

EXPLANATORY STATEMENT

Issued by the authority of the Minister for Aged Care and Seniors

Aged Care Rules 2025

Purpose and Operation

The Royal Commission into Aged Care Quality and Safety (Royal Commission), which delivered its Final Report: Care, Dignity and Respect in March 2021, identified systemic failures in the aged care system and made 148 recommendations to improve the quality, safety, and governance of aged care services in Australia.

In response, the Government committed to a comprehensive reform program, including the development of a new legislative framework to replace the *Aged Care Act 1997*. The *Aged Care Act 2024* (the Act) establishes a rights-based foundation for aged care, centred on the dignity, autonomy, and wellbeing of older people. The *Aged Care Rules 2025* (the Rules) are made under the Act and provide the detailed operational requirements necessary to give effect to its provisions.

The purpose of the Rules is to establish the operational detail required to implement the Act which introduces a new rights-based framework for aged care in Australia. These Rules form part of the Commonwealth's aged care legal framework and are designed to ensure that the principles, conditions and obligations set out in the Act are translated into clear, enforceable requirements for aged care providers, workers, and regulators.

The Rules provide additional legislative mechanisms to support the delivery of safe, high-quality, and person-centred aged care services. They set out the specific requirements relating to provider registration, care and services obligations, pricing and payment arrangements, quality standards, complaints handling, and compliance and enforcement processes. These provisions are essential to ensuring that the rights of older people accessing funded aged care services are upheld and that providers are held accountable for the care they deliver.

The Rules also supplement the framework established under the Act for the Aged Care Quality and Safety Commission to monitor and enforce compliance with the Act and Rules.

In addition, the Rules give effect to key reforms arising from the Royal Commission, including the Code of Conduct for aged care workers and providers, strengthened provider suitability requirements, and enhanced transparency measures such as public reporting of provider performance and pricing.

The Rules aim to improve the quality and safety of aged care services, promote accountability and transparency, and ensure that older people receive care that is respectful, responsive, and aligned with their individual needs and preferences.

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

Background

The Rules are structured into chapters that align with the architecture of the Act. Each chapter is supported by detailed provisions that clarify the responsibilities of providers, the rights of older people accessing funded aged care services, and the powers of regulators.

The Rules are intended to be co-located with the Act to ensure clarity and accessibility for users. As delegated legislation, they provide the necessary flexibility to respond to emerging issues and to make timely adjustments where required. This approach supports a more responsive and adaptive aged care system, capable of meeting the evolving needs of older people.

The Rules mark a significant step in the transformation of aged care in Australia, embedding the principles of care, dignity, and respect into the regulatory framework and ensuring that older people receive the quality care they deserve.

The Rules are designed to support the implementation of key reforms, including:

- the rights-based legislative framework that focuses on quality and safe funded aged care services and places the needs of older individuals at the centre of the aged care system.
- a new registration model for aged care providers, replacing the previous approval system with a more flexible and risk-based approach.
- enhanced provider obligations, including requirements to deliver care that is safe, respectful, and responsive to individual needs.
- a strengthened Code of Conduct for aged care workers and providers, with enforceable standards of behaviour.
- a new monitoring and compliance framework, including graduated enforcement powers for the Aged Care Quality and Safety Commission.
- improved transparency and accountability, including clearer pricing Rules and public reporting obligations.
- a new complaints management framework, designed to be more accessible and responsive to older people and their families.

Authority

Subsection 602(1) of the Act provides that the Minister may make legislative instruments prescribing matters that are required or permitted by the Act, or that are necessary or convenient to give effect to the Act. The Rules are made under this section, and many others set out in the Act, and provide the operational detail necessary to implement the new aged care framework established by the Act.

In accordance with subsection 33(3) of the *Acts Interpretation Act 1901*, the power to make these Rules includes the power to amend, repeal, or vary them as necessary. This ensures that the Rules can be updated promptly in response to emerging issues, sector feedback, or changes in policy direction.

Commencement

The Rules will commence on 1 November 2025, aligning with the commencement of the Act. This coordinated start date ensures that the new legislative framework and its supporting

operational detail come into effect simultaneously, providing clarity and continuity for aged care providers, care recipients, and regulators.

Consultation

Extensive consultation was undertaken informing both the development of the Act and the Rules. This included consultation with advisory bodies such as the Aged Care Council of Elders, the National Aged Care Advisory Council and peak bodies.

Drafts of the Rules were released in stages for progressive consultation between September 2024 and May 2025, with feedback incorporated into the final Rules to ensure they are practical, proportionate, aligned with the intent of the Act, and aligned with the needs of older people, providers, and the broader aged care sector. During the consultations, over 450 submissions were received.

The consultations on the Rules built on previous consultation processes for the policy and draft legislation for the Act. Public consultations were held on the foundations of the Act over a five-week period from 4 August 2023 to 8 September 2023, with feedback received from over 2,000 stakeholders. Consultations on the Exposure Draft of the Bill for the new Aged Care Act commenced on 14 December 2023, concluding on 8 March 2024. During this 12 week consultation period, the Department received over 320 written submissions and surveys and engaged with over 10,000 people who attended webinars, workshops and targeted roundtable discussions.

Impact Analysis

The Office of Impact Analysis has advised that a detailed impact analysis is not required for the Aged Care Rules 2025, except for Chapter 7 Part 7—Subsidy for residential care as it relates to the new care minutes supplement. In September 2025, the Department completed a detailed impact analysis for the care minutes supplement (see relevant components of Part 7 of Chapter 7), OIA24-08087, included at **Attachment C**.

General

This instrument is a legislative instrument for the purposes of the *Legislation Act 2003*.

Details of this instrument are set out in **Attachment A**.

This 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**.

Abbreviations and Acronyms used in this explanatory statement

- **Acts Interpretation Act** means the *Acts Interpretation Act 1901*.
- **Aged Care Act** means the *Aged Care Act 1997*.
- **AN-ACC** means Australian National Aged Care Classification
- **Appointed Commissioner** means: the Commissioner, or the Complaints Commissioner.
- **APS employee** means an employee engaged under the *Public Service Act 1999*.
- **Bill** means the Aged Care Bill 2024.
- **CHSP** means the Commonwealth Home Support Program, a specialist aged care program.
- **Code** means the Aged Care Code of Conduct established by section 14 of the Act.
- **Commission Act** means the *Aged Care Quality and Safety Commission Act 2018*.
- **Commission** means the Aged Care Quality and Safety Commission established by section 344 of the Act.
- **Commissioner** means the Commissioner of the Commission.
- **Consequential Bill** means the Aged Care (Consequential Amendments) Bill 2024.
- **Criminal Code** means the *Criminal Code Act 1995*.
- **CRPD** means the United Nations Convention on the Rights of Persons with Disabilities done at New York on 13 December 2006, as amended and in force for Australia from time to time.
- **Department** means the Department of Health, Disability and Ageing.
- **External Affairs Power** means external affairs power in section 51(xxix) of the Commonwealth Constitution
- **ICESCR** means the International Covenant on Economic, Social and Cultural Rights done at New York on 16 December 1966, as amended and in force for Australia from time to time.
- **Legislation Act** means the *Legislation Act 2003*.
- **MPSP** means the Multi-Purpose Service Program, a specialist aged care program.
- **NATSIFACP** means the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, a specialist aged care program.
- **National Health Reform Act** means the *National Health Reform Act 2011*.
- **NDIA** means the National Disability Insurance Agency.
- **NDIS** means the National Disability Insurance Scheme.
- **Privacy Act** means the *Privacy Act 1988*.
- **Public Governance, Performance and Accountability Act** means the *Public Governance, Performance and Accountability Act 2013*. **Public Service Act** means the *Public Service Act 1999*.
- **Regulatory Powers Act** means the *Regulatory Powers (Standard Provisions) Act 2014*.
- **Royal Commission** means the *Royal Commission into Aged Care Quality and*

Safety.

- **Final Report** means the Royal Commission's Final Report: *Care, Dignity and Respect*.
- **Rules** means the Aged Care Rules 2025.
- **Quality Standards** means the Aged Care Quality Standards established at subsection 15(1).
- **Sickness and hospital benefits aspect of the social welfare power** means sickness and hospital benefits aspect of the social welfare power in section 51(xxiiiA) of the Constitution.
- **SIRS** means Serious Incident Response Scheme.
- **System Governor** means the Secretary of the Department.
- **Taskforce** means the Aged Care Taskforce.
- **TCP** means the Transition Care Program, a specialist aged care program.
- **Transitional Act** means the *Aged Care (Transitional Provisions) Act 1997*.
- **WHS Act** mean the *Work Health and Safety Act 2011*.

Chapter 1 – Introduction

Part 1 – Preliminary

Section 1-5 – Name

This section provides that this instrument is the *Aged Care Rules 2025* (the rules).

Section 2-5 – Commencement

This section provides for the commencement of each provision in the rules, as set out in the table at subsection 2-5(1).

The table provides that the whole of the instrument commences at the same time as the *Aged Care Act 2024* (Aged Care Act) commences.

Subsection 2-5(2) explains that information in column 3 of the table is not part of the rules. Information may be inserted in this column, or information in it may be edited, in any published version of this instrument.

Section 3-5 – Authority

Section 3-5 provides that this instrument is made under the Aged Care Act (the Act).

Section 4-5 – Simplified outline of this instrument

This section provides a simplified outline of the rules. The simplified outline is included to assist readers to understand the substantive provisions. The outline is included as a navigation aid and is not intended to be comprehensive. It is intended that readers should rely on the substantive provisions of the rules.

Part 2 – Definitions

Section 5-5 – Definitions

This section contains definitions that are used in the rules. The definitions also provide cross references to specific definitions throughout the rules, the Act or in other Acts.

The note at the top of this section refers readers to section 7 of the Act for definitions of expressions that are already defined in the Act.

2023 MM category means a category for an area provided for by the Modified Monash Model, as the model existed on 13 April 2025, and known as MM 1, MM 2, MM 3, MM 4, MM 5, MM 6 or MM 7.

Aboriginal or Torres Strait Islander Health Practitioner means a person who is registered under the National Law in the Aboriginal and Torres Strait Islander health practice profession.

Aboriginal or Torres Strait Islander Health Worker means a person who is:

- a full member of the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners and not an Aboriginal or Torres Strait Islander Health Practitioner;

- or holds a Certificate II or higher in Aboriginal or Torres Strait Islander Primary Health Care Practice from a registered training organisation.

accepted mental health condition means a mental health condition for which:

- the Repatriation Commission has accepted liability to pay a pension under the Veterans' Entitlements Act; or
- the Military Rehabilitation and Compensation Commission has accepted liability to pay compensation under the MRC Act or the *Safety, Rehabilitation and Compensation Act 1988*.

accommodation bond agreement means an agreement between an individual in the pre2014 accommodation class and a registered provider in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider that meets the requirements set out in section 287-25.

accommodation bond retention amount means an amount that a registered provider may deduct from an accommodation bond balance in accordance with section 287-95.

accommodation charge agreement means an agreement between an individual in the pre2014 accommodation class and a registered provider in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider that meets the requirements set out in section 287-115.

accommodation wing, of an approved residential care home, includes any of the following:

- a building;
- a floor or level of a building;
- an annex to a building;

that is used to provide accommodation for an individual to whom funded aged care services are being delivered in the home.

ACN has the same meaning as in the *Corporations Act 2001*.

Act means the *Aged Care Act 2024*.

ad hoc higher everyday living agreement see section 284-2 of the rules.

AFM assessment item means the Australian Modified Functional Independence Measure assessment item of the AN-ACC Assessment Tool.

AFM cognition score, for an individual, means the individual's total score for communication and social cognition on the AFM assessment item.

AFM communication score, for an individual, means the individual's total score for communication on the AFM assessment item.

AFM eating score, for an individual, means the individual's score for eating on the AFM assessment item.

AFM motor score, for an individual, means the individual's total score for self-care, sphincter control, transfers and locomotion on the AFM assessment item.

AFM social cognition score, for an individual, means the individual's total score for social cognition on the AFM assessment item.

AFM transfers score, for an individual, means the individual's total score for transfers on the AFM assessment item.

Aged Care Assessment Manual means the Aged Care Assessment Manual, published by the Department, as existing on 1 November 2025.

The note that accompanies this definition refers the reader to the Department's website where the Aged Care Assessment Manual could be viewed in 2025.

aged care financial report, for a registered provider, means the report required by section 166-310.

age pension means age pension under Part 2.2 of the Social Security Act.

agitation score, for an individual, means the individual's score for physically aggressive or inappropriate behaviour on the Behaviour Resource Utilisation Assessment assessment item of the AN-ACC Assessment Tool.

AKPS assessment item means the Australia modified Karnofsky Performance Status assessment item of the AN-ACC Assessment Tool.

AKPS score, for an individual, means the individual's score on the AKPS assessment item.

allied health assistant means a person who holds a Certificate IV in Allied Health Assistance from a registered training organisation.

allied health profession means a health profession other than the following:

- dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist);
- medical;
- midwifery;
- nursing.

allied health professional means a person who is any of the following:

- a registered health practitioner who:
 - is registered under the National Law to practise an allied health profession, other than as a student (within the meaning of the National Law); or
 - holds non-practising registration under the National Law in an allied health profession;
- an Aboriginal or Torres Strait Islander Health Worker;
- an art therapist;
- an audiologist;
- a certified practicing nutritionist;

- a counsellor;
- a dietitian;
- an exercise physiologist;
- a genetic counsellor;
- a music therapist;
- an orthoptist;
- an orthotist;
- a podiatrist;
- a prosthetist;
- a recreational therapist;
- a rehabilitation counsellor;
- a social worker;
- a sonographer;
- a speech pathologist.

AN-ACC Assessment Tool means the Australian National Aged Care Classification Assessment Tool, published by the Department, as existing on 1 April 2021.

The note that accompanies this definition refers the reader to the Department's website where the AN-ACC Assessment Tool could be viewed in 2025.

AN-ACC Reference Manual means the Australian National Aged Care Classification Reference Manual, published by the Department, as existing on 1 April 2021.

The note that accompanies this definition refers the reader to the Department's website where the AN-ACC Reference Manual could be viewed in 2025.

annual accountability report, for a registered provider, means the report required under section 166-745.

annual activity report, for a registered provider, means the report required under section 166-725.

annual financial declaration statement, for a registered provider, means the statement required under section 166-605.

annual prudential compliance statement, for a registered provider, means the statement required by section 166-360.

annual statement of financial compliance and income and expenditure, for a registered provider, means the statement required by section 166-730.

annual wellness and reablement report, for a registered provider, means the report required under section 166-615.

antipsychotic medication, in relation to medication management, means the prescription of medications to an individual for the purposes of the treatment of a diagnosed condition of psychosis.

approval year, for an approved higher maximum accommodation payment amount, means the period of 1 year beginning on:

- the day the approval takes effect under section 290-25 or 290-30 (as applicable); or
- any later anniversary of that day.

approved health practitioner means a medical practitioner, nurse practitioner or registered nurse.

approved higher maximum accommodation payment amount means a higher maximum accommodation payment amount (expressed as a refundable accommodation deposit amount) approved by the Pricing Authority under subsection 290(6) of the Act.

ARIA value, for a location, means the value given to that location in accordance with the methodology set out in the document titled *Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA)*, Occasional Papers: New Series Number 14, published by the Department in October 2001, as the document existed on 1 July 2013.

The note that accompanies this definition refers the reader to the Department's website where the document titled *Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA)* could be viewed in 2025.

art therapist means a person who is registered with the Australian, New Zealand and Asian Creative Arts Therapies Association as a Creative Art Therapist.

assistance dog means a dog that is an assistance animal within the meaning of the *Disability Discrimination Act 1992*.

AT-HM List means the Assistive Technology and Home Modifications list published by the Department, as existing on 1 November 2025.

The note that accompanies this definition refers the reader to the Department's website where the AT-HM List could be viewed in 2025.

audiologist means a person who:

- is a full member of Audiology Australia and certified by Audiology Australia as an accredited audiologist; or
- is a full or ordinary member, or fellow audiologist, of the Australian College of Audiology incorporating the Hearing Aid Audiology Society of Australia with a certificate of recognition of competency, issued by that College, as both a hearing rehabilitation specialist and a diagnostic rehabilitation specialist.

audited income and expenditure report, for a registered provider, means the report required under section 166-640.

Australian accounting standards means the accounting standards in force under section 334 of the *Corporations Act 2001*.

Australian Commission on Safety and Quality in Health Care means the Commission established by subsection 8(1) of the *National Health Reform Act 2011*.

Australia New Zealand Food Standards Code has the same meaning as in the *Food Standards Australia New Zealand Act 1991*.

Australian Privacy Principle has the same meaning as in the *Privacy Act 1988*.

banning orders register means the register of banning orders established and maintained under section 507 of the Act.

Barthel Index of Activities of Daily Living assessment tool has the same meaning as in the Quality Indicator Program Manual.

base interest rate means a rate that:

- is the sum of the below threshold rate and 2%, expressed as a percentage; and
- takes effect on the first day of the month following the day when the below threshold rate is determined.

below threshold rate means the below threshold rate determined under subsection 1082(1) of the *Social Security Act 1991*.

Braden activity score, for an individual, means the individual's score for activity on the Braden Scale assessment item of the AN-ACC Assessment Tool.

Braden total score, for an individual, means the individual's total score on the Braden Scale assessment item of the AN-ACC Assessment Tool.

building status amount, for an individual for a day: see subsection 230-15(1).

calculation day, for a quarter, means the 15th day of the calendar month before the calendar month in which the quarter begins.

care minute: a minute is a ***care minute*** if it is spent delivering direct care, other than the following:

- the planning or delivery of activities to a group of individuals;
- the provision or maintenance of aids, appliances or equipment.

care minutes performance statement, for a registered provider, means the statement required by section 166-335.

Category A residential care home means an approved residential care home that, immediately before the transition time, was a multi-purpose service (within the meaning of section 104 of the *Subsidy Principles 2014*) that was a Category A service within the meaning of section 88 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Category B residential care home means an approved residential care home that, immediately before the transition time, was a multi-purpose service (within the meaning of section 104 of the *Subsidy Principles 2014*) that was a Category B service

within the meaning of section 89 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Category C residential care home means an approved residential care home that, immediately before the transition time, was a multi-purpose service (within the meaning of section 104 of the *Subsidy Principles 2014*) that was a Category C service within the meaning of section 90 of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Category D residential care home means an approved residential care home that is not a Category A residential care home, Category B residential care home or Category C residential care home.

certified practicing nutritionist means a person who is registered with the Australasian Association and Register of Practicing Nutritionists as a Certified Practicing Nutritionist.

chemical restraint: see subsection 17-5(2).

child safety compliance statement, for a registered provider, means the statement required under section 166-628.

