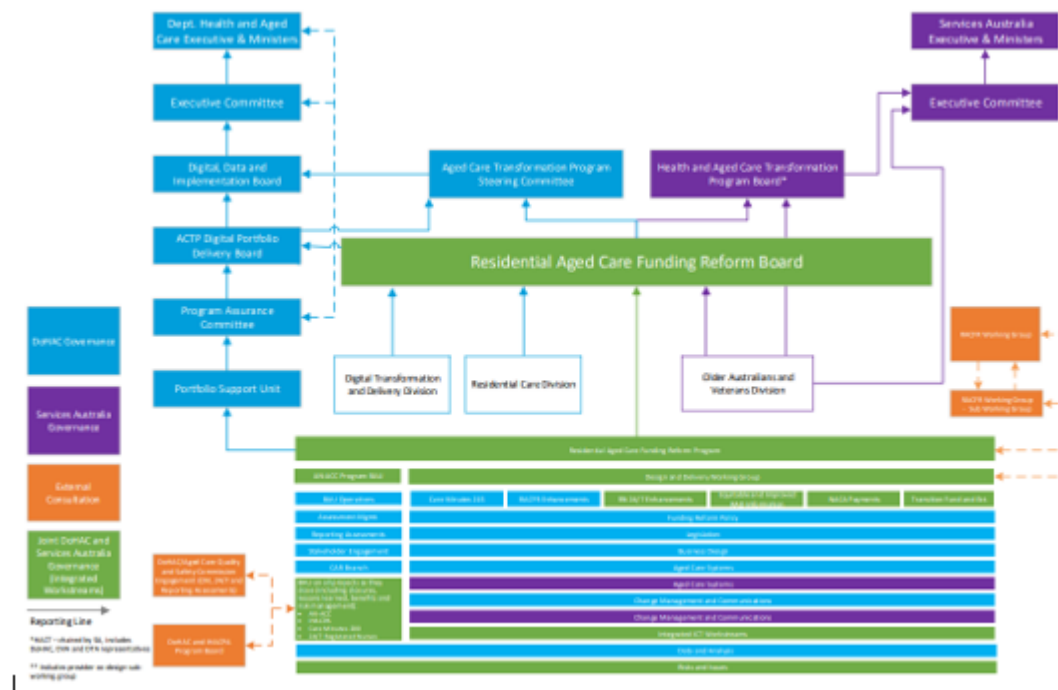
### *Implementation of preferred option*

The preferred option will be implemented as a Tier 2 project under the department's project management framework. Key project deliverables, milestones, risks and issues, and project budget will be tracked through an integrated project management system managed by the Residential Aged Care Funding Reform Project Management Office.

The project is supported by an established governance structure to provide appropriate executive management and oversight. This is supplemented by the computerised Altus reporting system which facilitates decision making at the appropriate management levels through standardised reporting to the department's senior executive.

Delivery of this project is governed by the Residential Aged Care Funding Reform Program Board which is chaired by the Senior Responsible Officer, First Assistant Secretary, Residential Care Division. This board was established to provide governance over the implementation of the new residential aged care funding model (the AN-ACC), and new aged care payment system, which was successfully implemented in October 2022. This board has oversight of all residential aged care funding changes and has joint membership across the department and Services Australia. This board sits under the department's Aged Care Transformation Program Steering Committee and Services Australia's Health and Aged Transformation Program Board. Figure 2 below provides a more detailed overview of the governance structure.

## **Figure 2: Residential Aged Care Funding Reform Governance Framework**



There are 4 key streams of work to implement Option 3. These include:

- Legislation
- ICT system changes
- Communication
- Development of audit requirements

Further information on each of these streams of work is provided under the headings below.

## Legislation

The *Aged Care Act 2024* (the new Act) is set to commence on 1 November 2025. As the policy change to link funding to care minutes is set to commence on 1 October 2025, it will be first legislated under the *Aged Care Act 1997* (the current Act) through amendments to subordinate legislation in advance of 1 October 2025.

The primary legislation of the new Act will also be amended prior its 1 November 2025 commencement date to provide a legislative basis for provider-based supplements to enable the care minutes supplement (as the new Act in its existing form does not enable this kind of supplement). The amendment bill to enable this was introduced in July 2025 (the Aged Care and Other Legislative Amendment Bill 2025). Subordinate legislation will also be developed to establish the detail of the care minute supplement under the new Act.

As the first Care Minute Performance Statement and audit is not due until October 2026, this will not be legislated under the current Act. Instead, it is expected that it will be set out in the Aged Care Rules (subordinate legislation) from the commencement of the New Act in November 2025.

### Information and Communication Technology System changes

Information Communication and Technology (ICT) changes to the department's IT systems and to Service Australia's payment system are needed to capture funding eligibility, transmit this to Services Australia, and for Services Australia to pay the new variable rate supplement.

The ICT changes do not need to be in place until the commencement of the supplement in April 2026, and this means there is significant lead time to design, consult and implement ICT changes. The department has commenced ICT design work for this policy change, including completion of High-Level Business Requirements and Detailed Business Requirements.

The department's ICT changes are scheduled to occur in the February 2026 release, almost 3 months ahead of the first care minutes supplement payments being made in early May 2026. The department's ICT changes will primarily be to the Government Provider Management System (GPMS) and will leverage existing care minutes functionality within GPMS wherever possible. It is expected that Services Australia's ICT build will also be completed around this time, allowing significant testing to occur before go-live in April 2026.

### *Communication and engagement*

A communications plan has been developed to ensure the sector is fully aware of how the funding changes and associated care minutes reporting and auditing assurance arrangements will operate well in advance of their commencement.