CHSP is short for the program known as the Commonwealth Home Support Program.

CHSP contribution: see subsection 286-15(1).

compensation has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

compensation payer has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

complainant: see subsection 361-10(1).

complaint determination has the same meaning as in paragraph 361(1A)(d) of the Act.

compliance report, for a registered provider, means the report required under section 166-620.

conditionally included AT-HM item means a product, item of equipment or home modification:

- that is listed in the part of the AT-HM List headed “Conditional inclusions”; and
- that is not an excluded AT-HM item.

conditionally included communication and information management item means a product or item of equipment:

- that is listed in the part of the AT-HM List headed “Conditional inclusions” under “Communication and information management”; and
- that is not an excluded AT-HM item.

conditionally included domestic life item means a product or item of equipment:

- that is listed in the part of the AT-HM List headed “Conditional inclusions” under “Domestic life”; and
- that is not an excluded AT-HM item.

consecutive unplanned weight loss, in relation to unplanned weight loss, means a decrease in the weight of an individual of any amount, as determined by comparing the weight of an individual from the finishing weight of the previous quarter against the starting weight, middle weight and finishing weight for the current quarter.

Consumer Experience Assessment means an assessment using the Quality-of-Care Experience Aged Care Consumers ©Flinders University 2022 (QCE-ACC) Tool.

contact includes physical contact, face-to-face contact, oral communication, written communication and electronic communication.

continuing service delivery branch: see subsection 263A-5(1).

continuity of care plan: see section 149-75.

Co-operatives National Law means the Law set out in the appendix to the *Co-operatives (Adoption of National Law) Act 2012* (NSW), and applying in a State or Territory under the following:

- *Co-operatives (Adoption of National Law) Act 2012* (NSW);
- *Co-operatives National Law Application Act 2013* (Vic);
- *Co-operatives National Law Act 2020* (Qld);
- *Co-operatives National Law (South Australia) Act 2013* (SA);
- *Co-operatives National Law (Tasmania) Act 2015* (Tas);
- *Co-operatives National Law (ACT) Act 2017* (ACT);
- *Co-operatives (National Uniform Legislation) Act 2015* (NT).

counsellor means a person who:

- is registered as a registered counsellor with the Australian Counselling Association or the Psychotherapy and Counselling Federation of Australia; and
- has a qualification covered by level 7, 8, 9 or 10 of the Australian Qualifications Framework (within the meaning of the *Higher Education Support Act 2003*).

counted mainstream individual: see subsection 176-15(5).

counted NATSIFACP individual: see subsection 176-35(5).

current wait time, for the allocation of a place for a classification type for a service group to an individual, on a day (the ***current day***) before the place is allocated to the individual, means the time starting at the time the individual’s access approval for the classification type for the service group was given and ending at the end of the day before the current day.

daily remaining income amount, for an individual for a day: see subsection 231-17(5).

daily total essential expenses, for an individual for a day: see subsection 231-17(4).

DAP index number, for an indexation day: see section 302-15.

day of eligible residential funded aged care services: see subsection 239-15(4).

day of recognised residential care: see subsections 176-20(4) and (5).

DEMMI score, for an individual, means the individual's total score on the De Morton Mobility Index assessment item.

De Morton Mobility Index assessment item means the De Morton Mobility Index assessment item of the AN-ACC Assessment Tool.

dietitian means a person who is accredited by Dietitians Australia as an Accredited Practising Dietitian.

disruptiveness score, for an individual, means the individual's score for verbally disruptive or noisy behaviour on the Behaviour Resource Utilisation Assessment assessment item of the AN-ACC Assessment Tool.

diverse cultural activities includes cultural activities for the following:

- Aboriginal or Torres Strait Islander persons;
- individuals from culturally, ethnically and linguistically diverse backgrounds;
- who are lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations, gender diverse or bodily diverse.

diverse individual, means an individual who is:

- an Aboriginal or Torres Strait Islander person, including an Aboriginal or Torres Strait Islander person from the stolen generations; or
- a veteran or war widow; or
- from a culturally, ethnically and linguistically diverse background; or
- experiencing homelessness or at risk of experiencing homelessness; or
- a parent or child who is or was separated by forced adoption or removal; or
- an adult survivor of institutional child sexual abuse; or
- a care-leaver, including a Forgotten Australian or former child migrant placed in out of home care; or
- lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations or is gender diverse or bodily diverse; or
- an individual with disability or mental ill-health; or
- neurodivergent; or
- deaf, deafblind, vision impaired or hard of hearing.

diversional therapist means a person who holds any of the following qualifications from a registered training organisation:

- Certificate IV in Leisure and Health;
- Diploma in Leisure and Health;
- Bachelor of Health Science;

- Bachelor of Applied Science with a major in:
 - Leisure and Health; or
 - Therapeutic Recreation.

emergency department presentation means when an individual presents to an emergency department or an urgent care centre including where that presentation is in person or via a technology enabled platform.

end-of-life care means the care provided in what is sometimes referred to as the terminal phase of life, where death is imminent and likely to occur within 3 months.

environmental restraint: see subsection 17-5(3).

excluded AT-HM item means a product, item of equipment or home modification that is listed in the part of the AT-HM List headed “Exclusions”.

exercise physiologist means a person who is accredited by Exercise & Sports Science Australia as an Accredited Exercise Physiologist.

fall means an event that results in an individual coming to rest inadvertently on the ground, floor or other lower level.

fall resulting in major injury means a fall that results in one or more of the following:

- bone fracture;
- joint dislocation;
- closed head injury with altered consciousness;
- closed head injury with subdural haematoma.

fee reduction supplement daily threshold amount for a day means the amount obtained by rounding down to the nearest cent the amount equal to 15% of the basic age pension amount (worked out on a per day basis) on the day.

fee reduction supplement fortnightly threshold amount for a fortnight means the amount obtained by rounding down to the nearest cent the amount equal to 15% of the basic age pension amount (worked out on a per fortnight basis) for the fortnight.

financial support statement, for a registered provider, means the statement required by section 166-315.

finishing weight, in relation to unplanned weight loss, means the weight of an individual recorded in the third month of a quarter.

first asset threshold: see subsection 319-5(6).

first income threshold: see subsection 319-5(2).

formal agreement has the same meaning as in the old Act.

fortnightly base home support individual amount, for an individual for a fortnight: see subsection 197-10(9).

fortnightly base individual amount, for an individual for a fortnight: see subsection 197-10(8).

fortnightly individual contribution cap, for an individual for a fortnight: see subsection 197-10(7).

fortnightly remaining income amount, for an individual for a fortnight: see subsection 197-10(6).

fortnightly total essential expenses, for an individual for a fortnight: see subsection 197-10(4).

fortnightly total income amount, for an individual for a fortnight: see subsection 197-10(5).

fourth asset threshold: see subsection 319-5(9).

fourth income threshold: see subsection 319-5(5).

general purpose financial report for a registered provider, means the report required by section 166-345.

genetic counsellor means a person who is registered with the Human Genetics Society of Australasia as a Certified Genetic Counsellor.

Ghent Global Incontinence Associated Dermatitis Categorisation Tool means the version 1.0 (June 2017) of the *Ghent Global IAD Categorisation Tool (GLOBIAD)* developed by Skin Integrity Research Group, at Ghent University.

The note that accompanies this definition refers the reader to the Department's website where the Ghent Global Incontinence Associated Dermatitis Categorisation Tool could be viewed in 2025.

giving day, for a financial support statement, has the meaning given by subsection 166-320(3).

grant agreement means one or more grants of financial assistance to a registered provider for the delivery of funded aged care services entered into by the System Governor on behalf of the Commonwealth under section 264 of the Act.

group A residential care home, for a payment period: see subsection 239-15(2).

group B residential care home, for a payment period: see subsection 239-15(3).

has specialised Aboriginal or Torres Strait Islander status: an approved residential care home ***has specialised Aboriginal or Torres Strait Islander status*** on a day if a determination that the home has specialised Aboriginal or Torres Strait Islander status under subsection 243(3) of the Act is in effect on the day.

has specialised homeless status: an approved residential care home ***has specialised homeless status*** on a day if a determination that the home has specialised homeless status under subsection 243(3) of the Act is in effect on the day.

health profession has the same meaning as in the National Law.

health professional means a person who is registered under the National Law in a health profession.

health service standards assessment: see subsection 109-10(4).

higher cognitive ability: an individual who is mobile only with assistance has **higher cognitive ability** if the individual's AFM cognition score is 22 or more.

higher everyday living agreement: see section 284 of the Act.

higher function: an individual who is not mobile has **higher function** if the individual's RUG total score is 16 or less.

higher pressure sore risk: an individual who is not mobile has **higher pressure sore risk** if the individual's Braden total score is 13 or less.

home or community fee reduction supplement determination, for an individual, means a determination made under section 197-10 in relation to the individual (including as varied).

home or community place, for an approved residential care home of a registered provider in or from which the provider delivers funded aged care services through the service group home support, assistive technology or home modifications under the MPSP, means a place allocated to the registered provider for delivering those services in or from that home.

home support compounding factors: see section 81-7.

home support functional independence score, for an individual, means the individual's total score for:

- the questions in the sections of the Integrated Assessment Tool headed "Function", other than the following:
 - questions in the form "Is the need being met?";
 - the question headed "Upper body strength"; and
- the questions in the section of the Integrated Assessment Tool headed "De Morton Mobility Index (DEMMI) - Modified".

home support needs met score, for an individual, means the individual's total score for the questions in the Integrated Assessment Tool in the form "Is the need being met?".

hospital admission means when an individual is accepted by a hospital inpatient speciality service for ongoing management, whether planned or unplanned and including an admission of any length and occurring in any location.

ICD-10 Australian Modified Pressure Injury Classification System means the classification system contained in the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)*, as published by the Independent Health and Aged Care Pricing Authority, and as existing on 1 November 2025.

The note that accompanies this definition refers the reader to the Independent Health and Aged Care Pricing Authority's website where the ICD-10 Australian Modified Pressure Injury Classification System could be viewed in 2025.

illness separated couple has the same meaning as in the Social Security Act.

in a service group: a funded aged care service is ***in a service group*** if the service is in a service type that is in the service group.

The note that accompanies this definition refers the reader to Part 3 of the rules.

included AT-HM item means a product, item of equipment or home modification:

- that is listed in the part of the AT-HM List headed "Inclusions"; and
- that is not an excluded AT-HM item.

included communication and information management item means a product or item of equipment:

- that is listed in the part of the AT-HM List headed "Inclusions" under "Communication and information management"; and
- that is not an excluded AT-HM item.

included domestic life item means a product or item of equipment:

- that is listed in the part of the AT-HM List headed "Inclusions" under "Domestic life"; and
- that is not an excluded AT-HM item.

included home modifications item means a product, item of equipment or home modification:

- that is listed in the part of the AT-HM List headed "Inclusions" under "Home modifications"; and
- that is not an excluded AT-HM item.

included managing body functions item means a product or item of equipment:

- that is listed in the part of the AT-HM List headed "Inclusions" under "Managing body functions"; and
- that is not an excluded AT-HM item.

included mobility item means a product or item of equipment:

- that is listed in the part of the AT-HM List headed "Inclusions" under "Mobility"; and
- that is not an excluded AT-HM item.

included self-care item means a product or item of equipment:

- that is listed in the part of the AT-HM List headed "Inclusions" under "Self-care"; and
- that is not an excluded AT-HM item.

income tested fee, for an individual in the pre2014 residential contribution class for a day: see subsection 285A-13(1).

The note that accompanies this definition explains that for an individual in the pre-2014 residential contribution class, the calculation of the daily means tested amount involves the individual's income but not their assets (see section 319-15).

Incontinence Associated Dermatitis means a type of irritant contact dermatitis characterised by erythema and oedema of the perianal or genital skin, and may be accompanied by bullae, erosion or secondary cutaneous infection.

The note that accompanies this definition explains that this definition is consistent with the Ghent Global Incontinence Associated Dermatitis Categorisation Tool.

independently mobile: an individual is ***independently mobile*** if the individual's DEMMI score is 13 or more.

index number, for a quarter, means the All Groups Consumer Price Index number (being the weighted average of the 8 capital cities) published by the Australian Statistician for that quarter.

individual nominee: see subsection 6-15(2).

individual's room, in an approved residential care home:

- means a room, or a part of a room, in the home that:
 - is intended to be occupied as personal space by an individual to whom funded aged care services are delivered in the home; and
 - contains a bed to be used by the individual; and
- includes:
 - the areas that are in the immediate vicinity of the bed in the room or the part of the room; and
 - the contents of the room or the part of the room; and
 - an ensuite, or a shared bathroom and toilet, that is for the use of the individual.

Injune means the Injune Multi-Purpose Service, 7 Fifth Avenue, Injune Queensland 4454

Integrated Assessment Tool means the Integrated Assessment Tool published by the Department, as existing on the day this instrument commences.

The note that accompanies this definition refers the reader to the Department's website where the Integrated Assessment Tool could be viewed in 2025..

Integrated Health and Aged Care Services Module means the Integrated Health and Aged Care Services Module published by the Australian Commission on Safety and Quality in Health Care, as existing on 30 June 2025.

The note that accompanies this definition refers the reader to the Australian Commission on Safety and Quality in Health Care website where the Integrated Health and Aged Care Services Module could be viewed in 2025..

judgment has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

key personnel of a person or body to which the Grantee Code of Conduct applies means:

- if the person or body is a registered provider—a responsible person of the registered provider;
- if the body is not a registered provider—any person who:
 - is responsible for the executive decisions of the person or body; or
 - has authority or responsibility for (or significant influence over) planning, directing, operating or controlling the activities of the person or body.

The note that accompanies this definition refers the reader to the definition of **responsible person** in section 12 of the Act.

local region means an aged care planning region specified in the document titled *2018 Aged Care Planning Regions by Statistical Areas Level 2 (SA2) 2016 - Australia* published by the Department, as existing on the day this instrument commences.

The note under this definition refers the reader to the Department's website where the document titled *2018 Aged Care Planning Regions by Statistical Areas Level 2 (SA2) 2016 - Australia* could be viewed in 2025.

lower cognitive ability: an individual who is mobile only with assistance has **lower cognitive ability** if the individual's AFM cognition score is 10 or less.

lower function: an individual who is not mobile has **lower function** if the individual's RUG total score is 17 or more.

lower pressure sore risk: an individual who is not mobile has **lower pressure sore risk** if the individual's Braden total score is 14 or more.

low means individual: an individual to whom a registered provider is delivering funded aged care services for a classification type for the service group residential care is a **low means individual** if, on the start day for the individual for the classification type, the individual's means tested amount was less than the maximum accommodation supplement amount for that day.

low means resident: see section 230-13.

low means resident percentage: see section 230-13.

The note that accompanies this definition refers the reader to the Australian Bureau of Statistic website where the *Australian Statistical Geography Standard (ASGS) Edition 3* could be viewed in 2025..

maximum daily amount of the transitional resident contribution: see subsection 285A-10(1).

maximum permissible interest rate for a day, means the maximum rate for the day worked out in accordance with section 301-5.

maximum possible daily accommodation payment amount for an individual for a day: see step 3 of the method statement in subsection 296-5(3).

means tested care fee, for an individual in the post2014 residential contribution class: see subsection 285A-14(1).

means testing class: each of the following is a **means testing class**:

- full-pensioner;
- part pensioner;
- seniors health card holder;
- self-funded retiree.

mechanical restraint: see subsection 175(4).

medical or psychological treatment in relation to a priority 1 reportable incident under section 165A-25 means treatment that may only be provided by a medical practitioner, nurse practitioner, registered nurse, psychologist or social worker.

medical practitioner has the same meaning as in the National Law.

medical treatment authority, for an individual (the **individual concerned**), means an individual or body that, under an appointment in writing that is in effect under the law of the State or Territory in which the individual concerned accesses funded aged care services, can give informed consent to the provision of medical treatment (however described) to the individual concerned if the individual concerned lacks capacity to give that consent.

medication, in relation to medication management, means a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical or mental health of an individual.

medium cognitive ability: an individual who is mobile only with assistance has **medium cognitive ability** if the individual's AFM cognition score is between 11 and 21 (inclusive).

member of a couple has the same meaning as in the Social Security Act.

merging service delivery branch: see subsection 263A-5(1).

middle weight, in relation to unplanned weight loss, means the weight of an individual recorded in the second month of a quarter.

minimum monetary spend amount, for an approved residential care home that has been, or is proposed to be, significantly refurbished, means the amount worked out by multiplying \$25,000 by 40% of the lower of:

- the total number of individual's rooms in the home before the commencement of the refurbishment; and
- the total number of individual's rooms in the home after the completion of the refurbishment.

mobile only with assistance: an individual is **mobile only with assistance** if the individual's DEMMI score is between 4 and 12 (inclusive).

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 exists from time to time.

The note that accompanies this definition refers the reader to the Department's website where the Modified Monash Model categorisation for a location could be viewed in 2025..

monthly performance report, for a registered provider, means the report required under section 166-610.

MPSP is short for Multi-Purpose Service Program.

MRC Act means the *Military Rehabilitation and Compensation Act 2004*.

music therapist means a person who is registered with the Australian Music Therapy Association as a Registered Music Therapist.

national efficient price: the **national efficient price** for residential care activity is \$280.01.

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

National Safety and Quality Health Service Standards means the standards of that name developed by the Australian Commission on Safety and Quality in Health Care under paragraph 9(1)(e) of the *National Health Reform Act 2011*, as existing on 31 May 2021.

The note that accompanies this definition refers the reader to the Australian Commission on Safety and Quality in Health Care website where the National Safety and Quality Health Service Standards could be viewed in 2025..

NATSIFACP is short for the program known as the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

NDIS screening application means a screening application within the meaning of paragraph 181Y(5)(a) of the NDIS Act.

newly built home: see section 230-20.

nominated entity: see subsection 95-5(1).

no-show circumstances: see subsections 11A-5(3) and (4).

not mobile: an individual is **not mobile** if the individual's DEMMI score is 3 or less.

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

NWUA (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.

occupational therapist means a person who is registered under the National Law in the occupational therapy profession.

occupied bed, for an approved residential care home on a day, means an operational bed for the home that is occupied by an individual to whom funded aged care services are delivered on the day.

offline bed, for an approved residential care home, means a bed covered by the approval of the home that is covered by a notice under section 167 of the Act given in accordance with section 167-70 of this instrument.

old Act wait time, for an individual who, immediately before the transition time, was approved under section 22-1 of the old Act as a recipient of home care but was not a prioritised home care recipient (within the meaning of the old Act), means the time starting at the time the individual's approval as a recipient of home care was given and ending immediately before the transition time.

old Principles means Principles made under section 96-1 of the Old Act.

operational bed, for an approved residential care home, means a bed covered by the approval of the home that is not an offline bed for the home.

orthoptist means a person who is registered with the Australian Orthoptic Board.

orthotist means a person who:

- is a certified member of the Australian Orthotic Prosthetic Association; and
- is certified by that Association as a qualified orthotist.

pedorthist means a person who is registered with Pedorthic Association of Australia as a Certified Pedorthist.

Pension Rate Calculator A means the Rate Calculator at the end of section 1064 of the Social Security Act.

permitted uses reconciliation has the meaning given by section 166-325.

physical restraint: see subsection 17-5(5).

physiotherapist means a person who is registered under the National Law in the physiotherapy profession.

police certificate, for a person, means:

- a report about the person's criminal conviction record prepared by:
 - the Australian Federal Police; or
 - the Australian Criminal Intelligence Commission; or
 - an agency accredited by the Australian Criminal Intelligence Commission; or

- the police force or police service of a State or Territory; or
- for a responsible person of a registered provider that delivers funded aged care services in South Australia, or an aged care worker delivering funded aged care services in South Australia—the screening check known as the Aged Care Sector Employment Check issued to the person by the Department administered by the Minister administering the *Child Safety (Prohibited Persons) Act 2016* (SA).

polypharmacy, in relation to medication management, means the prescription of 9 or more medications to an individual.

post-2014 flexible accommodation class: an individual is in the ***post-2014 flexible accommodation class*** if:

- the individual entered a flexible care service (within the meaning of the old Act) before the transition time; and
- the approved provider of the service charged the individual an accommodation payment (within the meaning of the old Act); and
- if, at the transition time, the individual is not accessing funded aged care services through the residential care service group under a specialist aged care program:
 - the individual has a transition break period; and
 - the transition break period is not more than 28 days; and
- since the transition time, the individual has not ceased accessing funded aged care services through the residential care service group under a specialist aged care program for a continuous period of more than 28 days.

post-2014 home contribution class: an individual is in the ***post-2014 home contribution class*** if:

- on 12 September 2024, the individual was approved as a recipient of home care (within the meaning of the old Act); and
- the individual has not elected, in the approved form, to cease being a member of the class or of the post-2014 residential contribution class.

post-2014 residential accommodation class: an individual is in the ***post-2014 residential accommodation class*** if:

- at the transition time, the individual is in the post-2014 residential contribution class; and
- since the transition time, the individual has not:
 - both:
 - elected, in the approved form, to cease being a member of the post-2014 residential contribution class; and
 - ceased accessing funded aged care services in an approved residential care home and started accessing funded aged care services in another approved residential care home; or
 - ceased accessing funded aged care services in an approved residential care home for a continuous period of more than 28 days.

post-2014 residential contribution class: an individual is in the ***post-2014 residential contribution class*** if the individual has not elected, in the approved form, to cease being a member of the class, and:

- all of the following apply to the individual:
 - before the transition time, the individual entered residential care (within the meaning of the old Act) other than as a recipient of respite care (within the meaning of that Act) and other than residential care provided through a multi-purpose service (within the meaning of the *Subsidy Principles 2014*);
 - immediately before the transition time, the individual was not a continuing residential care recipient (within the meaning of the old Act);
 - if, at the transition time, the individual is not accessing funded aged care services in an approved residential care home:
 - the individual has a transition break period; and
 - the transition break period is not more than 28 days; or
- all of the following apply to the individual:
 - the individual is a member of the post-2014 home contribution class at the transition time;
 - the individual has entered residential care after the transition time;
 - the individual has not elected, in the approved form, to cease being a member of the post-2014 home contribution class.

pre-2014 accommodation class: an individual is ***in the pre-2014 accommodation class*** at a particular time (the ***test time***) that is on or after the transition time if:

- immediately before the transition time, any of the following agreements were in effect for the individual:
 - a formal agreement (within the meaning of the old Act);
 - an accommodation bond agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*);
 - an accommodation charge agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*); or
- all of the following apply to the individual:
 - immediately before the transition time, an agreement of a kind mentioned in paragraph (a) was not in effect for the individual;
 - at the transition time, the individual was not accessing funded aged care services in an approved residential care home, but had previously received residential care through a residential care service (within the meaning of the old Act), and the most recent agreement of any kind under the old Act that had been in effect for the individual was an agreement of a kind mentioned in paragraph (a);
 - at the test time, the individual has a transition break period and the transition break period is not more than 28 days; or
- both of the following apply to the individual:
 - immediately before the transition time, an agreement of a kind mentioned in subparagraph (a)(ii) or (iii) was not in effect for the individual, but the individual was eligible under the old Act to enter into such an agreement;

- at the transition time, the individual was accessing funded aged care services in an approved residential care home;
- unless, before the test time, the individual:
 - had ceased accessing funded aged care services in an approved residential care home (the *first home*); and
 - had started accessing funded aged care services in another approved residential care home (the *second home*); and
 - had elected in the approved form, before starting to access funded aged care services in the second home, to cease being a member of the pre-2014 residential contribution class.

pre-2014 maximum permissible interest rate: see section 287-165.

pre-2014 minimum permissible asset value: see subsection 287-45(3).

pre-2014 residential contribution class: an individual is in the ***pre-2014 residential contribution class*** if:

- immediately before the transition time, the individual was a continuing residential care recipient (within the meaning of the old Act); and
- if, at the transition time, the individual is not accessing funded aged care services in an approved residential care home:
 - the individual has a transition break period; and
 - the transition break period is not more than 28 days; and
- the individual has not elected, in the approved form, to cease being a member of the class.

pressure injury means a localised injury to the skin or underlying tissue, or both, usually over a bony prominence as a result of pressure, shear or a combination of these factors.

previous weight, in relation to unplanned weight loss by an individual in a quarter, means the individual's finishing weight for the previous quarter.

price agreement day, for an individual and an approved residential care home, means:

- the day on which the registered provider for the approved residential care home and the individual enter into an accommodation agreement for the approved residential care home in accordance with section 293 of the Act; or
- if the accommodation agreement between the registered provider for the approved residential care home and the individual is varied because the individual proposes to change the individual's room and the proposed move is voluntary—the day on which the accommodation agreement is varied in relation to the individual's room; or
- if the individual is notified by the registered provider for the approved residential care home that the individual's room is to be changed for 28 days or longer, and the proposed move is not voluntary—the day on which the notice is given.

Pricing Authority advice activity means an activity mentioned in paragraph 131A(1)(c) of the *National Health Reform Act 2011* conducted for the purpose of performing a function mentioned in paragraph 131A(1)(a) of that Act.

principal home has the meaning given by section 11A of the Social Security Act other than subsections 11A(8) and (9) (which deal with the effect of absences from the principal home).

The note that accompanies this definition explains that an individual's principal home may be in a retirement village (see section 12 of the Social Security Act).

priority 1 notice: see section 165A-25.

priority 1 reportable incident: see section 165A-25.

priority 2 notice: see section 165A-30.

priority 2 reportable incident: see section 165A-30.

priority category waiting proportion, for a priority category for a classification type for the service group home support on a day, means the number of waiting individuals who have that priority category for the classification type for the service group divided by the total number of waiting individuals for all priority categories for the classification type for the service group on the day.

prosthetist means a person who:

- is a certified member of the Australian Orthotic Prosthetic Association; and
- is certified by that Association as a qualified prosthetist.

qualifying residential care home, for a payment period: see subsection 23915(1).

Quality Indicator Program Manual means the National Aged Care Mandatory Quality Indicator Program Manual 4.0—Part A, as existing on 1 November 2025.

The note that accompanies this definition refers the reader to the Department's website where the Quality Indicator Program Manual could be viewed in 2025..

quality indicators report, for a registered provider, means the report required by Subdivision C of Division 3 of Part 2 of Chapter 5.

Quality of Care Experience Aged Care Consumers ©Flinders University 2022 (QCEACC) Tool has the same meaning as in the Quality Indicator Program Manual.

Quality of Life Aged Care Consumers ©Flinders University 2022 (QOL-ACC) Tool has the same meaning as in the Quality Indicator Program Manual.

Quality of Life Assessment means an assessment using the Quality of Life Aged Care Consumers ©Flinders University 2022 (QOL-ACC) Tool.

quarterly financial report, for a registered provider, means the report required by section 166-340.

queue rate means:

- for the priority category high for the classification type ongoing for the service group home support—0.25; or
- for the priority category medium for the classification type ongoing for the service group home support—1; or
- for the priority category standard for the classification type ongoing for the service group home support—1.25.

recreational therapist means a person who is a certified member of the Australian Recreational Therapy Association.

reduced daily amount of the resident contribution, for an individual for a day: see subsection 231-17(7).

reference period, for a quarter, has the meaning given by subsection 176-20(6).

refunding event means an event referred to in paragraph 311(1)(a) or (b) of the Act.

refund period means:

- in relation to the refund of a refundable deposit balance—the period within which the refundable deposit balance must be refunded in accordance with section 311 of the Act; or
- in relation to the refund of an accommodation bond balance—the period within which the accommodation bond balance must be refunded in accordance with section 287-102 of this instrument.

refurbishment cost, for an approved residential care home that has been, or is proposed to be, significantly refurbished, means:

- unless paragraph (b) applies—the total cost of the refurbishment or proposed refurbishment of the home; or
- if the refurbishment or proposed refurbishment includes fire safety improvements, and the cost of the fire safety improvements is more than 25% of the minimum monetary spend amount for the home—the total cost of the refurbishment or proposed refurbishment, reduced by the amount by which the cost of the fire safety improvements exceeds 25% of the minimum monetary spend amount for the home.

registered health practitioner has the same meaning as in the National Law.

registered nurse staff member means a staff member of a registered provider who is a registered nurse.

registered training organisation has the same meaning as in the *National Vocational Education and Training Regulator Act 2011*.

rehabilitation counsellor means a person who is a member of the Australian Society of Rehabilitation Counsellors.

reimbursement arrangement has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

remedial massage therapist means a person who holds either of the following qualifications from a registered training organisation:

- a Diploma of Remedial Massage Therapy;
- a Certificate IV in Massage Therapy.

required combined staff average number of care minutes per individual per day in respect of an approved residential care home for a quarter: see subsection 176-20(1).

required registered nurse average number of care minutes per individual per day in respect of an approved residential care home for a quarter: see subsection 176-20(2).

residential care compounding factors: see section 81-8.

residential care fee reduction supplement determination, for an individual, means a determination made under subsection 231-16(2) in relation to the individual (including as varied).

residential care place, for an approved residential care home of a registered provider in which the provider delivers funded aged care services through the service group residential care under the MPSP, means a place allocated to the registered provider for delivering those services in that home.

restorative care means an intensive short-term period of care after an illness or injury to help an individual maintain or regain independence.

restorative care partner: see subsection 148-40(4).

restrictive practices nominee: see subsection 6-15(1).

restrictive practices substitute decisionmaker: see section 6-20.

Rockwood frailty score, for an individual, means the individual's score on the Rockwood Frailty Score assessment item of the AN-ACC Assessment Tool.

RRMA Classification means the document titled *Rural, Remote and Metropolitan Area Classification*, as existing at the transition time, setting out certain categories of areas in Australia that have been determined by the Department by reference to population size and remoteness of locality on the basis of 1991 census data published by the Australian Bureau of Statistics in 1994.

The note that accompanies this definition refers the reader to the Department's website where the RRMA Classification for a location could be viewed in 2025..

RUG total score, for an individual, means the individual's total score on the Resource Utilisation Group - Activities of Daily Living assessment item of the AN-ACC Assessment Tool.

seclusion: see subsection 17-5(6).

second asset threshold:

- for an individual in the post-2014 residential contribution class: see paragraph 319-5(7)(a); or
- in any other case: see paragraph 319-5(7)(b).

second income threshold: see subsection 319-5(3).

seniors health card has the same meaning as in the Social Security Act.

serious offence conviction: a person has a ***serious offence conviction*** if the person has been:

- convicted of murder or sexual assault; or
- convicted of, and sentenced to imprisonment for, any other form of assault.

service activity report for a registered provider, means the report required under section 166-645.

service delivery report, for a registered provider, means the report required under section 166-625.

service demographics report, for a registered provider, means the report required under section 166-735.

settlement has the same meaning as in the *Health and Other Services (Compensation) Act 1995*.

significant compounding factors:

- for a classification assessment for an individual for a classification type for the service group home support—the individual has ***significant compounding factors*** if the home support compounding factors for the individual, considered together, indicate that the individual has significantly higher care needs relative to the needs of other individuals with similar home support functional independence scores and home support needs met scores; and
- for a classification assessment for an individual for the classification type ongoing for the service group residential care—an individual mentioned in an item of the table in section 81-8 has ***significant compounding factors*** if the residential care compounding factors for the individual, considered together, indicate that the individual has significantly higher care needs relative to the needs of other individuals mentioned in that item.

significantly refurbished home means an approved residential care home in relation to which a determination under subsection 230-30(1) or 230-35(1) is in effect.

significant unplanned weight loss, in relation to unplanned weight loss, means a decrease in the weight of an individual that is equal to or greater than 5%, as determined by comparing the finishing weight of the previous quarter against the finishing weight for the current quarter.

Social Security Act means the *Social Security Act 1991*.

social worker means a person who is certified by the Australian Association of Social Workers as an Accredited Social Worker.

sonographer means a person who is registered with the Australian Sonographer Accreditation Registry as an Accredited Medical Sonographer.

specialist Aboriginal or Torres Strait Islander programs means specialist programs for Aboriginal or Torres Strait Islander persons and includes, but is not limited to, the following:

- programs to deliver care and services that are culturally safe for, and tailored to meet the particular needs of, the Aboriginal or Torres Strait Islander persons to whom funded aged care services are being delivered in the approved residential care home in question;
- programs to promote social and cultural engagement and participation of Aboriginal or Torres Strait Islander persons.

specialist aged care program fee: see subsection 286-10(1).

specialist homeless programs means specialist programs for persons with a background as a homeless person and includes, but is not limited to, the following:

- programs and interventions to manage complex behavioural needs of persons with that background;
- programs to promote social engagement and participation of persons with that background.

speech pathologist means a person who is certified by Speech Pathology Australia as a Certified Practising Speech Pathologist.

standing higher everyday living agreement: see section 284-2.

starting weight, in relation to unplanned weight loss, means the weight of an individual recorded in the first month of a quarter.

Statement of Accounting Concepts SAC 1 means Statement of Accounting Concepts SAC 1 “Definition of the Reporting Entity” published by the Australian Accounting Standards Board, as existing on 6 March 2020.

The note that accompanies this definition refers the reader to the Australian Accounting Standards Board website where the Statement of Accounting Concepts SAC 1 could be viewed in 2025..

supported individual: an individual is a **supported individual** if, immediately before the transition time, the individual was a supported resident within the meaning of the *Aged Care (Transitional Provisions) Act 1997*.

surplus and uncommitted funds for a registered provider and a financial year means financial assistance the System Governor, on behalf of the Commonwealth, has granted the registered provider in the financial year relating to the same or similar activities and that are:

- surplus and uncommitted; and

- confirmed by provided financial statements.

target classification type wait time: see section 93-14.

target priority category wait time, for a priority category for a classification type for the service group home support on a day, means:

- for the priority category urgent—1 month; or
- for the priority category high, medium or standard—the result of multiplying the wait time factor on the day by the queue rate for the priority category.

TCP is short for Transition Care Program.

third asset threshold: see subsection 319-5(8).

third income threshold: see subsection 319-5(4).

transitional agreed amount: see subsection 285A-25(2).

transitional basic daily fee: see subsection 285A-11(1).

transitional bed reservation fee: see subsection 285A-20(1).

transitional compensation payment fee: see subsection 285A-10(2).

transitional higher everyday living agreement: see subsection 285A-25(2).

transitional higher everyday living fee: see subsection 285A-25(1).

transitional pre-entry fee: see subsection 285A-15(1).

transitional pre-entry period: see subsection 285A-15(1).

transitional resident contribution: see subsection 285A-5(1).

transition break period, for an individual, means the sum of:

- the number of days in a continuous period that ended immediately before the transition time during which the individual was not being provided with residential care through a residential care service (within the meaning of the old Act) other than because the person was on leave (within the meaning of that Act); and
- the number of days in a continuous period beginning at the transition time during which the individual was not accessing funded aged care services in an approved residential care home.

The period mentioned in paragraph (a) and the period mentioned in paragraph (b) must each be a period of at least one day.

unavoidable service cost: see subsections 284-11(16) and (17).

unplanned weight loss means:

- significant unplanned weight loss; or
- consecutive unplanned weight loss.

unrealisable asset has the meaning given by subsections 11(12) and (13) of the Social Security Act.

unreduced daily amount of the resident contribution, for an individual for a day: see subsection 231-17(6).

unreduced individual contribution for the delivery of a funded aged care service to an individual on a day means the amount that would be the individual contribution for the delivery of the service to the individual on the day if step 4 in the method statement in subsection 273(2) of the Act were disregarded.

veteran means a person:

- who is taken to have rendered eligible war service under section 7 of the Veterans' Entitlements Act; or
- in respect of whom a pension is payable under subsection 13(6) of that Act; or
- who is:
 - a member of the Forces within the meaning of subsection 68(1) of that Act; or
 - a member of a Peacekeeping Force within the meaning of that subsection; or
- who is:
 - a member within the meaning of the MRC Act; or
 - a former member within the meaning of that Act; or
- who is an employee within the meaning of the *Safety, Rehabilitation and Compensation Act 1988*.

The note that accompanies this definition explains that the Acts mentioned in paragraphs (d) and (e) of this definition provide that, in some cases:

- (a) a member of the Forces, or a member of a Peacekeeping Force, includes a person who is no longer serving; and
- (b) an employee includes a person who has ceased to be an employee.