The first tranche of communications began in December 2024. The sector was informed of the policy change with a direct email to all providers as well as a newsletter article in the weekly *Your Aged Care Update* outlining the change. These linked to a detailed fact sheet outlining the planned funding and assurance changes. An excel-based calculator was also published which allows providers to input certain assumptions (such as the AN-ACC price that will apply in April 2026, and a home's care minutes targets and care minutes delivered from October-December 2025) and see what the impact of this change would be on their funding.

A public webinar was also held on 1 May 2025 to further ensure the residential aged care sector was aware of the funding changes and provide more detail on the assurance changes. 3845 people registered for this event, and 2197 people attended the live event. As this webinar was held during the caretaker period only pre-submitted questions were answered during the webinar. Stakeholders were however able to submit questions in advance and during the webinar. Pre-submitted questions not answered in the webinar, and questions submitted during the webinar were answered in a published frequently asked questions (FAQ) document in the weeks following the event.

Communication with the sector on the funding changes will continue, with the communications in advance of 1 October 2025 focused on ensuring providers are aware of the changes and on increasing their care minutes delivery. Communications in the lead up to the payment changes from 1 April 2026 will focus on ensuring providers understand the details of the funding changes, including how they can check their care minutes compliance levels that will be used to calculate their payments, how this change will appear on their payment statements and who to contact if it appears they are not being paid correctly. These communications will be undertaken jointly between the department and Services Australia.

### *Development of audit requirements*

The department has procured (through the Management Advisory Services panel) an audit firm to support the development of the audit guidelines.

Draft guidelines have been developed to support providers to engage an auditor. The Aged Care Quality Sector Reference Group was consulted as part of the establishment of these guidelines. These guidelines are expected to be published in late June 2025.

Guidelines were developed for providers and auditors to support them to perform these audits. The department has undertaken consultation with aged care providers, the Auditing and Assurance Standards Board, and with the three accounting professional associations. Feedback has been provided on the draft guidance published in early July 2025. The department will seek final feedback on the developed products after the finalisation of the Aged Care Rules 2025.

### *Implementation risks*

#### **Enabling legislation is not passed to the Aged Care Act 2024**

There is a low risk that the necessary amendments to the *Aged Care Act 2024* to enable the funding change will not pass Parliament before this new Act is scheduled to commence operation in November 2025. Contingencies are being investigated for if this were to occur. If these proved unsuccessful there is a risk the linking of funding to care minutes could be delayed until passage of the relevant Bill.

### **Changes to ICT infrastructure is delayed**

The department is implementing substantial ICT enabled reforms for changes related to the new Act and the commencement of new Support at Home Program. This reform package means that there are ICT capacity constraints for all GPMS changes until at least October 2025.

There is a risk that these ICT capacity constraints would extend into early 2026 which could risk the delivery of the necessary ICT changes to enable the funding change. This policy change is rated as a high priority for implementation and is scheduled to be implemented in the February 2026 release (well in advance of the first payment being made in May 2026), as such this risk is low.

Manual work around contingencies will be developed to ensure that any ICT delay does not lead to a delay in the commencement of the policy.

### **Assurance arrangements are not sufficiently effective**

As has been outlined earlier in this Impact Analysis, linking funding to care minutes delivery creates a substantial fraud risk, with respect to providers misreporting their care delivery, and their financial performance, to obtain supplement amounts above what they would otherwise be entitled to receive. This is managed through the planned additional assurance arrangements (primarily the annual audits of all care minutes reporting). There is however a risk that despite these assurance arrangements there is an unacceptable amount of misreporting. This risk will be monitored through the continuation of the department's reporting assessment program. Under the reporting assessment program around 10% of services care minute reporting will be checked each year.

These checks will identify whether the external audits are appropriately identifying mis-reporting. If it is found that they are not sufficiently effective, refinements to assurance arrangements and processes will be developed. This could include improvements to audit guidance, engagement with auditors and their professional associations and the regulator of registered company auditors (the Australian Securities and Investment Commission) where it was identified that particular auditors are not meeting their professional standards or regulations. It could also include more significant changes such as an increase in coverage of the reporting assessment program (noting this would be a decision of Government).



## 7. Evaluation

The change to linking funding to care minutes in metropolitan areas and refinements to assurance arrangements will be incorporated into the department's existing care minutes and 24/7 RN monitoring and evaluation plan. The success of the measure will be monitored quarterly through analysing the care minutes performance data collected quarterly through the QFR. An evaluation of the care minutes and 24/7 RN responsibilities will commence in early 2026 and will include evaluation of the success of this policy change in achieving its objectives.

The department will also evaluate the linking of Government funding to care minute compliance to measure and assess whether the proposed policy is achieving the two objectives of ensuring providers meet their care minutes targets and to minimise the extent to which Government funding is provided for care minutes that are not delivered.

The department will undertake evidence generating activities such as examining industry reporting (i.e. the QFR and the ACFR) and engaging with relevant sector stakeholders.

The department already has a monitoring and evaluation plan in place for the care minutes and 24/7 RN measures. Ongoing monitoring by the department involves the routine collection of information through the QFR on the performance of providers against their individual care minutes targets for their homes. The ongoing monitoring undertaken as part of the monitoring and evaluation plan has been effective in identifying the under-delivery of care minutes outlined in Section 1 of this Impact Analysis. This policy change to link funding to care minutes performance will be incorporated into the existing monitoring and evaluation plan.