Veterans' Entitlements Act means the *Veterans' Entitlements Act 1986*.

waiting individual, for a priority category for a classification type for a service group on a day, means an individual who:

- has an access approval in effect for the classification type for the service group; and
- has been assigned the priority category for the classification type for the service group; and
- has not been allocated a place for the classification type for the service group.

wait time factor: see section 93-13 of the rules.

Section 6-5 - References to actions taken or statements given

Section 6-5 provides that a reference to an action taken or a statement given by an allied health assistant, allied health professional, diversional therapist or a registered health practitioner is a reference to such actions or statements that are within the person's professional scope of practice.

Section 6-15 - Nominating restrictive practices nominees

Section 6-15 provides that a ***restrictive practices nominee***, for a restrictive practice in relation to an individual means either an individual (a natural person), nominee group (more than one natural person), or if there is more than one individual nominee or nominee group nominated, the individual nominee or nominee group that takes precedence.

In order to be a restrictive practices nominee, the nomination and the individual(s) must meet the requirements set out in subsection 6-15(2) discussed below. If there is no restrictive practices nominee nominated in accordance with section 6-15, item 1 of the table in subsection 6-20(2) (as explained below) would not be applicable.

Paragraph 6-15(1)(a) sets out that if there is only a single nominee then that person is the restrictive practices nominee. Subsection 6-15(1)(b) provides that if there is only a nominee group (discussed below) then that nominee group is the restrictive practices nominee. Subsection 6-15(1)(c) provides that if there is more than one individual nominee, or a nominee group and one or more individual nominees, then the individual nominee or nominee group (as applicable) that takes precedence under the nomination is the restrictive practices nominee (see paragraph 6-15(9)(a)).

This allows the individual (the individual concerned) to nominate more than one individual and/or a nominee group as a restrictive practices nominee and to stipulate who takes precedence in the event that the individual nominates more than one restrictive practices nominee.

Subsection 6-15(2) provides that an ***individual nominee*** for a restrictive practice in relation to an individual concerned means an individual who:

- has been nominated by the individual concerned in accordance with this section as an individual who can give informed consent to the use of the restrictive practice in relation to the individual concerned if they lack capacity to give that consent;
- agreed in writing to the nomination and has not withdrawn the agreement; and
- has the capacity to give the informed consent to the use of a restrictive practice (as mentioned in paragraph (a)).

Subsection 6-15(3) provides that ***nominee group*** for restrictive practice in relation to an individual concerned means a group of individuals:

- who have been nominated by the individual concerned in accordance with this section as a group of individuals who can jointly give informed consent to the use of the restrictive practice in relation to the individual concerned if they lack capacity to give that consent;
- each of whom has agreed in writing to the nomination and has not withdrawn the agreement; and

- each of whom has the capacity to give the informed consent to the use of a restrictive practice (as mentioned in paragraph (a)).

This means that an individual can nominate more than one individual to be a restrictive practices nominee as part of a nominee group.

Subsection 6-15(4) makes clear that an individual may make, vary or revoke a nomination only if they have the requisite capacity to do so.

The reference to ‘capacity’ in subsections 6-15(1) to (4) means that the individual concerned has the mental or cognitive ability to make independent and supported informed decisions about consent to the use of a restrictive practice. An individual’s consent, or lack thereof, to the use of a restrictive practice is not in itself indicative of whether they have capacity.

Subsection 6-15(5) requires that a nomination, variation or revocation of a nomination be made in writing.

Subsection 6-15(6) has the effect of limiting the size of a nominee group to three members or less.

Subsection 6-15(7) provides that an individual cannot make a nomination that includes more than one nominee group. Subsections 6-15(6) and (7) place limits on who the individual concerned can nominate as their restrictive practices nominee. This is intended to balance the choice of the individual with the burden on registered providers in circumstances where they may need to contact a large number of individuals to facilitate their written consent to the nomination. This could result in significant delays to the determination of whether consent will be provided to the use of a restrictive practice.

Subsection 6-15(8) provides that an individual can be nominated as an individual nominee or as a member of a nominee group but not both. The intention of this provision is to reduce complications that may arise if an individual had responsibilities as both an individual nominee and as a member of a nominee group.

Subsection 6-15(9) requires that if a nomination (or a varied nomination) nominates more than one individual nominee, or both one or more individual nominees and a nominee group, the nomination (or varied nomination) must provide for an order of precedence in which the individual nominees and nominee group (as applicable) are nominated.

In addition, when a nominee group is nominated, the nomination or varied nomination must also state the rules that will apply if members of the nominee group cannot agree on whether to give informed consent to the use of a restrictive practice. For example, a nomination may require all members of the nominee group to make a unanimous decision whether to give or refuse informed consent to the use of a restrictive practice, and where agreement cannot be reached, provide for a resolution mechanism (eg, the eldest takes precedence, or the restrictive practice cannot be used at all). The intent of this provision is to provide clarity in respect of the restrictive practices nominee when a dispute occurs.

Subsection 6-15(10) provides that the individual concerned may nominate, as an individual nominee or as a member of a nominee group, an aged care worker of a registered provider that is delivering funded aged care services to the individual concerned only if the aged care

worker also happens to be the partner or relative of the individual concerned. Subsections 11(4) and (5) of the Aged Care Act define the term aged care worker.

The intention of subsection 6-15(10) is to generally exclude aged care workers of a registered provider from being appointed as the restrictive practices nominee to minimise any risk of a conflict of interest arising where a decision must be made regarding the use of a restrictive practice in relation to an individual accessing funded aged care services from that registered provider. Often partners or relatives of the individual may volunteer for the registered provider, and it is not uncommon, especially in rural and remote locations, that partners or relatives may be staff of the registered provider. Subsection 6-15(10) ensures that in these situations, the individual concerned may nominate their family members. A nomination by an individual concerned of an individual nominee or nominee group will only be effective for the purpose of section 6-20 if it complies with all the relevant requirements as set out in this section.

In line with the *Quality of Care Amendment (Restrictive Practices) Principles 2022*, it is intended that the rules will be amended with effect from 1 December 2026 to repeal subsection 6-15. This will end the interim measures introduced to address unexpected outcomes in relation to the interaction of restrictive practices consent arrangements with State and Territory guardianship and consent laws.

Section 6-20 - Meaning of restrictive practices substitute decision-maker

Section 6-20 sets out who is a “restrictive practices substitute decision-maker”. It provides that in the first instance, a restrictive practices substitute decision-maker for a restrictive practice in relation to an individual (individual concerned) is appointed by the law of the State or Territory in which the individual concerned accesses funded aged care services, or under an appointment in writing that is in effect under the law of that State or Territory. The definition makes clear, that the substitute decision-maker is an individual or body that can give informed consent to the use of the restrictive practice in relation to the individual if the individual lacks capacity to give that consent. If such an individual or body cannot be appointed or there are significant delays in making the appointment, section 6-20 then provides for a hierarchy of individuals or bodies who may be the restrictive practices substitute decision-maker depending on the circumstances.

Section 6-20 allows for certain individuals or bodies to be authorised to give (or refuse to give) informed consent to the use of a restrictive practice on an individual’s behalf where the individual lacks the capacity to give that consent (or refusal).

The definition of restrictive practices substitute decision-maker under section 6-20 substantially replicates the previous definition of “restrictive practices substitute decision-maker” in the *Quality of Care Principles 2014*. It means that where an individual lacks capacity to give informed consent to the use of a restrictive practice and an individual or a body is authorised to give (or refuse to give) informed consent on behalf of that individual under the law of the State or Territory in which the individual is accessing funded aged care services, then that individual or body is the restrictive practices substitute decision-maker.

If there is more than one person who has been appointed (whether jointly or otherwise) under the relevant State or Territory law as an individual or body who can give informed consent to the use of a restrictive practice, a registered provider should refer to the relevant State and Territory arrangements to determine the order of precedence. If the relevant State or Territory

arrangements do not provide for an order of precedence, the restrictive practice cannot be used until the matter is resolved by the person or body that made the authorisation because it would be unclear who would be the restrictive practices substitute decision-maker. These arrangements ensure that State and Territory laws that enable an individual or body to give consent to the use of restrictive practices on behalf of a person who does not have capacity to consent to the use of a restrictive practice themselves, are relied on in the first instance. The intention of subsection 6-20(2) is to provide a mechanism to identify a “restrictive practices substitute decision-maker” where there is no clear mechanism under the relevant State or Territory law to appoint an individual or body that can give informed consent to the use of a restrictive practice in respect of an individual where that individual lacks the capacity to do so, or where an application has been made for such an appointment but there is a significant delay in deciding the application. In so doing, it authorises certain persons for the purposes of the use of restrictive practices in relation to an individual under the Act to be able to give (or refuse to give) informed consent to the use of a restrictive practice, when they would not otherwise have this authority under State and Territory laws. The wording of the provision also means that as State and Territory laws are amended, those arrangements must be relied upon in the relevant jurisdiction in the first instance.

This also means that where an individual or body has not been so appointed even though a clear mechanism exists under State or Territory law, or an application for such an appointment is underway but a decision has not yet been made and this is not because of a significant delay, a registered provider cannot use a restrictive practice in relation to an individual who does not have the capacity to give that consent, except in an emergency, and cannot refer to the hierarchy under subsection 6-20(2).

While some States and Territories have clear mechanisms to appoint a person who is a “restrictive practices substitute decision-maker”, others do not have any mechanism or there is ambiguity as to whether, under their laws, such a person or body can be appointed. The intent of this provision is to continue the temporary mechanism to appoint a “restrictive practices substitute decision-maker” where state and territory laws do not have a clear mechanism to appoint a person who can consent to the use of a restrictive practice on behalf of another person that was established under the *Quality of Care Principles 2014*. This means the table setting out the hierarchy can be used when a mechanism under State and Territory law to appoint a “restrictive practices substitute decision-maker” is ambiguous, uncertain, unclear, or unsettled. This section seeks to ensure that Commonwealth legislation does not override State and Territory laws where there are clear mechanisms for an individual or body to be appointed as a person who can give consent to the use of a restrictive practice on behalf of another person, while providing a pathway for approved providers trying to navigate complex and at times unclear state and territory legal arrangements. As this provision is only an interim measure, it is intended to encourage States and Territories to amend their laws to allow for an individual or body to be authorised to give informed consent to the use of a restrictive practice in relation to an individual where the individual lacks the capacity to give consent themselves.

The Government received advice from State and Territory governments that in many jurisdictions, the relevant laws that authorise persons or bodies to give consent on another’s behalf may not allow, and in some cases prevent, the giving of consent across all forms of restrictive practices, or only some, depending on the jurisdiction. Subsection 6-20(2) also makes clear that the table will only have effect to authorise other individuals as a “restrictive practices substitute decision-maker” where there is no individual or body appointed for a

restrictive practice in relation to an individual under the law of a State or Territory in which the individual is accessing funded aged care services. Additionally there must be either no clear mechanism to make such an appointment or an application has been made for an appointment under the law of the State or Territory but there is a significant delay in deciding the application. When determining whether a delay is “significant”, regard should be had to the relevant circumstances of the situation. The intent of this provision, as it applies to delays, is that this arrangement will only be in place for the period in which a decision regarding the appointment is pending. Once the decision about the appointment has been made, then the laws of the State or Territory will prevail, and the table will have no effect in relation to identifying a different person as the restrictive practices substitute decision-maker. This means that if the relevant body decides not to appoint the person the subject of the application, that the restrictive practice cannot be used. This recognises that in the jurisdictions that already have arrangements described in subsection 6-20(1), it can take some time for an appointment to occur. If any item of the table applies and the individual identified in that item does not provide consent to the use of the restrictive practice, then the restrictive practice cannot be used. In these circumstances, registered providers cannot seek consent from another person listed below in the table in subsection 6-20(2).

Item 1 of the table in subsection 6-20(2) will only apply if there is a restrictive practices nominee (outlined in section 6-15, explained above) for the individual concerned. In these circumstances, the restrictive practices substitute decision-maker in relation to the individual is that restrictive practices nominee.

Item 2 of the table will apply if item 1 of the table does not apply. That is, if an individual concerned does not have a restrictive practices nominee, but they do have a partner (including a spouse or de-facto partner) with whom they have a close continuing relationship, who has capacity to act as a restrictive practices substitute decision-maker, and has agreed in writing to be a restrictive practices substitute decision-maker for the individual (and has not withdrawn that agreement), then the restrictive practices substitute decision-maker for the individual concerned is that partner.

Item 3 of the table will only apply where items 1 and 2 do not apply in relation to the individual concerned. This allows a relative or friend of the individual who meets the following criteria, to be that individual’s restrictive practices substitute decision-maker:

- who, immediately before the individual concerned entered an approved residential care home, was an unpaid carer for the individual; and
- who has a personal interest in the welfare of the individual concerned on an unpaid basis; and
- with whom the individual concerned has a close continuing relationship; and
- who has agreed, in writing, to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned (and has not withdrawn that agreement); and
- who has capacity to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned.

Where there is more than one such relative or friend, then the eldest of those individuals (highest age) is the restrictive practices substitute decision-maker. For example, if the individual concerned has two sisters who equally meet the definition in Column 1 of item 3 of the table in subsection 6-20(2), and one sister was born in the year 1966, and the other in the year 1959, then the sister born in the year 1959 is the eldest and therefore the restrictive

practices substitute decision-maker. However, it should be noted that all the criteria in Column 1 must be met by both individuals before deferring to the eldest. For example, if the eldest child of the individual was not a carer for the individual immediately prior to their entry into an approved residential care home, but the youngest child of the individual was, then the youngest child would be the restrictive practices substitute decision-maker, provided all the other criteria in Column 1 have been met.

These arrangements provide a simple non-discretionary way for registered providers to easily determine the restrictive practices substitute decision-maker for an individual. The arrangements also provide legal certainty around who can give (or refuse to give) informed consent to the use of a restrictive practice on an individual's behalf. This is important to the consideration of the immunity arrangements under section 163 of the Act.

“Unpaid basis” and “personal interest” are further clarified in subsections 6-20(3) and (4), explained below.

Item 4 of the table is the fourth tier and is only applicable where items 1, 2, and 3 do not apply. If items 1, 2, and 3 do not apply, but the individual concerned has a relative or friend who meets the following criteria, then that individual is the restrictive practices substitute decision-maker in relation to the individual concerned:

- If the relative or friend has:
 - a personal interest in the welfare of the individual concerned on an unpaid basis; and
 - a close continuing relationship with the individual concerned; and
 - agreed, in writing, to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned (and has not withdrawn that agreement); and
 - capacity to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual concerned.

Column 2 of item 4 of the table also clarifies that if there is more than one such relative or friend, then the eldest of those individuals (meaning of eldest explained above) is the restrictive practices substitute decision-maker.

The requirement in items 2, 3 and 4 of the table that the partner, or relative or friend (as applicable) must have agreed in writing aims to ensure that the individual is willing to fulfil the role of a restrictive practices substitute decision-maker. If the partner, relative or friend (as the case may be) does not agree in writing (for example, they only provide verbal agreement), then those respective items in the table would not be applicable.

In referring to “capacity” in items 2, 3, and 4 of the table, the intent is that the relevant restrictive practices substitute decision-maker must have the mental or cognitive ability to make a decision regarding the use of a restrictive practice in order to meet the criteria. An individual's consent, or lack thereof, to the use of a restrictive practice is not in itself indicative of whether they have capacity.

References to “close continuing relationship” in the arrangements under items 2, 3 and 4 of the table are intended to include relationships where the individual and the individual concerned maintain regular contact, in person, through letters or forms of electronic communication (such as telephone, emails, or social media platforms), and the individual

displays genuine care and interest in the well-being and preferences of the individual concerned through these communications.

Item 5 of the table provides that under the fifth and final tier of the hierarchy of consent arrangements, if items 1, 2, 3 and 4 of the table do not apply, but there is a medical treatment authority for the individual concerned (see definition in section 5-5 above), the restrictive practices substitute decision-maker for the individual is that medical treatment authority. If item 5 applies and the medical treatment authority does not provide consent to the use of a restrictive practice, then the restrictive practice cannot be used.

Column 2 of item 5 also provides that if there are two or more medical treatment authorities under the laws of the State or Territory in which the individual concerned is accessing funded aged care services, and the relevant laws provide an order of precedence for these medical treatment authorities, then the individual or body that takes precedence under that law is the restrictive practices substitute decision-maker in relation to the individual concerned.

However, if there are two or more medical treatment authorities under the laws of the State or Territory in which the individual concerned is accessing funded aged care services, and the laws do not provide for an order of precedence for these medical treatment authorities, but only one of the medical treatment authorities is an individual (that is, a natural person, as opposed to a body or entity), then that individual is the restrictive practices substitute decision-maker for the individual concerned. Lastly, if there are two or more medical treatment authorities under the laws of the State or Territory in which the individual concerned accesses funded aged care services, and the laws do not provide for an order of precedence for these medical treatment authorities, and more than one of the medical treatment authorities is an individual, then the eldest of these individuals is the restrictive practices substitute decision-maker for the individual concerned.

This means, for example, if the individual resides in Victoria, and an individual or body has been appointed as a guardian with the power to make medical treatment decisions (as defined by the *Medical Treatment Planning and Decisions Act 2016 (Vic)*) for the individual concerned, then that individual or body is also authorised under this instrument to make an informed consent decision about the use of a restrictive practice in relation to the individual concerned, if the individual does not have capacity to provide consent themselves. This provision applies regardless of whether the use of a restrictive practice is considered to be 'medical treatment' (however described) under the law of the relevant State or Territory.

Subsection 6-20(3) provides that for the purposes of paragraph (a) of column 1 of item 3 in the table in subsection 6-20(2), a person was an unpaid carer for the individual concerned if:

- the person was not employed, hired, retained or contracted (whether directly or through an employment or recruiting agency) as a carer for the individual concerned; and
- no payment or benefit other than one or more of the following was or will be made or given to the person for being a carer for the individual concerned:
 - a carer payment or equivalent benefit;
 - payment in kind; or
 - a payment or benefit as a beneficiary under the will of the individual concerned.

An example of a person delivering care on an “unpaid basis” is a neighbour who cooks, cleans and provides daily basic care to the person and receives a carers allowance from the government.

Subsection 6-20(4) provides that for the purposes of the reference to “unpaid basis” in paragraph (b) of column 1 of item 3 and paragraph (a) of column 1 of item 4 in the table, a person (who is a relative or friend) has a personal interest in the welfare of the individual concerned on an unpaid basis if:

- the person was not employed, hired, retained or contracted (whether directly or through an employment or recruiting agency) to have that interest, including as a carer or support person; and
- no payment or benefit other than one or more of the following is or will be made or given to the person for having the interest:
 - a carer payment or equivalent benefit;
 - payment in kind; or
 - a payment or benefit as a beneficiary under the individual’s will.

If none of the items in the table in subsection 6-20(2) apply, and the individual concerned does not have capacity to consent to the use of a restrictive practice themselves, restrictive practices cannot be used by the registered provider in relation to that individual. The registered provider should deal with this situation in the same way that they would if an individual or body authorised to provide informed consent denies consent to the use of a restrictive practice.

In cases where there is no clear mechanism under State or Territory law, where no person is able to give (or refuses to give) consent to the use of a restrictive practice, and such use is necessary to ensure the welfare of the individual concerned or others, registered providers should seek the appointment of a medical treatment authority under the relevant State or Territory laws. Once an individual or body has been appointed as the medical treatment authority under the relevant State and Territory laws, the registered provider can rely on that person to be the restrictive practices substitute decision-maker in accordance with item 5 of the table for the purposes of the Commonwealth legal framework.

In respect of item 5 of the table, each State and Territory has its own arrangements for a medical treatment authority to be appointed, as summarised in Table 1, and these arrangements may be revised from time to time.

Table 1: State and Territory medical treatment authority arrangements as at the date of commencement of this instrument

	<u>Terminology</u>	<u>Relevant Law</u>
<u>Australian Capital Territory</u>	<u>Guardian with authority to consent to medical procedure or treatment</u>	<u>Guardianship and Management of Property Act 1991 (ACT)</u>
<u>New South Wales</u>	<u>Guardian with authority to consent to medical or dental treatment</u>	<u>Guardianship Act 1987 (NSW)</u>

<u>Northern Territory</u>	<u>Adult guardian with authority to consent to health care action or decision-maker appointed under an Advance Personal Plan made by the individual</u>	<u>Guardianship of Adults Act 2016 (NT) / Advance Personal Planning Act 2013 (NT)</u>
<u>Queensland</u>	<u>Guardian for an adult with impaired capacity for personal matters (including health matters) or attorney for personal matters (including health matters) under an Enduring Power of Attorney</u>	<u>Guardianship and Administration Act 2000 (Qld) / Powers of Attorney Act 1998 (Qld)</u>
<u>South Australia</u>	<u>Guardian with authority to provide consent to medical treatment</u>	<u>Guardianship and Administration Act 1993 (SA)</u>
<u>Tasmania</u>	<u>Guardian with authority to consent to medical or dental treatment</u>	<u>Guardianship and Administration Act 1995 (Tas)</u>
<u>Victoria</u>	<u>Guardian with the power to make medical treatment decisions</u>	<u>Medical Treatment Planning and Decisions Act 2016 (Vic)</u>
<u>Western Australia</u>	<u>Enduring guardian or guardian authorised to make a treatment decision</u>	<u>Guardianship and Administration Act 1990 (WA)</u>

If there is a genuine emergency, restrictive practices can be used by a registered provider without consent first being sought from the restrictive practices substitute decision-maker if the use is in accordance with section 162-15. However, following that use, the registered provider must determine who the restrictive practices substitute decision-maker is to notify them of the use of the restrictive practice in accordance with section 162-35.

In line with the *Quality of Care Amendment (Restrictive Practices) Principles 2022*, it is intended that the rules will be amended with effect from 1 December 2026 to repeal subsection 6-20(2). This will end the interim measures introduced to address unexpected outcomes in relation to the interaction of restrictive practices consent arrangements with State and Territory guardianship and consent laws.

Division 2 – Matters prescribed for definitions in section 7 of the Act

Section 7-1 – Accommodation bond

This section provides that an **accommodation bond** means an amount that does not accrue daily and that is paid or payable by an individual in the pre 2014 accommodation class in accordance with an accommodation bond agreement.

Section 7-2 – Accommodation bond balance

This section provides that an **accommodation bond balance** is, at a particular time, an amount equal to the difference between:

- an accommodation bond, other than:
 - an accommodation bond that is to be paid by periodic payment; or
 - the part of an accommodation bond that is to be paid by periodic payment; and
- the sum of any amounts that have been, or are permitted to be, deducted from the accommodation bond in accordance with Subdivision D of Division 3 of Part 2 of Chapter 9 of this instrument as at that time.

Section 7-3 – Accommodation charge

This section provides that an **accommodation charge** means an amount that accrues daily and that is paid or payable by an individual in the pre 2014 accommodation class in accordance with an accommodation charge agreement.

Section 7-8 – Approved needs assessors

Section 7-8 prescribes the kinds of entity and criteria for the purposes of the definition of **approved needs assessor** in section 7 of the Act. Paragraph (a) of that definition provides that an **approved needs assessor** means a person who is approved by an entity of a kind prescribed by the rules.

Subsection (1) provides that the kind of entity is an entity specified in the document titled *Single Assessment System assessment organisations by service area, region, state and territory*, published by the Department, as existing on the day this instrument commences.

The note under this subsection refers the reader to the Department's website where the document titled *Single Assessment System assessment organisations by service area, region, state and territory* could be viewed in 2025.

Paragraph (b) of the definition of **approved needs assessor** in section 7 of the Act provides that an **approved needs assessor** is a person who meets any criteria including training or qualification requirements prescribed by the rules.

Subsection (2) provides that the criteria for a person are that the person is an individual who is employed or otherwise engaged by an entity prescribed in subsection (1).

The note under subsection (2) explains that an individual engaged by an entity includes an independent contractor.

Section 7-11 – Cost

This section provides the definition of **cost** for the purposes of section 7 of the Act. The cost for the delivery by a registered provider of a funded aged care service for which the subsidy basis is cost means the amount charged by the provider for the delivery of the service.

Section 7-12 – Direct care

This section provides prescribes funded aged care services for the purposes of the definition of **direct care** of section 7 of the Act. Section 7 of the Act provides that **direct care** means any funded aged care services prescribed by the rules which are delivered to an individual by a direct care staff member.

This section prescribes the following funded aged care services as **direct care**:

- the funded aged care services listed and described in items 2, 3, 4, 5, 6 and 7 of the table in section 8-150 of the rules;
- the funded aged care services listed and described in items 3, 4, 5 and 6 of the table in section 8-155 of the rules.

Section 7-13 – Entry contribution

This section provides the definition of **entry contribution** for the purposes of section 7 of the Act. This section provides that **entry contribution** means a payment that was made before 1 October 1997 by an individual in the pre 2014 accommodation class in accordance with a formal agreement.

Section 7-14 – Entry contribution balance

This section provides the definition of **entry contribution balance** for the purposes of section 7 of the Act. This section provides that **entry contribution balance** is, at a particular time, an amount equal to the difference between:

- the amount of an entry contribution; and
- the sum of any amounts that have been, or are permitted to be, deducted from the entry contribution in accordance with a formal agreement as at that time.

Section 7-17 – Entry day

This section is made for the purposes of the definition of **entry day** in section 7 of the Act. Section 7 of the Act provides that, for a classification type for a service group, **entry contribution** means the day, or the day worked out in accordance with a method, prescribed by the rules. The following subsections under section 7-17 provide that the first day the individual access a funded aged care service for the relevant classification level and relevant classification type for the service group is the relevant entry day.

Subsection (2) provides the entry day for the classification type ongoing. The first day an individual accesses a funded aged care service for the classification type ongoing through a service group is the entry day for the individual for that classification type for that service group.

Subsection (3) provides the entry day for the classification type short-term for the services groups home support, assistive technology and home modifications. The first day an

individual accesses a funded aged care service for a classification level for the classification type short term for the service group home support, assistive technology or home modifications is the entry day for the individual for the period of effect for that classification level.

Subsection (4) provides the entry day for the classification type short-term for the service group residential care. The first day an individual accesses a funded aged care service for the classification type short term for the service group residential care is the entry day for the individual for that classification type for that service group.

Subsection (5) provides the entry day for the classification type hospital transition. The first day an individual accesses a funded aged care service for a classification level for the classification type hospital transition for a service group is the entry day for the individual for the period of effect for that classification level.

Section 7-19 – Homeowner

This section provides the definition of **homeowner** for the purposes of section 7 of the Act. Paragraph 7-19(a) provides that an individual who is not a member of a couple is a **homeowner** if:

- the individual has a right or interest in the individual's principal home; and
- the individual's right or interest in the individual's principal home gives the individual reasonable security of tenure in the home.

Paragraph 7-19(b) provides that an individual who is a member of a couple is a **homeowner** if:

- the individual, or the individual's partner, has a right or interest in one residence that is the individual's principal home, or the partner's principal home, or the principal home of both of them; and
- the individual's right or interest, or the individual's partner's right or interest, in the home gives the individual, or the individual's partner, reasonable security of tenure in the home.

Section 7-20 – Lifetime cap

This section provides the definition of **lifetime cap** for the purposes of section 7 of the Act. The amount for the **lifetime cap** is:

- unless paragraph (b) applies—\$135,318.69; or
- for an individual in the post 2014 home contribution class or the post 2014 residential contribution class—\$84,571.66.

Section 7-21 – Price charged

This section provides that, for the purposes of the definition of **price charged** in section 7 of the Act, the price charged for the delivery by a registered provider of a funded aged care service means the amount charged by the provider for the delivery of the service.

Section 7-22 – Serious injury or illness

Section 7-22 provides that for the purposes of the definition of serious injury or illness in section 7 of the Act, each of the following is also a serious injury or illness:

- malnutrition.
- dehydration.

Section 7-23 – Service Delivery Branch

This section provides the definition of ***service delivery branch*** for the purposes of section 7 of the Act. ***A service delivery branch*** of a registered provider means a place of business of the registered provider through which the provider delivers funded aged care services to an individual through the service group home support, assistive technology or home modifications.

Part 3 – Aged care service list

Part 3 of Chapter 1 outlines the aged care service list which prescribes the list of services for which funding may be payable under the Act. Establishing a single aged care service list will introduce consistency between funded aged care services. It will mean that for the first time, everyone can go to one location to see all the funded aged care services that an older person might be able to access. The aged care service list is to help individuals have discussions with assessors and make decisions about the services they need. It will also provide individuals and providers with clarity about the services that the Commonwealth will fund and under what programs those services are funded.

Division 1 – Preliminary

Section 8-5 – Aged care service list

Section 8-5 provides that for the purposes of subsection 8(1) of the Act:

- each service listed and described in an item of a table in a section of Division 2, 4, 6 or 8 of this Part is a service for which funding may be payable under the Act; and
- this Part lists and describes each service, and specifies the service type that the service is in; and
- this Part specifies, for each service type:
 - the service group the service type is in; and
 - any specialist aged care program under which the service type can be delivered; and
 - whether the service type can only be delivered under a specialist aged care program; and
 - each provider registration category under which the service type can be delivered; and
- this Part specifies, for each service mentioned in paragraph 8(1)(g) of the Act:
 - the means testing category for the service; and
 - the subsidy basis for the service; and
- this Part specifies, for the service groups home support, assistive technology and home modifications, that all service types in those service groups must be delivered in a home or community setting; and
- this Part specifies, for the service group residential care, that all service types in the service group must be delivered in a residential care home.

Section 8-10 – Subsidy basis

Section 8-10 prescribes that the subsidy basis for each funded aged care service referred to in paragraph 8(1)(g) of the Act is cost.

The subsidy basis is cost as the prices for services must reflect the costs to deliver that service. This cost-based approach to prices gives providers the flexibility to charge different prices for services delivered in different circumstances. These circumstances could include:

- days of the week and times of the day (for example, standard business hours and non-standard business hours)
- different types of the same service (for example, personal care for a participant with complex needs and a participant with less complex needs)
- different types of meals (for examples a price for a complete meal and prices for individual elements of a meal such as an entree or dessert).

Section 8-12 – Service types

Section 8-12 provides that for the purposes of subsection 8(2) of the Act, the following service types are prescribed:

- allied health and therapy;
- assistance with transition care;
- care management;
- community cottage respite;
- domestic assistance;
- equipment and products;
- hoarding and squalor assistance;
- home adjustments;
- home maintenance and repairs;
- home or community general respite;
- meals;
- nursing care;
- nutrition;
- personal care;
- residential accommodation;
- residential clinical care;
- residential everyday living;
- residential non-clinical care;
- restorative care management;
- social support and community engagement;
- therapeutic services for independent living;
- transport.

Division 2 – Home support service types

Section 8-15 – Allied health and therapy

Section 8-15 prescribes the services that are included in the service type *allied health and therapy*, in the service group home support.

Subsections (2) and (3) of the provision set out parameters that apply for all allied health and therapy services. These are:

- the service is for the individual to regain or maintain physical, functional or cognitive abilities that support the individual to remain safe and independent at home;
- the service is for the management of conditions related to age-related disability or decline.
- the service may include clinical intervention, expertise, care and treatment, review, education (including techniques for self-management), and advice and supervision to improve capacity;
- the service aims to give the individual the skills and knowledge to manage their own condition and promote independent recovery where appropriate;
- the service may be delivered in person or via telehealth, as appropriate;
- the service may be delivered individually or in a group-based format (such as clinically supervised group exercise classes), as appropriate;

Subsection (3) also sets out that the services can be delivered by a registered health practitioner or allied health professional (as defined in section 5-5 of the rules), except the services provided by Aboriginal or Torres Strait Islander Health Practitioner assistance or Aboriginal and Torres Strait Islander Health Worker assistance where the service may be delivered directly by an Aboriginal or Torres Strait Islander Health Practitioner (as defined in section 5-5 of the rules) or Aboriginal or Torres Strait Islander Health Worker (as defined in section 5-5 of the rules). The provisions allow for the flexible determination of interventions by the professional provided that they meet these parameters and are within the scope of practice of the professional. Subsection (3) also allows for the service to be delivered by an allied health assistant or aged care worker working under the supervision of the professional. This allows for this flexibility to enable the efficient delivery of treatment programs where delivery under supervised delegation is appropriate.

The table under subsection 3 lists the specific types of services in the service type *allied health and therapy* and are outlined below.

Item 1 in the table prescribes allied health assistance as a service in the service type *allied health and therapy*. It is described in column 2 as being allied health therapy assistance.

Item 2 in the table prescribes podiatry as a service in the service type *allied health and therapy*. It is described in column 2 as being podiatry.

Item 3 in the table prescribes social work as a service in the service type *allied health and therapy*. It is described in column 2 as being social work activities.

Item 4 in the table prescribes speech pathology as a service in the service type *allied health and therapy*. It is described in column 2 as being speech pathology.

Item 5 in the table prescribes diet or nutrition as a service in the service type *allied health and therapy*. It is described in column 2 as being assistance with diet or nutrition.

Item 6 in the table prescribes Aboriginal or Torres Strait Islander health practitioner assistance as a service in the service type *allied health and therapy*. It is described in column 2 as being assistance provided by an Aboriginal or Torres Strait Islander health practitioner.

Item 7 in the table prescribes Aboriginal or Torres Strait Islander Health worker assistance as a service in the service type *allied health and therapy*. It is described in column 2 as being assistance provided by an Aboriginal or Torres Strait Islander Health worker.

Item 8 in the table prescribes physiotherapy as a service in the service type *allied health and therapy*. It is described in column 2 as being physiotherapy.

Item 9 in the table prescribes psychology as a service in the service type *allied health and therapy*. It is described in column 2 as being psychology.

Item 10 in the table prescribes exercise physiology as a service in the service type *allied health and therapy*. It is described in column 2 as being exercise physiology.

Item 11 in the table prescribes occupational therapy as a service in the service type *allied health and therapy*. It is described in column 2 as being occupational therapy.

Item 12 in the table prescribes counselling or psychotherapy as a service in the service type *allied health and therapy*. It is described in column 2 as being counselling or psychotherapy.

Item 13 in the table prescribes music therapy as a service in the service type *allied health and therapy*. It is described in column 2 as being music therapy.

Section 8-20 – Assistance with transition care

This section provides a list of services within the service type *assistance with transition care* which are to be provided to individuals in receipt of the specialist aged care program – the Transition Care Program (TCP). Items one to three apply to all individuals receiving funded aged care services through TCP regardless of their care setting. Items one and two must be provided to all individuals receiving funded aged care services through TCP. Item three must be provided as needed to individuals receiving funded aged care services through TCP who need to access a medical practitioner. Items four to seven must be provided to individuals receiving funded aged care services through TCP re in a home/community care setting who need them.

Item 1 in the table prescribes the service transition care management. It is described in column 2 as providing initial and ongoing assessment, planning and management, and coordination and monitoring, of the individual's movement from hospital, through the TCP and back into the community or into a residential care home, including the following:

- ensuring that:
 - the individual's care and services plan is carried out; and
 - progress against the care and services plan goals is monitored;
- acting as a central point of contact;
- liaising with and organising all care requirements provided by external service providers (including registered health practitioners and allied health professionals);
- administration and operation of the TCP, including documentation relating to the individual;

- arranging for another aged care assessment if needed prior to the completion of the individual's transition care episode;
- managing the individual's transition into their post transition care arrangements, including a comprehensive written and verbal handover.

Item 2 in the table prescribes the service assistance to access medical practitioner as a service in the service type *assistance with transition care*. It is described in column 2 as being Transport for the individual to visit a medical practitioner, or assistance in arranging a home visit by a medical practitioner.

Item 3 in the table prescribes the service transition care medication management. It is described in column 2 as the provision of medication management, including:

- Implementation of a safe and efficient system to manage prescribing, procuring, dispensing, supplying, packaging, storing and administering of both prescription and over the counter medicines
- Administration of and monitoring the effects of, medication (including injections), including supervision and physical assistance with taking both prescription and over the counter medication under the delegation and clinical supervision of a registered nurse or other appropriate registered health practitioner.

Item 4 in the table prescribes the service transition care emergency or after hours assistance. It is described in column 2 as the requirement to have at least one suitably skilled employee of the registered provider or an appropriate agency and continuously on call to give emergency assistance when needed.

Item 5 in the table prescribes the service transition care continence management. It is described in column 2 as:

- assisting the individual to:
 - maintain continence or manage incontinence; and
 - use aids and appliances designed to assist continence management;
- the supply of aids and appliances designed to assist continence management to meet the individual's needs, including the following:
 - commode chairs, over-toilet chairs, bed-pans, uridomes, and catheter and urinary drainage appliances;
 - as many continence aids (such as disposable urinal covers, pants, pads, chair pads and enemas) as are needed to meet the individual's needs

Item 6 in the table prescribes the service waste management. It is described in column 2 as the safe disposal of transition care related organic and inorganic was material.