Under the existing care minutes and 24/7 RN responsibilities monitoring and evaluation plan, the department will undertake an initial evaluation of care minutes and 24/7 RN policy, tentatively scheduled to commence in the second half of 2026 to provide insights into the continuing implementation and observable outcomes and impacts of the 24/7 RN and care minutes measures. This timing will allow this evaluation to also investigate the initial effectiveness of linking funding to care minutes in increasing providers compliance with the care minutes responsibility. It will also allow for the early investigation of any unintended consequences of the measures, and propose potential policy responses to address these, as well as consideration of the potential benefits and risks of extending the policy beyond MM1 services.

This evaluation will also be the first formal opportunity to examine whether the care minutes measures have contributed to improvements in the quality of care residents receive. The evaluation will primarily involve the analysis of performance data already available to the department using its regular data collection activities. This includes AN-ACC assessment data, the National Aged Care Mandatory Quality Indicators Program, Residents' Experience Survey and the Aged Care Provider Survey and the Aged Care Worker Survey. Data collected by the ACQSC may also inform the evaluation, including Aged Care Quality Standards performance assessments and Serious Incident Response Scheme reports. In addition, interviews/focus groups with residents, aged care workers and their representatives and peak bodies will be undertaken.

This evaluation will be undertaken in accordance with the department's Evaluation Strategy 2023-2026 and will consider the following 5 key evaluation questions.

1. **Appropriateness:** Why were the care minutes and 24/7 RN measures implemented and to what extent do they remain appropriate interventions.
2. **Effectiveness:** To what extent is the residential aged care sector delivering the targets for care minutes and the provision of 24/7 RN care as expected, and why or why not?
3. **Impact:** To what extent is each measure contributing to an improvement in the quality and safety of care provided to residents, for whom, and why or why not?
4. **Efficiency** - How efficiently have the measures been implemented to ensure the achievement of the minimum staffing level requirements?

5. **Sustainability:** In which ways are the measures affecting the operation of the residential aged care system, and its ability to offer safe, high-quality care to residents?

A further evaluation is planned for 2029 to provide a comprehensive assessment of the overall effectiveness and efficiency of care minutes and 24/7 RN policy, informing consideration of their ongoing rationale, design and delivery. 2029 was selected as it allows for the measures to have the required effect on achieving the policy objectives and will provide enough data for the department to undertake a comprehensive analysis of the impacts of the policy and to identify and address any issues. It also allows time for the providers to implement the required reporting and workforce management systems, and to identify any problems they are having with achieving their care minutes targets. Furthermore, it also allows any benefits in care delivered to be identified and potentially measured. The department will respond to any unexpected issues if they arise.

The evaluation will assist in determining whether Government funding is effective and being used by providers for the purpose of delivering the required number of care minutes.

The success of this policy change will be measured quarterly by monitoring:

- the rate at which homes in MM1 increase their total and RN care minutes delivery
- the % of homes that are meeting their total and RN minutes in MM1
- for homes not delivering their care minutes, the average gap between their targets and their minutes delivered
- the care underspend in MM1 (i.e. the funding provided for care minutes that are not being delivered).

The data to monitor these metrics is already collected through the QFR each quarter. The above measures will be baselined in the October – December 2024 quarter. The reason for selecting this period to baseline the measures is that the policy change was announced around the end of this quarter. This policy is expected to drive increased compliance with care minutes targets from the time of announcement (even in advance of implementation) because of the time it takes to recruit additional staff.

Ongoing monitoring will also be undertaken on whether providers appear to be aiming for compliance thresholds (short of 100%) to maximise their funding versus wage costs. Based on this, monitoring refinements to the supplement rates table may be proposed as part of the annual AN-ACC pricing process (implemented on 1 October each year).

### **Stakeholder engagement and consultation**

The department will engage with a variety of stakeholder groups for evaluation purposes.

Providers from all MM regional classifications and with different business models can provide information on the impacts of the proposed policies including reporting, care delivery and business sustainability (including financial implications).

Providers, particularly those in MM1, directly impacted by linking funding to care delivery can provide information on how effective these policies are in achieving care minutes compliance and ensuring Government funding for care is appropriately spent.

Direct engagement with providers will provide an opportunity for the Government to collect qualitative information that can provide context to quantitative information collected in the QFR, 24/7 R/N and ACFR reports. This engagement will consider homes in different locations and with different business models, financial status, resident cohorts or any other characteristic that is identified as affecting care minutes compliance and care funding.

Provider peak bodies will be consulted as they can provide a consolidated view of providers in relation to care minutes compliance and funding. This engagement will be more efficient than engaging with providers individually and can assist the department to target further engagement with specific providers.



Government departments will also be consulted for evaluation purposes. For example, the department will continue to engage with the ACQSC to support them to undertake regulatory action against providers for care minutes non-compliance. The ACQSC can help the department identify factors leading to care minutes non-compliance and whether the proposed policy options are successfully moving providers towards care minutes compliance or not.

The department will engage with Services Australia to ensure that the payment systems are working as intended as the linking of funding to care minutes compliance adds complexity to ICT systems and funding distribution.

Residential aged care advisory groups, such as the Council of Elders<sup>58</sup>, will be consulted to identify whether care minutes policy is leading to improved care quality or not.

The department will also consult with groups that represent specific resident cohorts such as CALD and First Nations aged care residents.

The department will also engage with established aged care advisory bodies including the Residential Aged Care Funding Reform Working Group (Working Group)<sup>59</sup> and the National Aged Care Advisory Council (NACAC)<sup>60</sup> to obtain comprehensive feedback on care minutes compliance and related activities as members of these groups represent stakeholders from across the sector. Additionally, these groups were consulted during the development of the proposed policies and therefore have a comprehensive understanding of the aims, objectives and rationale for linking care funding to care minutes compliance.