Please note there is a service delivery requirement related to item 1 – transition care management in these rules at section 148-35.

Section 8-25 – Care management

Section 8-25 provides the services that are included in the service type *care management*, in the service group home support. These are reflected in a table form.

Item 1 in the table prescribes home support care management as a service in the service type *care management*. It is described in column 2 as being activities that ensure funded aged care services contribute to the overall wellbeing of the individual, including implementing the care and services plan for the individual, service coordination, monitoring, review and evaluation, advocacy, support and education, but not including administrative costs funded through prices on services.

Administrative costs are considered excluded activities for care management, to ensure that care management funding is used directly for participant-focused activities that contribute to an individual's overall health, wellbeing and quality of life.

The legislative note within column 2 provides that for requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of the Aged Care Rules. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of the Aged Care Rules.

Home support care management is a set of activities that contribute to the overall safety, wellbeing, health and quality of life of an older person. It ensures that the delivery of approved funded aged care services reflects individual needs, preferences and cultural preferences, while assisting participants to understand and access the level of support they need.

Home support care management must be delivered to all participants receiving services under the ongoing Support at Home classifications and the End-of-Life Pathway. This includes participants who are self-managing. This is reflected in the registration criteria for providers at section 109-25 and the service delivery requirement at section 148-45.

Section 8-30 – Community cottage respite

Section 8-30 provides the services that are included in the service type *community cottage respite* in the service group home support. These are reflected in a table form.

Item 1 in the table prescribes cottage respite as a service in the service type *community cottage respite*. It is described in column 2 as being overnight care for the individual that is provided:

- in a cottage-style respite facility; and
- in a community setting (other than in the individual's home, the home of a carer of the individual or the home of a host family); and
- to provide respite for a carer of the individual.

Section 8-35 – Domestic assistance

Section 8-35 provides the services that are included in the service type *domestic assistance*, in the service group home support. These are reflected in a table form.

Item 1 in the table prescribes general house cleaning as a service in the service type *domestic assistance*. It is described in column 2 as being:

- the provision of, or assistance with, light household cleaning, including mopping, vacuuming, washing dishes, and general tidying of surface areas, that ensure the individual remains safe at home;

- the supply of equipment or consumables required for cleaning mentioned above
- but does not include professional cleaning that would usually be paid for by an individual (such as carpet cleaning, pest control, dry cleaning or pet care).

This allows for cleaning that assists the individual to keep their home in a liveable state in order to enable them to stay independent in their homes. It covers tasks the individual would have usually performed themselves and does not extend to specialised cleaning that would have previously involved using a professional.

Item 2 in the table prescribes laundry services as a service in the service type *domestic assistance*. It is described in column 2 as being:

- provision of, or assistance with, laundry activities including but not limited to the laundering of clothing and bedding and the ironing of clothing;
- the supply of consumables required for laundry activities mentioned in above;
- but does not include dry cleaning.

Item 3 in the table prescribes shopping assistance as a service in the service type *domestic assistance*. It is described in column 2 as being the provision of shopping, or assistance with shopping activities, including developing a shopping list, online shopping, driving to a shop and assisting with the collection of shopping, but not including the cost of the shopping.

Section 8-40 – Hoarding and squalor assistance

Section 8-40 provides the services that are included in the service type *hoarding and squalor assistance*, in the service group home support. These are reflected in a table form.

Item 1 in the table prescribes hoarding and squalor supports as a service in the service type *hoarding and squalor assistance*. It is described in column 2 as being services for an individual who is experiencing symptoms of hoarding disorder or who is living in severe domestic squalor, including, for example, the following:

- implementing the care and services plan for the individual;
- a one off clean up;
- review and evaluation;
- linking the individual to specialist support services.

The legislative note in column 2 directs the reader to requirements for care and services plans. See paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of the rules. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of the rules.

Section 8-45 – Home maintenance and repairs

Section 8-45 provides the services that are included in the service type *home maintenance and repairs*, in the service group home support. These are reflected in a table form.

Item 1 in the table prescribes gardening as a service in the service type *home maintenance and repairs*. It is described in column 2 as being:

- The provision of or assistance with, maintenance of a residential garden, including essential light gardening such as mowing lawns, pruning shrubs and clearing yards that contribute to maintaining the individual's home in a safe and habitable condition.

- The service does not include professional gardening services that would usually be paid for by an individual (such as tree removal, landscaping or farm or water-feature maintenance), gardening services that relate to visual appeal rather than safety or accessibility, or services that are the responsibility of other parties (such as landlords or government housing authorities).

Item 2 in the table prescribes assistance with home maintenance and repairs as a service in the service type *home maintenance and repairs*. It is described in column 2 as being:

- Essential minor repairs and maintenance that the individual used to be able to do themselves, or that are required to maintain safety (such as cleaning gutters, replacing lightbulbs and repairing broken door handles), or that are required to address an imminent age-related safety risk (such as repairing uneven flooring that poses a falls risk or a section of carpet damaged by a wheelchair).

The service assistance with home maintenance and repairs is intended to allow for repairs to be completed that broadly would have been completed by the individual previously, except if the individual was previously a tradesperson, trades assistant or handyman with specialist skills and equipment. However, it allows flexibility around where a service that would typically be delivered professionally can be done so as to avoid an immediate safety risk. For example, fixing uneven flooring that would pose a falls risk.

Items 2 and 3 do not allow for professional services that would usually be paid for by an individual or services that are the responsibility of other parties such as landlords or government housing authorities.

Item 3 in the table prescribes expenses for home maintenance and repairs as a service in the service type *home maintenance and repairs*. It is described in column 2 as being the supply of equipment or consumables required for that service.

The provision allows for small items that are required as part of the service ‘assistance with home maintenance and repairs’ such as screws and tap washers.

Section 8-50 – Home or community general respite

Section 8-50 provides the services that are included in the service type *home or community general respite*, in the service group home support. These are reflected in a table form.

Item 1 in the table prescribes flexible respite as a service in the service type *home or community general respite*. It is described in column 2 as being support and assistance for the individual that is provided during the day or overnight and in the individual’s home.

Item 2 in the table prescribes community and centre-based respite as a service in the service type *home or community general respite*. It is described in column 2 as being small day outings or structured group activities for the individual that are provided in a community setting to enable the individual to develop, maintain or support independent living and social interaction.

Column 2 describes both services as providing respite for a carer of the individual.

Section 8-55 – Meals

Section 8-55 provides the services that are included in the service type *meals*, in the service group home support. These are reflected in a table form in the section.

Item 1 in the table prescribes meal delivery as a service in the service type *meals*. It is described in column 2 as being the preparation, packaging and delivery of pre-prepared meals, but not including takeaway food delivery or meal delivery for other members of the household.

Item 2 in the table prescribes meal preparation as a service in the service type *meals*. It is described in column 2 as being support to prepare meals in the home or community.

Column 2 describes both services as not including the cost of ingredients.

Section 8-60 – Nursing care

Section 8-60 provides the services that are included in the service type *nursing care*, in the service group home support. These are reflected in a table form.

- Item 1 in the table prescribes registered nurse clinical care as a service in the service type *nursing care*.
- Item 2 in the table prescribes enrolled nurse clinical care as a service in the service type *nursing care*.
- Item 3 in the table prescribes nursing assistant clinical care as a service in the service type *nursing care*.

Clinical care matters specified in subsection 8-60(2), provided by the clinical professionals in items 1 to 3, include:

- the assessment, treatment and monitoring of clinical conditions;
- administration of medications;
- wound care;
- clinical continence management;
- management of skin integrity;
- education;
- specialist service linkage.

Item 4 in the table prescribes nursing care consumables as a service in the service type *nursing care*. It is described in column 2 as being the supply of consumables used in the delivering of clinical care mentioned in items 1 to 3, including oxygen and specialised products for wound care, continence management and skin integrity.

The provision allows for the purchase of items as specified above. The intent of the provision is not to cover everyday nursing consumables that a nurse would be expected to carry in the course of their typical service delivery (such as bandages and antiseptics). The intent of the provision is to cover consumables required by the individual in relation to an identified clinical need, such as:

- barrier cream and dressings for skin integrity and wound care,
- cannulas, tubing, masks, connectors, nasal tissues and padding used in the supply of oxygen,
- pads, catheters and sheaths for continence.

The provision allows for flexibility in the types of items that can be purchased provided they are related to the needs specified in the provision.

Section 8-65 – Nutrition

Section 8-65 provides the services that are included in the service type *nutrition*, in the service group home support. There is one service which is reflected in a table form.

Item 1 in the table prescribes nutrition supports as a service in the service type *nutrition*. It is described in column 2 as being the supply of supplementary dietary products (enteral and oral) and aids that are required for conditions related to age-related functional decline or impairment, and prescribed by a dietitian or registered health practitioner.

The provision allows for the purchase of dietary products as prescribed by the dietitian or registered health practitioner. There is flexibility as to what products can be purchased, provided that the need for nutrition supplements relates to age-related functional decline or impairment and not an unrelated need, such as weight loss.

Section 8-70 – Personal care

Section 8-70 provides the services that are included in the service type *personal care*, in the service group home support. These are reflected in a table form.

Item 1 in the table prescribes assistance with self-care and activities of daily living as a service in the service type *personal care*. It is described in column 2 as being attendant care to meet essential and ongoing needs (such as mobility, eating and hygiene), but not including professional services that would usually be paid for by an individual (such as waxing or hairdressing).

Item 2 in the table prescribes assistance with self-administration of medications as a service in the service type *personal care*. It is described in column 2 as being assistance with self-administration of medications, including arranging for medications to be dispensed by a pharmacist, but not including prescribing or administering medications.

Item 3 in the table prescribes continence management (non-clinical) as a service in the service type *personal care*. It is described in column 2 as being attendant non-clinical care to manage continence needs (such as support to access advice or funding, or assistance changing aids).

Section 8-75 – Restorative care management

Section 8-75 provides the services that are included in the service type *restorative care management*, in the service group home support. These are reflected in a table form.

Item 1 in the table prescribes home support restorative care management as a service in the service type *restorative care management*. It is described in column 2 as being the provision of specialist coordination services for individuals with the classification level SAH restorative care pathway for the classification type short-term for the service group home support.

Administrative costs are considered excluded activities for restorative care management, to ensure that restorative care management funding is used directly for participant-focused activities that contribute to an individual's overall health, wellbeing and quality of life.

Restorative care management must be delivered by a registered provider to individuals receiving services under the Restorative Care Pathway through an appropriate restorative care partner.

This is reflected in the registration criteria for providers at section 109-25 and the service delivery requirement at section 148-40.

Section 8-80 – Social support and community engagement

Section 8-80 provides the services that are included in the service type *social support and community engagement*, in the service group home support. These are reflected in a table.

Item 1 in the table prescribes group social support as a service in the service type *social support and community engagement*. It is described in column 2 as being support in a group setting, including service and activity identification and linkage.

Item 2 in the table prescribes individual social support as a service in the service type *social support and community engagement*. It is described in column 2 as being support on an individual basis, including service and activity identification and linkage, assistance to participate in social interactions (in-person or online) or assistance to visit services or participate in telephone and web-based check-in services.

Item 3 in the table prescribes accompanied activities as a service in the service type *social support and community engagement*. It is described in column 2 as being accompanying the individual to activities, including attendance at medical or other appointments, but not including the cost of the appointments.

Item 4 in the table prescribes cultural support as a service in the service type *social support and community engagement*. It is described in column 2 as being culturally focused support, including service and activity identification and linkage, assistance to access translating and interpreting services and translation of information into the individual's chosen language, referral pathways to advocacy or community organisations or assistance in attending cultural and community events.

For items 2, 3 and 4, column 2 notes the exclusion of costs as specified under subsection (2) of fees associated with participation in an activity, such as tickets, accommodation and membership fees.

Item 5 in the table prescribes digital education and support as a service in the service type *social support and community engagement*. It is described in column 2 as being technology-focused support, including provision of or assistance with access to training or direct assistance in the use of technologies to improve digital literacy to aid independence and participation (such as paying bills online, accessing telehealth services and connecting with digital social programs), but not including the purchase of smart devices for the purpose of online engagement.

Item 6 in the table prescribes assistance to maintain personal affairs as a service in the service type *social support and community engagement*. It is described in column 2 as being support for maintaining the individual's financial and legal affairs but not including service fees (such as funeral plans or accountant's fees).

For items 1-6, column 2 notes the purpose of the service to facilitate meeting the individual's need for social contact or company or participation in community life (including diverse cultural activities).

Item 7 in the table prescribes expenses to maintain personal affairs as a service in the service type *social support and community engagement*. It is described in column 2 as being an internet or phone service (or both) for an individual who is homeless or is at risk of homelessness, and who needs support to maintain connection to funded aged care services

The provision allows for these utilities to be paid in circumstances as described. The primary intent of the service is to ensure that the participant can maintain connection to the aged care registered provider in the first instance.

Section 8-85 – Therapeutic services for independent living

Section 8-85 provides the services that are included in the service type *therapeutic services for independent living*, in the service group home support. These are reflected in a table.

Subsections (2) and (3) of the provision set out parameters that apply for all of the services:

- the service uses evidence-based techniques to manage social, mental and physical wellbeing in support of the individual remaining safe and independent at home;
- the service is for the management of conditions related to age-related disability or decline;
- the service does not include relaxation massage or fees associated with participation in an activity (such as tickets, accommodation, membership fees, or supplies for an activity such as craft materials);
- the service may include treatment, education and advice;
- the service aims to give the individual the skills and knowledge to manage their own condition and promote independent recovery where appropriate;
- the service may be delivered in person or via telehealth, as appropriate;
- the service may be delivered individually or in a group-based format, as appropriate;
- the service may be delivered directly by a registered health practitioner or allied health professional (as applicable); or by an allied health assistant or aged care worker, under the supervision of a registered health practitioner or allied health professional, where safe and appropriate to do so. Enabling services to be delivered under supervised delegation provides flexibility and efficiency.

The rule allows for the flexible determination of interventions by the registered health professional or allied health professional provided that they meet these parameters, the parameters specified in the items below, and are within the scope of practice of the professional.

Item 1 in the table prescribes acupuncture as a service in the service type *therapeutic services for independent living*. It is described in column 2 as being acupuncture provided by a registered health practitioner but not including herbal medicine.

Item 2 in the table prescribes chiropractics as a service in the service type *therapeutic services for independent living*. It is described in column 2 as being chiropractic therapy provided by a registered health practitioner.

Item 3 in the table prescribes diversional therapy as a service in the service type *therapeutic services for independent living*. It is described in column 2 as being diversional therapy provided by an allied health professional or a diversional therapist

Item 4 in the table prescribes remedial massage as a service in the service type *therapeutic services for independent living*. It is described in column 2 as being remedial massage prescribed by an allied health professional and provided by an allied health professional or a remedial massage therapist.

Item 5 in the table prescribes art therapy as a service in the service type *therapeutic services for independent living*. It is described in column 2 as being art therapy provided by an allied health professional.

Item 6 in the table prescribes osteopathy as a service in the service type *therapeutic services for independent living*. It is described in column 2 as being osteopathy provided by a registered health practitioner.

Section 8-90 – Transport

Section 8-90 provides for the services that are included in the service type *transport*, in the service group home support. These are reflected in a table.

Item 1 in the table prescribes direct transport as a service in the service type *transport*. It is described in column 2 as being provision of a car and driver for group and individual transport services to connect the individual with their usual activities, and including fuel.

Item 2 in the table prescribes indirect transport as a service in the service type *transport*. It is described in column 2 as being supply of a service voucher for taxi or rideshare services for group and individual transport services to connect the individual with their usual activities.

The service type *transport* lists exclusions in subsection 2:

- an individual's purchase of a vehicle;
- an individual's vehicle running costs;
- licence costs;
- professional transit services (such as public transport, flights or ferries);
- travel for holidays.

The rule allows transport to connect an older person with community and attend their usual activities. The service is not intended to cover travel costs associated with other services, such as the service accompanied activities under *social support and community engagement* in Section 8-80, where providers will need to factor any travel costs into the cost for that service.

Division 3 – Other specified matters for home support service types

Section 8-95 – All service types must be delivered in a home or community setting

Section 8-95 provides that all service types in the service group home support must be delivered in a home or community setting.

Home or community setting is defined in subsections 10(6) and 10(7) of the Act. Subsection 10(6) defines **home or community setting** as a place in a home, or in the community, where funded aged care services are delivered. Subsection 10(7) provides that, despite the definition in subsection (6), a **home or community setting** does not include any of the following places:

- A group home funded under the National Disability Insurance Scheme;
- A hospital;
- A psychiatric facility;
- A prison or detention centre;

Home or community setting is intended to be broad to enable the delivery of services in the home support, assistive technology and home modifications service groups in the places that best suit individuals who choose to age at home.

Section 8-100 – Other specified matters—service types that can only be delivered under specialist aged care programs

Section 8-100 provides that certain service types within the service group home support can only be delivered under specialist aged care programs, and the provider registration category under which the service type can be delivered. These are reflected in a table.

Item 1 of the table provides that the service type *assistance with transition care* can only be delivered under the specialist aged care program TCP and can be delivered by a provider registered in the category nursing and transition care.

Item 2 of the table provides that the service type *community cottage respite* can only be delivered under the specialist aged care programs CHSP, MPSP, and NATSIFACP, and can be delivered by providers registered in the category personal and care support in the home or community.

Item 3 of the table provides that the service type *hoarding and squalor assistance* can only be delivered under the specialist aged care programs CHSP, MPSP, and NATSIFACP, and can be delivered by providers registered in the category advisory and support services.

Section 8-105 – Other specified matters—other service types

Section 8-105 provides the service types in the service group home support that can be delivered under a specialist aged care program and the provider registration category under which the service type can be delivered. It also includes the means testing category for the service types. These are reflected in a table form in the section and each item is outlined below.

Item 1 of the table provides that the service type *allied health and therapy* is in the service group home support, can be delivered under the specialist aged care programs CHSP, MPSP, and NATSIFACP, and can be delivered by providers registered in the category personal and

care support in the home or community. The means testing category for this service type is clinical supports.

Item 2 of the table provides that the service type *care management* is in the service group home support, can be delivered under the specialist aged care programs MPSP and NATSIFACP, and can be delivered by providers registered in the category personal and care support in the home or community. The means testing category for this service type is clinical supports.

Item 3 of the table provides that the service type *domestic assistance* is in the service group home support, can be delivered under the specialist aged care programs CHSP, MPSP, NATSIFACP, and TCP, and can be delivered by providers registered in the category home and community services. The means testing category for this service type is everyday living.

Item 4 of the table provides that the service type *home maintenance and repairs* is in the service group Home Support, can be delivered under the specialist aged care programs CHSP, MPSP, NATSIFACP, and TCP, and can be delivered by providers registered in the category home and community services. The means testing category for this service type is everyday living.

Item 5 of the table provides that the service type *home or community general respite* is in the service group Home Support, can be delivered under the specialist aged care programs CHSP, MPSP, and NATSIFACP, and can be delivered by providers registered in the category personal and care support in the home or community. The means testing category for this service type is independence.

Item 6 of the table provides that the service type *meals* is in the service group Home Support, can be delivered under the specialist aged care programs CHSP, MPSP, NATSIFACP, and TCP, and can be delivered by providers registered in the category home and community services. The means testing category for this service type is everyday living.

Item 7 of the table provides that the service type *nursing care* is in the service group Home Support, can be delivered under the specialist aged care programs CHSP, MPSP, NATSIFACP, and TCP, and can be delivered by providers registered in the category nursing and transition care. The means testing category for this service is clinical supports.

Item 8 of the table provides that the service type *nutrition* is in the service group Home Support, can be delivered under the specialist aged care programs MPSP, NATSIFACP, and TCP, and can be delivered by providers registered in the category personal and care support in the home or community. The means testing category for this service is clinical supports.

Item 9 of the table provides that the service type *personal care* is in the service group Home Support, can be delivered under the specialist aged care programs CHSP, MPSP, NATSIFACP, and TCP, and can be delivered by providers registered in the category personal and care support in the home or community. The means testing category for this service type is independence.

Item 10 of the table provides that the service type *restorative care management* is in the service group Home Support, can be delivered under the specialist aged care programs MPSP and NATSIFACP, and can be delivered by providers registered in the category personal and care support in the home or community. The means testing category for this service type is clinical supports.

Item 11 of the table provides that the service type *social support and community engagement* is in the service group Home Support, can be delivered under the specialist aged care programs CHSP, MPSP, and NATSIFACP, and can be delivered by providers registered in the category advisory and support services. The means testing category for this service type is independence.

Item 12 of the table provides that the service type *therapeutic services for independent living* is in the service group Home Support, can be delivered under the specialist aged care programs CHSP, MPSP, and NATSIFACP, and can be delivered by providers registered in the category personal and care support in the home or community. The means testing category for this service type is independence.

Item 13 of the table provides that the service type *transport* is in the service group Home Support, can be delivered under the specialist aged care programs CHSP, MPSP, and NATSIFACP, and can be delivered by providers registered in the category home and community services. The means testing category for this service type is independence.

Division 4 – Assistive technology service types

Section 8-110 – Equipment and products

Section 8-110 provides the services that are included in the service type *equipment and products*, in the service group assistive technology. These are reflected in a table.

Subsection (2) and (3) sets out the means testing category for each service:

- For a service listed and described in any of items 1 to 10 of the table, the means testing category is independence.
- For the service listed and described in item 11 of the table, the means testing category is clinical supports.

Column 1 in the table reflects the names of each service including distinguishing between non-loan (i.e. purchase) and loan items. This categorisation is to enable a reduced individual contribution to be applied to loaned items as per section 273-10 of the rules, so that individual contribution is only payable on 33.3% of the cost of the loaned item.

For items 1 to 10 of the table, column 2 prescribes the requirement that at least one of the following subparagraphs in paragraph 67(1)(b) of the Act applies to the service:

- each of the funded aged care services in the service type, or the funded aged care service, is an in-home, residential or other community support service and access to the funded aged care services in the service type, or the funded aged care service, is necessary to support the individual to live and be included in the community, and to prevent isolation or segregation of the individual from the community;

- access to the funded aged care services in the service type, or the funded aged care service, will facilitate personal mobility of the individual in the manner and at the time of the individual's choice;
- the funded aged care services in the service type each involve, or the funded aged care service involves, a mobility aid or device, or assistive technology, live assistance or intermediaries that will facilitate personal mobility of the individual;
- the funded aged care services in the service type are each, or the funded aged care service is, a health service that the individual needs because of the individual's impairment or because of the interaction of the individual's impairment with various barriers;
- the funded aged care services in the service type are each, or the funded aged care service is, a habilitation or rehabilitation service;
- the funded aged care services in the service type are each, or the funded aged care service is, a service that will assist the individual to access a service mentioned in subparagraph (iv) or (v);
- the funded aged care services in the service type, or the funded aged care service, will minimise the prospects of the individual acquiring a further impairment or prevent the individual from acquiring a further impairment.

Item 1 in the table prescribes managing body functions items (non-loan) as a service in the service type *equipment and products*. It is described in column 2 as being a service:

- that consists of the sourcing, supply and provision to the individual, other than on loan, of included managing body functions items; and
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Item 2 in the table prescribes managing body functions items (loan) as a service in the service type *equipment and products*. It is described in column 2 as being a service:

- that consists of the sourcing, supply and provision to the individual, on loan, of included managing body functions items; and
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Included managing body functions items means a product or item of equipment: (a) that is listed in the part of the AT-HM List headed "Inclusions" under "Managing body functions"; and that is not an excluded AT-HM item.

Item 3 in the table prescribes self-care items (non-loan) as a service in the service type *equipment and products*. It is described in column 2 as being a service:

- that consists of the sourcing, supply and provision to the individual, other than on loan, of included self-care items; and
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Item 4 in the table prescribes self-care items (loan) as a service in the service type *equipment and products*. It is described in column 2 as being a service:

- that consists of the sourcing, supply and provision to the individual, on loan, of included self-care items; and
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Included self-care items means a product or item of equipment that is listed in the part of the AT-HM List headed “Inclusions” under “Self-care” and that is not an excluded AT-HM item.

Item 5 in the table prescribes mobility items (non-loan) as a service in the service type *equipment and products*. It is described in column 2 as being a service:

- that consists of the sourcing, supply and provision to the individual, other than on loan, of included mobility items; and
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Item 6 in the table prescribes mobility items (loan) as a service in the service type *equipment and products*. It is described in column 2 as being a service:

- that consists of the sourcing, supply and provision to the individual, on loan, of included mobility items; and
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Included mobility items means a product or item of equipment that is listed in the part of the AT-HM List headed “Inclusions” under “Mobility” and that is not an excluded AT-HM item.

Item 7 in the table prescribes domestic life items (non-loan) as a service in the service type *equipment and products*. It is described in column 2 as being a service:

- that consists of the sourcing, supply and provision to the individual, other than on loan, of either or both of the following:
 - included domestic life items;
 - conditionally included domestic life items, if the conditions specified for the items in the AT-HM List are satisfied;
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Item 8 in the table prescribes domestic life items (loan) as a service in the service type *equipment and products*. It is described in column 2 as being a service:

- that consists of the sourcing, supply and provision to the individual, on loan, of either or both of the following:
 - included domestic life items;
 - conditionally included domestic life items, if the conditions specified for the items in the AT-HM List are satisfied; and
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Included domestic life item means a product or item of equipment that is listed in the part of the AT-HM List headed “Inclusions” under “Domestic life” and that is not an excluded AT-HM item.

Conditionally included domestic life item means a product or item of equipment that is listed in the part of the AT-HM List headed “Conditional inclusions” under “Domestic life” and that is not an excluded AT-HM item. The purchase or loan of these items will only be funded if the additional criteria specified for these items in the AT-HM List are met.

Item 9 in the table prescribes communication and information management items (non-loan) as a service is the service type *equipment and products*. It is described in column 2 as being a service:

- consists of the sourcing, supply and provision to the individual, other than on loan, of either or both of the following:
 - included communication and information management items, other than items that the individual is able to access under the Hearing Services Program administered by the Department;
 - conditionally included communication and information management items, if the conditions specified for the items in the AT-HM List are satisfied and the individual is not able to access the items under the Hearing Services Program administered by the Department; and
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Item 10 in the table prescribes communication and information management items (loan) as a service in the service type *equipment and products*. It is described in column 2 as being a service:

- consists of the sourcing, supply and provision to the individual, on loan, of either or both of the following:
 - included communication and information management items, other than items that the individual is able to access under the Hearing Services Program administered by the Department;
 - conditionally included communication and information management items, if the conditions specified for the items in the AT-HM List are satisfied and the individual is not able to access the items under the Hearing Services Program administered by the Department; and
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Included communication and information management item means a product or item of equipment that is listed in the part of the AT-HM List headed “Inclusions” under “Communication and information management” and that is not an excluded AT-HM item

Conditionally included communication and information management item means a product or item of equipment that is listed in the part of the AT-HM List headed “Conditional inclusions” under “Communication and information management” and that is not an excluded AT-HM item. The purchase or loan of these items will only be funded if the additional criteria specified for these items in the AT-HM List are met.

Included and conditionally included communication and information management items will only be funded where the individual is not able to access these items under the Hearing Services Program administered by the Department.

Item 11 in the table prescribes assistive technology prescription and clinical support as a service in the service type *equipment and products*. It is described in column 2 as either:

- the following, delivered by a registered health practitioner or an allied health professional;
 - identifying an issue or problem that restricts the individual’s physical, functional or cognitive ability

- assessing the level of assistive technology needed for the individual to regain or maintain physical, functional or cognitive ability
- identifying included AT-HM items and conditionally included AT-HM items (other than included home modifications items) that will assist the individual to regain or maintain physical, functional or cognitive ability; or
- any of the following wraparound activities for the supply to an individual of an included AT-HM item or a conditionally included AT-HM item under a service listed and described in any of items 1 to 10 of the table:
 - setting up, fitting or providing training on the use of the item;
 - providing support and troubleshooting to minimise abandonment of the item;
 - maintenance and follow up for the item (including evaluating the effects on the individual's functioning);
 - if the supply of the item to the individual is covered by a service listed and described in any of item 2, 4, 6, 8 or 10 of the table—maintenance, repair and refurbishment of the item or, at the end of the item's safe working life, disposal of the item;
 - administrative activities relating to the supply of the item.

Division 5 – Other specified matters for assistive technology service types

Section 8-115 – All service types must be delivered in a home or community setting

Section 8-115 prescribes that all service types in the service group assistive technology must be delivered in a home or community setting.

Section 8-120 – Other specified matters for assistive technology service types

Section 8-120 provides that the service type *equipment and products*:

- is in the service group assistive technology; and
- can be delivered under any of the following specialist aged care programs:
 - CHSP
 - MPSP
 - NATSIFACP
 - TCP; and
- can be delivered under the provider registration category assistive technology and home modifications.

Division 6 – Home modifications service types

Section 8-125 – Home adjustments

Section 8-125 provides the services that are included in the service type *home adjustments*, in the service group home modifications. These are reflected in a table form in the Section.

Subsection (2) and (3) sets out the means testing category for each service:

- For a service listed and described in item 1 of the table, the means testing category is independence.

- For the service listed and described in item 2 of the table, the means testing category is clinical supports

For item 1 of the table, column 2 prescribes the requirement that at least one of the following subparagraphs in paragraph 67(1)(b) of the Act applies to the service:

- each of the funded aged care services in the service type, or the funded aged care service, is an in-home, residential or other community support service and access to the funded aged care services in the service type, or the funded aged care service, is necessary to support the individual to live and be included in the community, and to prevent isolation or segregation of the individual from the community;
- access to the funded aged care services in the service type, or the funded aged care service, will facilitate personal mobility of the individual in the manner and at the time of the individual's choice;
- the funded aged care services in the service type each involve, or the funded aged care service involves, a mobility aid or device, or assistive technology, live assistance or intermediaries that will facilitate personal mobility of the individual;
- the funded aged care services in the service type are each, or the funded aged care service is, a health service that the individual needs because of the individual's impairment or because of the interaction of the individual's impairment with various barriers;
- the funded aged care services in the service type are each, or the funded aged care service is, a habilitation or rehabilitation service;
- the funded aged care services in the service type are each, or the funded aged care service is, a service that will assist the individual to access a service mentioned in subparagraph (iv) or (v);
- the funded aged care services in the service type, or the funded aged care service, will minimise the prospects of the individual acquiring a further impairment or prevent the individual from acquiring a further impairment.

Item 1 in the table prescribes home modifications items as a service in the service type *home adjustments*. It is described in column 2 as being a service:

- that consists of the sourcing, supply and provision to the individual of included home modifications items; and
- to which at least one of the subparagraphs in paragraph 67(1)(b) of the Act applies.

Included home modifications item means a product, item of equipment or home modification that is listed in the part of the AT-HM List headed "Inclusions" under "Home modifications"; and that is not an excluded AT-HM item.

Item 2 in the table prescribes home modifications prescription and clinical support as a service in the service type *home adjustments*. It is described in column 2 as being either:

- the following, delivered by a registered health practitioner or an allied health professional:

- identifying an issue or problem that restricts the individual's physical, functional or cognitive ability;
- assessing the level of home modification needed for the individual to regain or maintain physical, functional or cognitive ability;
- identifying included home modifications items that will assist the individual to regain or maintain physical, functional or cognitive ability; or
- any of the following wraparound activities for the supply to an individual of an included home modifications item under the service listed and described in item 1 of the table:
 - setting up, fitting or providing training on the use of the item;
 - coordination activities relating to the supply of the item.

Division 7 – Other specified matters for home modifications service types

Section 8-130 – All service types must be delivered in a home or community setting

Section 8-130 provides that all service types in the service group home modifications must be delivered in a home or community setting. A home or community setting is defined in subsections 10(6) and 10(7) of the Act.

Section 8-135 – Other specified matters for home modifications service types

Section 8-135 provides that the service type *home adjustments*:

- is in the service group home modifications; and
- can be delivered under any of the following specialist aged care programs:
 - CHSP;
 - MPSP;
 - NATSIFACP; and
- can be delivered under the provider registration category assistive technology and home modifications.

Division 8 – Residential care service types

The sections in division 8, outline the care and services that must be provided to all individuals receiving residential aged care services, if they need it. This includes both permanent residents and those receiving residential respite. This is a service delivery requirement under section 148-33 of the rules.

Section 8-140 – Residential accommodation

Section 8-140 provides the services that are included in the service type *residential accommodation*, in the service group residential care. These are reflected in a table form in the section and must be delivered in a residential care home to any individual who needs it.

Item 1 in the table prescribes accommodation as a service in the service type *residential accommodation* which relates to the physical building and grounds of the residential care service. The service is described in column 2 as being:

- capital infrastructure costs and depreciation of buildings and grounds used by individuals;

- communal areas for living, dining and recreation, as well as personal accommodation in either individual or shared rooms;
- refurbishments and replacements of fixtures, fittings and infrastructure;
- maintenance, of buildings and grounds used by individuals, to address normal wear and tear.

Item 2 in the table prescribes accommodation administration as a service in the service type *residential accommodation* which relates to administrative procedures and practices of a residential care home, which support its efficient and effective operation. The service is described in column 2 as being administration relating to the general operation of the residential care home, including accommodation agreements, accommodation bond agreements and accommodation charge agreements.

Section 8-145 – Residential everyday living

Section 8-145 provides the care and services that are included in the service type *residential everyday living*, in the service group residential care. These are reflected in a table form in the section and must be delivered in a residential care home to any individual who needs it.

Item 1 in the table prescribes operational administration and emergency assistance as a service in the service type *residential everyday living* which relates to the administrative procedures and protocols associated with everyday living, as well as the provision of emergency assistance to all individuals living in residential care homes. The service is described in column 2 as being:

- administration relating to:
 - o the delivery of the other services listed and described in the table; and
 - o service agreements;
- emergency assistance, including:
 - o at all times, having at least one suitable employee of the registered provider onsite and able to take action in an emergency;
 - o if an individual is in need of urgent medical attention— providing emergency assistance in accordance with the registered provider’s protocol for providing such assistance;
 - o activation of emergency plans in the case of fire, floods or other emergency;
 - o contingency planning for emergencies; and
 - o staff training for emergencies.

Item 2 in the table prescribes communication services as a service in the service type *residential everyday living* which relates to resident’s ability to maintain contact with family and friends, to avoid social isolation. The service is described in column 2 as access for individuals to an external telecommunications mechanism in the residential care home (and in individual’s rooms if requested), such as telephone, internet or Wi-Fi services, but not including any usage charges or device costs.

Item 3 in the table prescribes utilities (not including electrical equipment brought into the residential care home by individual) a service in the service type *residential everyday living*,

which ensures resident access to essential services, such as plumbing, electricity and water. The service is described in column 2 as being:

- utility running costs for the residential care home (such as electricity, water and gas);
- heating and cooling for bedrooms and common areas to a comfortable temperature;
- testing and tagging of all electrical equipment provided by the registered provider;

Item 4 in the table prescribes cleaning services and waste disposal as a service in the service type *residential everyday living* which ensures the living environment is clean, tidy and well maintained. The service is described in column 2 as being:

- cleanliness and tidiness of the entire residential care home, including the individual's personal area unless the individual chooses to and is able to maintain their personal area themselves; and
- safe disposal of organic and inorganic waste material.

Item 5 in the table prescribes communal furnishings as a service in the service type *residential everyday living* which should be provided for use of residents in the communal areas of the residential care home. The service is described in column 2 as fit-for purpose communal lounge and dining furniture including:

- televisions; and
- outdoor furniture - if the residential care home has a communal outdoor space.