The department is committed to engaging with these stakeholder groups as they are either directly or indirectly impacted by government policy to achieve care minutes compliance and ensuring government funding for care is spent on delivering quality care.

### **Ethics considerations**

Ethical practice in the evaluation of the 24/7 RN and care minutes measures (including the linking of funding to care minutes) will include:

- Carefully designed and conducted primary data collection with stakeholders that has a clear purpose, and for which free, prior and informed consent is received, where the opportunity to withdraw consent is provided. The intended use of data collected from them will be explained clearly to participants.
- Carefully designed, tailored approaches to the collection of data from people living in residential aged care, and their families and caregivers. Consideration will be given as to how to include the consumer voice effectively while minimising unnecessary or additional consultation burden.
- Communication by the department and evaluators to participants - and to stakeholders more generally, including residents and their families/carers, the workforce, providers and peak bodies and advocacy groups - as to how monitoring and evaluation data is used to keep track of sector performance, understand how the measures are impacting the quality of life for care recipients, and inform any decision to modify aspects of the approved provider responsibilities.
- Validation of proposed approaches to data collection with worker representative(s), peak bodies and associations, representing both providers and older people to ensure ethical considerations are well accounted for.

Ethical risks will likely arise in the evaluations because there is:

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<sup>58</sup> See details and membership at: Aged Care Council of Elders | Australian Government Department of Health, Disability and Ageing

<sup>59</sup> See details and membership at: Residential Aged Care (RAC) Funding Reform Working Group | Australian Government Department of Health, Disability and Ageing

<sup>60</sup> See details and membership at: National Aged Care Advisory Council | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.

- Potential primary research with aged care residents, who may be vulnerable in research for reasons of cognitive impairment, an intellectual disability or mental illness, and/or because they are in a dependent or unequal relationship (i.e. living in a residential aged care facility). Many aged care residents may also come from culturally and linguistically diverse (CALD) backgrounds and face participation barriers.
- Potential primary research with Aboriginal and Torres Strait Islander people who are residents, family members or carers, or who work in residential aged care. All engagement with Aboriginal and Torres Strait Islander people should uphold the principles for ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities set out in the NHMRC's Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders.
- Proposed use of existing data sets, which may create risks of identification or re-identification of individual people, people who come from very small cohorts, or individual providers.

The evaluation will require a formal ethics approval by a Human Research Ethics Committee(s) (HREC) to ensure the evaluation appropriately manages the risks identified above. This ethics approval is a critical step to protect the rights and well-being of all participants involved.

# Appendix A – Measuring the change in care minutes

## Objective

This paper walks through the methodology applied to predict the change in care minutes delivered by providers in response to the introduction of the various policy options listed above.

## Datasets used

- QFR Quarters 1- 4 2023-24
- Care minute targets Quarters 1- 4 2023-24

## Methodology

To predict the change in care minute performance across the impacted population, period to period, the department applies an iterative Markov process. We measured the transition probabilities between levels of care minute performance across a study period and iteratively applied the observed transition rates to the performance observed in the final quarter of the study period.

To model different policy options, assumptions are applied to the empirically derived transition matrix.

To model the impact of the policy options, three projections were developed:

- projections in MM1 without making any changes (using the empirically derived transition matrix for MM1);
- projections in MM1 adopting the policy with assurance arrangements (using the adjusted MM1 transition matrix); and
- projections in MM1 adopting the policy without assurance arrangements (applying a weighted average to the two previous projections, reflecting a non-compliance rate).

For the purposes of modelling the impact of the proposed policy with assurance, it was assumed that the probability of a provider getting worse, or remaining at the same level of performance, was halved. For providers that are meeting the responsibility, the probability that their performance remained consistent was not adjusted down.

The assumption that the probability of undesirable performance would halve was chosen as it broadly aligns with the proportion of the care under-spend captured by the new care minute supplement. It was assumed that halving the incentive to fall short of the care minutes responsibility would make providers twice as motivated to comply.

To model the transition from care minutes targets set at a sector average of 200 to care minutes targets set at a sector average of 215 minutes, the above models were applied to a starting dataset where care minutes were benchmarked against the 200 and 215 targets. The results from the model applied to data benchmarked against an average target of 200 were used for projected performance for Q1 2024-25. The remaining quarters were projected using QFR data benchmarked against the Care Minutes 215 target.

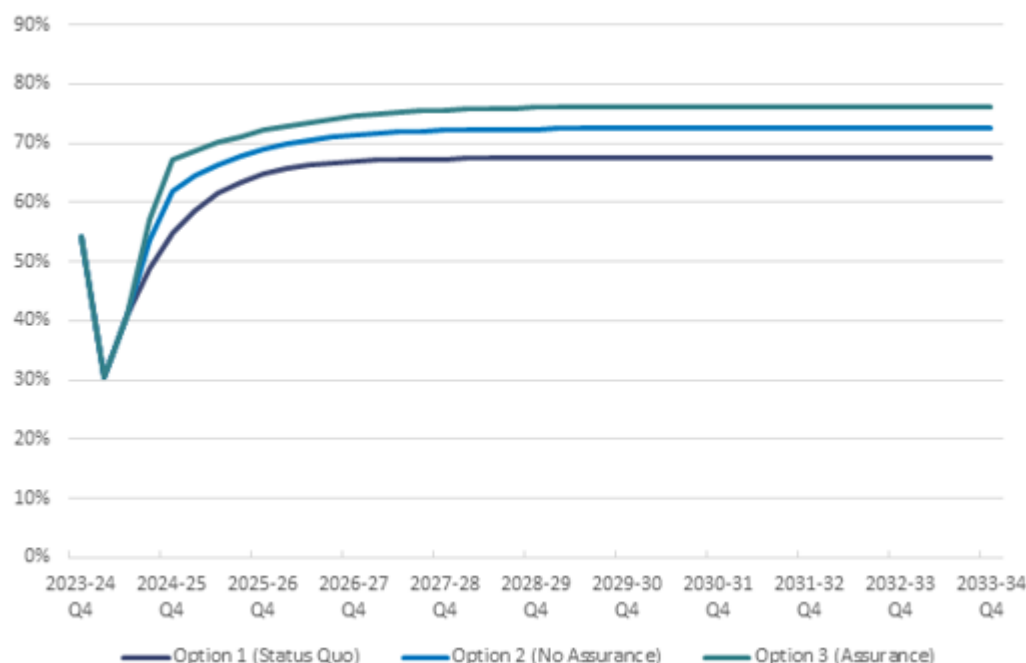
To project the impact without assurance, we must project a proportion of providers that will continue to behave as they currently do, but report higher performance. We do not have empirical evidence about the rate we would expect. To model this, we made three assumptions:

- the rate of this behaviour would be akin to the rate of ACFI appraisal downgrades (42%);
- these providers would report performance that was comparable to their compliant peers; and
- these providers would perform in a manner in-line with our no-policy projections.

We chose the rate of ACFI appraisal downgrades, as it represents a circumstance in which providers could misrepresent information to the department and obtain additional subsidy. As such, we believe it is an appropriate analogue.

## Results

**Figure A.1: Total Care Minute Compliance Rate, MM1**



**Table A.1 - Additional Care Minutes Delivered**

	2024-25	2025-26	2026-27	2027-28
Option 1	0	0	0	0
Option 2	30,404,519	44,333,674	37,532,700	41,220,028
Option 3	52,421,584	76,437,369	64,711,551	71,069,015

**Table A.2 - Value of Additional Care Minutes (\$) <sup>61</sup>**

	2024-25	2025-26	2026-27	2027-28
Option 1	0	0	0	0
Option 2	1,550,901,706	2,329,255,270	2,036,025,576	2,308,722,695
Option 3	2,673,968,458	4,015,957,362	3,510,388,923	3,980,556,371

<sup>61</sup> Measured at cost, using the average wage rate for care workers in 2023-24 increased by WPI.

**Table A.3 - Discounted Value of Additional Care Minutes (\$)<sup>62</sup>**

	2024-25	2025-26	2026-27	2027-28	Total
Option 1	0	0	0	0	0
Option 2	1,550,901,706	2,176,874,084	1,778,343,589	1,884,605,434	7,390,724,814
Option 3	2,673,968,458	3,753,231,179	3,066,109,637	3,249,319,714	12,742,628,989

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<sup>62</sup> Applying a discount rate of 7%, per Office of Impact Analysis guidance on cost benefit analysis.

# Appendix B – Measuring the change in subsidy payments

## Objective

This paper walks through the methodology applied to predict the change in subsidy payable as a result of adopting a care minute supplement. This includes the development of the supplement rate table (Table 2).

## Datasets used

- Projected changes in care minute delivery derived from Appendix A
- QFR Quarters 1-4 2023-24

## Methodology

### Cost of delivering care minutes

The care minute supplement has been designed to replace part of providers current AN-ACC subsidy. It was determined that this would best be done by substituting part of the Base Care Tariff (BCT).

This decision was made as substituting part of the variable subsidy component would require the creation of a supplement that scaled with acuity, and both dimensions of the care minute responsibility. While this is possible, it would be excessively complex, preventing providers from understanding how much money they could expect to receive.

To derive appropriate rate tables for the care minute supplement, first the cost of each hour of foregone care was measured. This was derived from the average hourly cost for staff at homes not meeting the care minute responsibility. These were indexed based on the wage rises that occurred after the reporting period, to bring them on par with the wage rate as of 31 December 2024.

For the purposes of the supplement, a blended rate for non-RN care minute staff was derived, applying the average proportions of EN and PCW hours reported in the QFR.

**Table B.1 – Cost per hour of foregone care minutes**

Staffing Category	MMI
Registered Nurse	\$ 87.50
Enrolled Nurse or PCW	\$ 58.48

The total cost of delivering care minutes for MM1 was then measured. This was done by measuring the cost of delivering 215 care minutes using non-RN staff, and the incremental cost of substituting 44 of those minutes for minutes delivered by an RN. By measuring in this manner, the double counting of costs was avoided, which would ultimately result in excessively harsh supplement rates.

**Table B.2 – Cost of Delivering 215 Care Minutes and 44 RN Care Minutes**

Staffing Category	MMI
Cost of 215 non-RN Care Minutes	\$ 209.56
Incremental Cost of 44 RN Care Minutes	\$ 21.28
Total	\$ 230.84

### Distribution of service performance

To avoid creating excessively many supplement rates, the distribution of provider performance against both dimensions of the care minute responsibility was observed. As outlined in Tables B.3 and B.4, relatively few services delivered performance that was more than 15% below their

target. As a result, <85% could be used as the bottom bin for the rates table, without acting as a material constraint on the accuracy of funding.

**Table B.3 – Distribution of Care Minute and RN Care Minute Performance in MM1, Q4 2023-24**

Total Care Minutes	RN Care Minutes					Total
	<0.85	0.85-0.9	0.9-0.95	0.95-1	>1	
<0.85	26	6	10	8	13	63
0.85-0.9	21	19	15	23	37	115
0.9-0.95	22	20	33	39	114	228
0.95-1	22	26	52	60	184	344
>1	49	30	73	115	631	898
Total	140	101	183	245	979	1648

### Deriving supplement rates (Table 2)

The next step was to identify how much subsidy ought to be withheld from the BCT. The amount withheld from the BCT was set to be the maximum amount withheld from a provider due to their performance. This would be aligned with performance in the (<85%, <85%) bin. As a result, it was set to be the difference between the cost of delivering 100% of both parts of the care minute responsibility, and delivering 86.25% of each. This is found by multiplying the costs in Table B.2 by 1-0.8625, deriving the maximum supplement rates as: 31.74 for just MM1.

The tables were then prepared with each increment funded to deliver 2.5% more than the previous, against each dimension of the responsibility. The rates from 97.5%-100% were adjusted such that providers would receive a different amount than providers meeting the responsibility. The bins corresponding to 97.5%-100% of the total care minute target were decreased by \$2, substantially less than the typical decrease associated with a 2.5% fall in performance. The bins corresponding to 97.5%-100% of the RN Care Minute target were decreased by \$0.25. Finally, rates were converted to NWAUs, to three decimal places, to allow the derived rates to be incremented in line with future AN-ACC pricing advice, including the maximum rate of the supplement.<sup>49</sup>

### Projected change in subsidy

To find the change in BCT payable, the maximum supplement rate was multiplied by the projected number of claim days per year impacted in the scenario. The maximum care minute supplement rate for each year was indexed in line with projected increases to the AN-ACC price.

Supplement payments were forecast by applying the projected performance arrived at in Appendix A to the supplement rates tables above, indexing in line with projected increases to the AN-ACC price. The resulting changes in payments are outlined in Table B.7.

It is expected that the total change in subsidy payable is the same for options 2 and 3, as we assume that the claims submitted by providers that overstate their performance will report the same average performance as those reporting accurately. Rather, we expect the difference to arise from differences in underlying performance. This is described in Appendix A – Change in Care Minutes.

**Table B.7 – Subsidy Payable (\$m nominal dollars)**

	2024-25	2025-26	2026-27	2027-28	Total
Reduction in BCT funding	\$0	\$443	\$1,900	\$2,027	\$4370
Supplement payments	\$0	\$412	\$1,783	\$1,917	\$4112
Net cost	\$0	-\$31	-\$117	-\$111	\$258



# Appendix C – Assurance costs

## *Objective*

This paper walks through the methodology applied to value the change in assurance costs resulting from the 3 options.

## *Methodology*

To measure the change in assurance costs for each option, we have identified the activities necessary to comply with the arrangements set out in each option, and estimated the average cost based on available evidence.

## *Costings - Option 1 & Option 2*

Option 1 is the status quo option, and as a result there are no additional costs associated with adopting it. At present, assurance arrangements include:

- Care Time Reporting Assessments; and
- QFR and ACFR reporting.

Option 2 does not involve any changes to the assurance arrangements, instead being entirely comprised of funding changes.

## *Costings Option 3*

The changes to assurance arrangements under Option 3 include:

- decreasing the coverage of Care Time Reporting Assessments to 10% of homes each year (down from 33%); and
- establishing a new Care Time Performance Statement, with a requirement that providers obtain an external audit opinion over the report.

## **Care time reporting assessments**

Care Time Reporting Assessments have been conducted since September 2023. To measure the cost of Care Time Reporting Assessments on providers, data is limited to feedback provided by providers. These reports have varied greatly, from 20 hours to 120 hours.

Providers have gotten better at preparing their responses to information requests over time. As a result, it is reasonable to assume that the current average time falls in the lower end of this range. For the purposes of costing, we will assume that it takes 30 hours.

Inspecting public job postings for accountant roles working for providers, the average salary falls over \$70,000-\$80,000, including superannuation. Applying an average work hours per year of 1,748, the cost per hour is \$43. This is increased by 63.5% to account for overhead costs, bringing the hourly cost to \$70.3.<sup>63</sup>

As a result, the change in throughput is decreasing the average burden on the sector, per service, from  $\$70.3 \times 30 \times 33\%$  to  $\$70.3 \times 30 \times 10\%$  or \$696 to \$211. The total burden on the sector is falling from \$1,809,600 to \$548,600 P/A. These are stated in 2024-25 dollars, and WPI forecasts from the 2025 Pre-Election Economic and Fiscal Outlook are applied.

## **Care Minute Performance Statement**

### *Report preparation*

As the care time performance statement requires no additional information beyond what is otherwise reported to the Department, the burden to prepare the report is low. We expect the

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<sup>63</sup> This represents an increase of 75% in line with the Office of Impact Analysis' Regulatory Burden Measurement Framework (see included reference), less 11.5% for superannuation otherwise included. Department of Prime Minister and Cabinet (PM&C), n.d., Regulatory Burden Measurement Framework

time should approximate that of participating in a reporting assessment, noting that responding to an information request also involves the collation of existing work papers. Efficiencies will be realised, in that these documents would also be required to enable the auditors to undertake payroll testing, leading to minimal additional time. As a result, an estimate of 20 hours is applied, from the low range of participating in a reporting assessment.

The same hourly salaries are applicable with respect to the compilation of the Care Minute Performance Statement, as are applicable for participation in a reporting assessment.

As a result, the cost of preparing a Care Minute Performance Statement is estimated as  $\$70.3 \times 20$ , or \$1,406. This is calculated on a per-provider basis, with an estimated sector burden of \$1,019,350 P/A. These are stated in 2024-25 dollars, and WPI forecasts from the 2025 Pre-Election Economic and Fiscal Outlook are applied.

#### *Assurance opinion*

Audit fees for providers vary greatly. Audit fees are a function of the size of the provider, the complexity of their financial statements, and the extent to which the reporting entity prioritises reporting quality.

Financial statements audit fees for providers are most closely related to the total assets of the reporting entity. Financial statements audits cost proportionately less for providers with more services, when controlling for total assets and direct care labour costs. This is not expected to hold for the Care Minute Performance Statement, with the workload scaling with the number of services.

Instead of using the current audit fees, it is more appropriate to benchmark the cost of assuring a Care Minute Performance Statement off the hours taken to conduct the reporting assessments, recognising the efficiency from the assurance being performed by the entity's external auditor.

The duration of Care Time Reporting Assessments has fallen to, on average, 17 workdays to complete. Staff conducting reporting assessments have on average, 8 reporting assessments in progress at any point in time. As such, the effort associated with a reporting assessment is approximately 2.15 workdays. If these staff have 1.5 hours of other miscellaneous duties in each workday, this means each reporting assessment involves 12.9 hours of work.

The median provider only has one service. It is expected that assuring their Care Minute Performance Statement would cost approximately \$2587.5, based on an average auditor charge out rate of \$200 p/h, if no efficiencies were realised from leveraging the existing work auditing payroll, and other employee benefits expenses.

The average provider has 3.65 services. There are efficiencies available in the preparation of these assurance opinions, above and beyond reporting assessments. This includes both the aforementioned economy of scale and the ability to leverage existing audit work over payroll information. It is unclear the extent to which these efficiencies will be realised or passed on to the client. As a result, it is expected that the average provider would pay between \$5175 and \$9500 for this assurance opinion.

For the purposes of the Impact Analysis, an average of \$7,555 per provider will be used. This applies a 20% discount, recognising the efficiency gains from assuring multiple services, and leveraging existing audit work. With the audits commencing in 2025-26, and continuing into the future, the WPI forecasts from the 2025 Pre-election Economic and Fiscal Outlook.

**Table C.1 - Cost of Assurance Activities (\$)**

	2024-25	2025-26	2026-27	2027-28
Option 1	0	0	0	0
Option 2	0	0	0	0
Option 3	0	-5,587,338	-5,768,926	-5,956,417

## Appendix D – Glossary of terms

Name	Description
Aged Care Act 1997	Primary legislation that covers Australian Government-funded aged care. It sets out rules for things like funding, regulation, approval of providers, quality of care and the rights of people receiving care. It is scheduled to be replaced with the Aged Care Act 2024 from November 2025
Aged Care Act 2024	The new primary legislation that will cover Australian Government-funded aged care from its commencement, scheduled for November 2025.
Aged Care Funding Instrument	The residential aged care funding model used by Government before the introduction of the AN-ACC funding model.
Aged Care Financial Report (ACFR)	Approved providers of residential aged care, home care, multi-purpose services and short restorative care are required to complete an ACFR containing financial reporting.
Aged Care Quality and Safety Commission (ACQSC)	End-to-end regulator of aged care services.
Aged Care Worker Survey	The Aged Care Worker Survey is conducted by the department to have a better understanding of the aged care workforce and to gather insights to support worker attraction, retention and satisfaction.
Aged Care Quality Standards	Standards that outline service obligations on providers.
Allied health services	Services provided by a broad range of health professionals who are not doctors, dentists, nurses, or midwives. Funding for allied health services is included in AN-ACC but not included as care minutes.
Approved residential aged care home (home)	A residential aged care home with Australian Government approval to provide residential aged care services.
Australian Institute of Health and Welfare (AIHW)	The AIHW is an independent statutory Australian Government agency with more than 30 years of experience working with health and welfare data.
Australian National Aged Care Classification (AN-ACC)	The AN-ACC is the funding model for residential aged care, effective from 1 October 2022.
AN-ACC class	Classification of residents that reflects their characteristics and determines the associated variable subsidy under the AN-ACC funding model. Determined through residential aged care funding assessment.
Base Care Tariff (BCT)	Fixed AN-ACC funding component for services reflecting characteristics of the reapproved residential aged care home such as location and

	specialisation for remote Aboriginal and Torres Strait Islander or homelessness.
Budget Process Operational Rules (BPORs)	The BPORs are standing rules for managing the Australian Government Budget and its related processes.
Care minutes	Minutes of care provided by registered nurses, enrolled nurses, personal care workers and assistants in nursing to residents each day. The care minutes requirement became mandatory from 1 October 2023. From 1 October 2024, care minutes increased to an average case-mix adjusted 215 minutes (including 44 minutes of registered nurse time).
Care minutes compliance	Residential aged care providers and their home/s compliance with their care minutes targets.
Care Minute Performance Statement	From the 2025-2026 financial year, all providers will be required to prepare and submit a Care Minutes Performance Statement as part of their annual ACFR. The Statement captures detailed information on: direct care minutes delivered, associated labour costs, registered nurse (RN) coverage, and occupied bed days.
Council of Elders	Council of Elders is a group of older people from diverse backgrounds with lived experience of ageing and aged care who provide advice to the Australian Government.
Department of Health, Disability and Aging (the department/DoHDA)	The Department supports the Australian Government to lead and shape Australia's health and aged care system and sporting outcomes through evidence-based policy, well targeted programs and best practice regulation.
Economic Review Committee	A committee of Cabinet responsible for examining all proposals in light of the Government's overall fiscal strategy, advising Cabinet on Budget spending priorities and initiating reviews of individual ongoing programmes. Membership of the ERC consists of the Prime Minister, Treasurer and the Minister for Finance, along with other selected portfolio ministers
Enforceable undertaking	An enforceable undertaking is a written agreement between the ACQSC and a provider or person that is offered to the ACQSC by the provider or person. It explains the actions that the provider or person will take (their "undertaking") to fix risk and non-compliance with their aged care responsibilities.
Home with a specialised homeless status	Specialised approved residential aged care homes are considered those eligible for additional BCT funding under the AN-ACC because of their specialised status, that is those in receipt of the specialised homeless BCT status (which can apply to a home in any location) and specialised First

	Nations services in rural and remote areas (MM 6-7)
Home without a specialised homeless status	Approved residential aged care home that does not meet specialised homeless provider and resident requirements. May be in any MMM location.
Independent Health and Aged Care Pricing Authority (IHACPA)	The IHACPA is an independent body that provides AN-ACC price recommendations to the Government.
IHACPA AN-ACC Pricing Studies	IHACPA's independent pricing advice reflects costing studies and analysis of financial data reported by providers. IHACPA may also make recommendations regarding adjustments to the NWAU values (weightings), including the weightings that apply to specialised BCTs, to ensure specialised BCT funding reflects the actual costs of delivering specialised care.
Modified Monash model (MM)	The Modified Monash model (MM) is a measure of remoteness and population size used by the department to define whether a location is city, rural, remote, or very remote. Locations are categorised from MM 1 to MM 7, with MM 1 denoting a major city and MM 7 a very remote location.
My Aged Care	My Aged Care is the official website to access information and services for aged care.
National Aged Care Advisory Council (NACAC)	The NACAC provides expert advice to government on key matters relating to the aged care sector.
National Aged Care Mandatory Quality Indicator Program	The National Aged Care Mandatory Quality Indicator Program collects information from residential aged care services on 14 quality indicators across critical areas of care that can affect the health and wellbeing of aged care home residents. This helps to monitor and improve the quality of services for older people living in residential care.
National Weighted Activity Units (NWAU)	The AN-ACC applies weightings or NWAU's to the AN-ACC price. The NWAU is a measure of a care service activity expressed as a common unit. The AN-ACC price is the price of a unit of care, or 1.00 NWAU.
Operational bed	Operational bed refers to a residential care place that was allocated to a provider and has since become available for a person to receive care.
Pacific Australia Mobility Scheme (PALM)	The PALM scheme helps to fill labour gaps in rural and remote Australia by allowing eligible Australian Business to hire workers from 9 Pacific Islands and Timor-Leste when there are not enough local workers available
Quarterly Financial Report (QFR)	Mandatory report by approved providers. Includes care minutes reporting.

Registered residential aged care provider (provider)	Registered residential aged care provider can receive an Australian Government subsidy under the Aged Care Act 1997 (the Act) and run Australian Government-subsided approved residential aged care homes. There are currently around 750 providers than run around 2600 services.
Resident	A person receiving accommodation and personal care 24 hours a day in an approved residential aged care service. Residents also receive access to nursing and general health care services.
Residents' Experience Survey and the Aged Care Provider Survey	The Residents' Experience Survey (formerly known as the Consumer Experience Interviews) enables aged care residents to advise the Department about the quality of their aged care.
Residential Aged Care Funding Reform Working Group	The Residential Aged Care Funding Reform Working Group advises the department on issues related to reform of the residential aged care funding system, including the AN-ACC, care minutes and the 24/7 RN responsibility.
Royal Commission into Aged Care Quality and Safety report	Report on aged care tabled on 1 March 2021. AN-ACC was implemented in response to recommendations in this report.
Sector-level care minutes dashboard	A sector-level care minutes dashboard is published on the department's website and updated quarterly. The dashboard provides information on the residential aged care sector's performance in relation to care minutes delivered compared to the sector average targets and the percentage of homes that meet their targets. This dashboard also provides information on compliance in different regions and by providers of different ownership types.
Services Australia	Services Australia is a Government agency responsible for AN-ACC payment and claims IT system – the Service Australia Aged Care Provider Portal.
Star Ratings	Star Ratings helps older people; their families and carers compare the quality of aged care homes. Each aged care home receives an Overall Star Rating and a rating against 4 sub-categories: 1. Residents' Experience; 2. Compliance; 3. Staffing; and 4. Quality Measures
Strategy and First Nations Group (SFN)	Strategy and First Nations Group (SFN) is an internal advisory Group within the Department of Health, Disability and Ageing which oversees strategic policy and relations, health economics, research and First Nations health

## Appendix E – Abbreviations

Abbreviation	Name
ACFR	Aged Care Financial Report
ACFI	Aged Care Funding Instrument
ACQSC	Aged Care Quality and Safety Commission
AIHW	Australian Institute of Health and Welfare
AN-ACC	Australian National Aged Care Classification
AIN	Australian National Aged Care Classification
BCT	Base Care Tariff
BPORs	Budget Process Operational Rules
department/DoHDA	Department of Health, Disability and Aging
CALD	Culturally and Linguistically Diverse
ERC	Economic Review Committee
EN	Enrolled Nurses
FAQ	Frequently Asked Questions
GPMS	Government Provider Management System
IHACPA	Independent Health and Aged Care Pricing Authority
MM	Modified Monash model
NACAC	National Aged Care Advisory Council
NWAU	National Weighted Activity Units
PCW	Personal Care Workers
QFR	Quarterly Financial Report
RN	Registered Nurse
SFN	Strategy and First Nations Group
UTS	University of Technology Sydney
UARC	University of Technology Sydney Ageing Research Collaborative