Item 6 in the table prescribes bedroom and bathroom furnishings (other than those that are customised or that the individual chooses to provide) as a service in the service type *residential everyday living* which should be provided for residents in their bedroom and bathrooms. The service is described in column 2 as being:

- a bed and a mattress that meet the individual's care, safety and comfort needs, including, if required, a bed that is adjustable to cater for the individual's needs and accommodates the individual's height and weight;
- equipment or technologies used to ensure the safety of the individual in bed and to avoid injury to the individual and to aged care workers;
- pillows (including, if required, pressure cushions, tri pillows and wedge pillows);
- a bedside table, bedside locker or bedside chest of drawers, wardrobe space, draw screens (for shared rooms), a visitor chair (if required) and an over bed table (if required);
- a fixture or item of furniture where the individual can safely lock and store valuables, if this is not provided by the furniture items mentioned in the point above;
- a chair, with arms, that meets the individual's care, safety and comfort needs, including, if required, a chair with particular features, such as an air, water or gel chair;
- a shower chair (if required), containers for personal laundry, and waste collection containers or bins for bedrooms and bathrooms;

- bed linen, blankets or doonas, air or ripple mattresses (if required), absorbent or waterproof covers, sheeting and bed pads (if required), bath towels, hand towels and face washers; and
- laundering of all products mentioned in the point above;

Item 7 in the table prescribes toiletry goods (other than those that are alternative items requested on the basis of the individual's personal preferences) as a service in the service type *residential everyday living* which should be provided to ensure the comfort and hygiene needs of residents are met. This includes substitute products to meet individual's medical needs. The service is described in column 2 as being:

- facial cleanser (or alternatives such as facial wipes), shower gel or soap, shower caps, shampoo and conditioner;
- toothpaste, toothbrushes and mouthwash;
- hairbrush or comb, shaving cream and disposable razors;
- tissues and toilet paper;
- moisturiser and deodorant;
- cleaning products for dentures, hearing aids, glasses and artificial limbs (and their storage containers);

Item 8 in the table prescribes personal laundry as a service in the service type *residential everyday living* which should be provided by the residential care home, for all linen and resident's personal clothing. This service is described in column 2 as being:

- laundering (other than by a special cleaning process such as dry cleaning or hand washing) items that can be machine washed, using laundry detergents that meet the individual's medical needs, such as skin sensitivities;
- if requested, ironing of machine-washed clothes (other than underwear and socks);
- a labelling system for the individual's clothing, but not including alternate labelling systems requested on the basis of the individual's personal preferences; and
- return of personal laundry to the individual's clothing storage space.

Item 9 in the table prescribes meals and refreshments as a service in the service type *residential everyday living* which requires the provision of food and drink for all residents, which meet their nutritional needs and are respectful of their wishes and preferences. This service is described in column 2 as being:

- at least 3 meals served each day (including the option of dessert with either lunch or dinner) plus morning tea, afternoon tea and supper, of adequate variety, quality and quantity to meet the individual's nutritional and hydration needs;
- special diets where required to meet the individual's medical, cultural or religious needs, including but not limited to enteral feeding, nutritional supplements, texture modified meals and thickened fluids, diets to address food allergies and intolerances, and vegetarian, vegan, kosher and halal diets (but not for meeting the individual's social preferences on food source such as non-genetically modified and organic);
- reasonable flexibility in mealtimes, if requested, so the individual can exercise choice;
- a variety of non-alcoholic beverages available at all times (such as water, milk, fruit juice, tea and coffee);
- eating and drinking utensils and eating aids if needed; and

- snack foods of adequate variety, including fruit and options suitable for texture modified diets, available at all times in the residential care home.

Section 8-150 – Residential non-clinical care

Section 8-150 provides the care and services that are included in the service type *residential non-clinical care*, in the service group residential care. These are reflected in a table form in the section and must be delivered in a residential care home to any individual who needs it.

Item 1 in the table prescribes care and services administration as a service in the service type *residential non-clinical care* which is administrative procedures and practices associated with non-clinical and clinical care. This service is described in column 2 as being:

- the delivery of the other services listed and described in the other items of this table; and
- the delivery of the services in the service type *residential clinical care*.

Item 2 in the table prescribes personal care assistance as a service in the service type *residential non-clinical care* which relates to normal activities of living that an individual would complete on a daily basis, that must be supported by the residential care home where required, through individual attention, individual supervision and physical assistance. This service is described in column 2 as being:

- bathing, showering, personal hygiene and grooming (other than hairdressing);
- dressing, undressing and using dressing aids;
- eating and drinking, and using utensils and eating aids (including actual feeding if necessary); and
- cleaning of personal items (and their storage containers) needed for daily living, including dentures, hearing aids, glasses, mobility aids and artificial limbs.

Item 3 in the table prescribes communication as a service in the service type *residential non-clinical care* which residential care homes must provide to residents to help meet their communication needs. This service is described in column 2 as being:

- assistance to address difficulties arising from impaired hearing, sight or speech, cognitive impairment, or lack of common language (for example, visual aids such as cue cards, paper-based photo or alphabet spelling communication boards or books, photo based easy language written information, and menu and activity choice boards or learning of key phrases); and
- fitting sensory communication aids and checking hearing aid batteries.

Item 4 in the table prescribes emotional support as a service in the service type *residential non-clinical care* which must be provided by the residential care home to ensure the emotional health and wellbeing of residents. This service is described in column 2 as being:

- if the individual is experiencing social isolation, loneliness or emotional distress—ongoing emotional support to, and supervision of, the individual (including pastoral support);
- if the individual is new to the residential care home—assisting the individual to adjust to their new living environment; and
- provision of culturally safe supports that have been determined in consultation with the individual and their supporters (if required).

Item 5 in the table prescribes mobility and movement needs (but not including motorised wheelchairs, electric mobility scooters, customised aids, or mobility aids requested on the basis of the individual's personal preference) as a service in the service type *residential non-clinical care* which residential care homes must provide to assist residents with their mobility and movement needs. This service is described in column 2 as being:

- assisting the individual with moving, walking and wheelchair use;
- assisting the individual with using devices and appliances designed to aid mobility;
- the fitting of artificial limbs and other personal mobility aids;
- supply and maintenance of crutches, quadruped walkers, walking frames, wheeled walkers, standing walkers, walking sticks, wheelchairs, and tilt-in-space chairs;
- aids and equipment used by aged care workers to move the individual, including for individuals with bariatric needs;
- taking into account:
 - the individual's care, safety and comfort needs; and
 - the individual's ability to use aids, appliances, devices and equipment; and
 - the safety of other individuals and of aged care workers and visitors to the residential care home;

Item 6 in the table prescribes continence management as a service in the service type *residential non-clinical care* which residential care homes must provide for residents to maintain their continence or manage their incontinence, including helping them to the toilet, changing of continence products and providing continence aids. This service is described in column 2 as being:

- assisting the individual to:
 - maintain continence or manage incontinence; and
 - use aids and appliances designed to assist continence management; and
- the supply of aids and appliances designed to assist continence management to meet the individual's needs, including the following:
 - commode chairs, over-toilet chairs, bed-pans, uridomes, and catheter and urinary drainage appliances; and
 - as many continence aids (such as disposable urinal covers, pants, pads, chair pads and enemas) as are needed to meet the individual's needs.

Item 7 in the table prescribes recreational and social activities as a service in the service type *residential non-clinical care* which residential care homes must provide to ensure residents have access to a range of different social events and recreational activities and equipment. This service is described in column 2 as being:

- tailored recreational programs and leisure activities (including communal recreational equipment and products) aimed at preventing loneliness and boredom, creating an enjoyable and interesting environment, and maintaining and improving the social interaction of the individual;
- These programs and activities must include the option of:
 - at least one recreational or social activity each day that is not screen-based, television-based or meal-based; and
 - regular outings into the community (but not including the cost of entry tickets, transport or purchased food and beverages associated with the outings).

Section 8-155 – Residential clinical care

Section 8-155 provides the care and services that are included in the service type *residential clinical care*, in the service group residential care. These are reflected in a table form in the section and must be delivered in a residential care home to any individual who needs it.

Item 1 in the table prescribes care and services plan oversight as a service in the service type *residential clinical care* which requires that residential care homes must provide a comprehensive care and services plan for each resident. This service is described in column 2 as being:

- the individual's care and services plan is carried out; and
- progress against the care and services plan goals is monitored.

This also notes that for requirements for care and services plans, see paragraph 148(e) of the Act and Subdivisions A and D of Division 3 of Part 4 of Chapter 4 of the rules. For Aged Care Quality Standards for care and services plans, see subsections 15-20(1) to (3) of the rules.

Item 2 in the table prescribes allied health, rehabilitation and therapeutic exercise therapy programs as a service in the service type *residential clinical care* which residential care homes must provide to ensure the resident has access to an appropriate therapy program developed for them, if it is needed. This service is described in column 2 as being:

- designed by:
 - appropriate registered health practitioners; or
 - appropriate allied health professionals; or
 - appropriate registered health practitioners and appropriate allied health professionals; and
- designed in consultation with the individual and their supporters (if required); and
- delivered in individual or group settings; and
- delivered by, or under the supervision, direction or appropriate delegation of:
 - registered health practitioners; or
 - allied health professionals; or
 - registered health practitioners and allied health professionals; and
- aimed at maintaining and restoring the individual's physical, functional and communication abilities to perform daily tasks for themselves, including through:
 - maintenance therapy that is designed to provide ongoing therapy services to prevent reasonably avoidable physical and functional decline and maintain and improve levels of independence in everyday living; and
 - if required, more focused restorative care therapy on a time-limited basis that is designed to allow the individual to reach a level of independence at which maintenance therapy will meet their needs;

This service does not include the following:

- intensive, long-term rehabilitation services required following (for example) serious illness or injury, surgery or trauma; and
- allied health services and appointments made for or by the individual or their supporters, that are in addition to those required to meet the individual's care needs under programs covered by paragraphs (a) to (e) of item 2.

Item 3 in the table prescribes medication management as a service in the service type *residential clinical care* which the residential care home must provide to residents to ensure they have safe administration of medication. This service is described in column 2 as being:

- implementation of a safe and efficient system to manage prescribing, procuring, dispensing, supplying, packaging, storing and administering of both prescription and over-the-counter medicines;
- administration and monitoring of the effects of medication (via all routes (including injections)), including supervision and physical assistance with taking both prescription and over-the-counter medication, under the delegation and clinical supervision of a registered nurse or other appropriate registered health practitioner; and
- reviewing the appropriateness of medications as needed under the delegation and clinical supervision of a registered nurse, or other appropriate registered health practitioner;
- but not including the cost of prescription and over-the-counter medications.

Item 4 in the table prescribes nursing as a service in the service type *residential clinical care* which details the range of nursing services that must be provided to residents to meet their care needs, either by or under the supervision of a registered nurse. This service is described in column 2 as being:

- initial comprehensive clinical assessment for input to the care and services plan for the individual, carried out:
 - in line with the individual's needs, goals and preferences; and
 - by a registered nurse; and
 - if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied health professionals;
- ongoing regular comprehensive clinical assessment of the individual, including identifying and responding appropriately to change or deterioration in function, behaviour, condition or risk, carried out:
 - in line with the individual's needs, goals and preferences; and
 - by a registered nurse, or an enrolled nurse under appropriate delegation by a registered nurse; and
 - if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied health professionals;
- all other nursing services, carried out:
 - by a registered nurse, or an enrolled nurse under appropriate delegation by a registered nurse; and
 - if required, in consultation with other appropriate registered health practitioners, appropriate allied health professionals, or appropriate registered health practitioners and appropriate allied health professionals.

Column 2 also describes some examples of nursing services including (but not limited to) chronic disease management, wound care, pain management plans and advance care planning.

Item 5 in the table prescribes dementia and cognition management as a service in the service type *residential clinical care* which residential care homes must provide specifically to residents with a cognitive impairment. This service is described in column 2 as being:

- development of an individual therapy and support program designed and carried out to:
 - prevent or manage a particular condition or behaviour; and
 - enhance the individual's quality of life; and
 - enhance care for the individual;
- ongoing support (including specific encouragement) to motivate or enable the individual to take part in general activities of the residential care home (if appropriate).

Item 6 in the table prescribes general access to medical and allied health services as a service in the service type *residential clinical care* which requires the residential care home to ensure the resident has general access to medical and allied health services that meet their particular care needs. This service is described in column 2 as:

- making arrangements for registered health practitioners to visit the individual for any necessary registered health practitioner appointments (but not the cost of the appointments or any gap payments charged for the appointments);
- making arrangements for the individual to attend any necessary registered health practitioner appointments (but not the cost of the appointments or any gap payments charged for the appointments, or transport or escort costs);
- if required, making arrangements for allied health professionals to visit the individual, or for the individual to visit an allied health professional, for any services or appointments mentioned in paragraph (f) of item 2 of this table (but not the cost of the appointments or any gap payments charged for the appointments, or transport or escort costs);
- if required, provision of audio-visual equipment for use with telehealth appointments;
- arranging for an ambulance in emergency situations.

Division 9 – Other specified matters for residential care service types

Section 8-160 – Service types must be delivered in a residential care home

Section 8-160 provides that the care and services listed within the residential care service types (specifically sections 8-140, 8-145, 8-150 and 8-155 of the rules) must be delivered in an approved residential care home by a registered provider. These services must be delivered to any permanent resident or residential respite recipient who needs it.

Section 8-165 – Other specified matters for residential care service types

Section 8-165 provides that the services listed within the residential care service type (specifically sections 8-140, 8-145, 8-150 and 8-155 of the rules) are part of the residential care service group, and can be delivered under:

- the specialist aged care programs of NATSIFACP, MPSP and TCP; and
- the provider registration category residential care.

Part 4 – Other key concepts

Section 11-5 – Provider registration categories

This section prescribes provider registration categories for the purposes of paragraph 11(3)(b) of the Act. The provider registration categories are:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

The note that accompanies this section refers the reader to paragraph 11(3)(a) of the Act which provides that the category residential care is also a provider registration category.

Section 11A-5 – Delivery of funded aged care services

This section provides for matters in relation to late cancellations and no-shows for the purposes of section 11A of the Act.

Subsections 11A(2) to (5) of the Act allows for circumstances where the only reason a provider is unable to provide a certain service is because the individual cancelled late (within the timeframe prescribed by the rules) or did not show for the service. A participant does not show for a service when the participant is not at home or in a pre-determined location when a worker arrives to deliver a scheduled service. This reflects common industry practices and provides protections for the registered provider. A registered provider should include their cancellation and no-show policies in their service agreements with participants.

Subsection 11A-5(1) provides that the period of 2 business days is prescribed for the purposes of late cancellations.

Subsection 11A-5(3) provides the *no-show circumstances* are as follows:

- the service was to be delivered by the registered provider to the individual through the service group home support, assistive technology or home modifications; and
- the service was scheduled to be delivered by the registered provider to the individual on the day referred to in paragraph 11A(2)(b) of the Act at an agreed time and place; and
- the only reason that the service was not delivered was:
 - the individual was required to be present (whether physically, by video link or other means) for the delivery of the service; and
 - the individual was not present as agreed for the delivery of the service on that day and at that time and place; and
 - the individual did not cancel the delivery of the service before the agreed time.

Subsection (4) also provides that a *no-show circumstances* also apply in relation to a service if:

- the service was to be delivered by the registered provider to the individual through the service group home support, assistive technology or home modifications; and

- the service was scheduled to be delivered by the registered provider to the individual on the day referred to in paragraph 11A(2)(b) of the Act at an agreed time and place; and
- the only reason that the service was not delivered was because the individual refused, or refused or failed to facilitate, access to the agreed place necessary for the delivery of the service.

Subsection 11A-5(5) provides that the circumstances in which subsection 11A(2) of the Act does not apply to a service is that the service was to have been delivered by a specialist aged care program (CHSP, MPS, NATSIFAC and TCP).

Part 5 – Aged Care Code of Conduct

Section 14-1 – Purpose of this Part

For the purposes of section 14 of the Act, section 14-1 confirms that this Part prescribes requirements in relation to the conduct of registered providers, aged care workers of registered providers, and responsible persons of registered providers. The Note of this section confirms the requirements are the Aged Care Code of Conduct, per section 7 of the Act.

Section 14-5 – Requirements

Section 14-5 prescribes requirements that must be adhered to in the course of delivering funded aged care services to individuals. This section refers to “I” to ensure the requirements are read and applied in the first person and in accordance with subsection 14-10(2).

Subsection 14-5(a) requires that registered providers, aged care workers of registered providers and responsible persons of registered providers must act with respect for individuals’ rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions.

The applicable laws and conventions are those laws and conventions that describe the human and legal rights afforded to individuals in the community and as individuals receiving funded aged care. For the aged care context, this includes Commonwealth aged care laws and state and territory laws about decision making and relevant human rights conventions, including the International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights and the Convention on the Rights of Persons with Disabilities.

The list under subsection 14-5 is not meant to be exhaustive.

Subsection 14-5(a) makes clear that registered providers, aged care workers of registered providers and responsible persons of registered providers must:

- support individuals to determine how they live and what happens to them. This includes supporting individuals to exercise choice and control over their care, funded aged care services they are provided with and to exercise dignity of risk where they wish; and
- support individuals to make decisions, including upholding their right to involve persons they have chosen in making decisions, and to use supported decision making (where appropriate or required).

Subsection 14-5(b) requires that registered providers, aged care workers of registered providers and responsible persons of registered providers must act in a way that treats individuals with dignity and respect and values their diversity. This includes recognising and appreciating an individual's individuality and diverse needs in all aspects of funded aged care services.

Subsection 14-5(c) requires that registered providers, aged care workers of registered providers and responsible persons of registered providers act with respect for the privacy of individuals. This includes respecting an individual's personal and physical privacy and ensuring individuals are not unnecessarily subjected to embarrassment or discomfort during service delivery.

Subsection 14-5(d) requires that registered providers, aged care workers of registered providers and responsible persons of registered providers deliver funded aged care services in a safe and competent manner, with care and skill. This means that care should be provided with attention, kindness and empathy, aged care workers and responsible persons should be sufficiently competent in their roles and be able to work in a safe manner, and continuity of care is supported through accurate record keeping and information sharing between aged care workers and with responsible persons.

Subsection 14-5(e) requires that registered providers, aged care workers of registered providers and responsible persons of registered providers act with integrity, honesty and transparency. This includes not providing inaccurate information, failing to disclose a conflict of interest or working despite being subject to an exclusion or revocation or suspension for a working screening check.

Subsection 14-5(f) requires that registered providers, aged care workers of registered providers and responsible persons of registered providers promptly take steps to raise and act on concerns about matters that may impact the quality and safety of funded aged care services. This is intended to safeguard against unsafe or poor quality care through the early identification and notification of risks that may impact the delivery of care to individuals.

Subsection 14-5(g) requires that registered providers, aged care workers of registered providers and responsible persons of registered providers deliver funded aged care services free from all forms of violence, discrimination, exploitation, neglect, and abuse and sexual misconduct.

Subsection 14-5(h) requires that registered providers, aged care workers of registered providers and responsible persons of registered providers take all reasonable steps to prevent and respond to all forms of violence, discrimination, exploitation, neglect and abuse and sexual misconduct.

The meaning of "sexual misconduct" in subsections 14-5(g) and 14-5(h) is intended to be consistent with the meaning of "unlawful sexual contact or inappropriate sexual conduct" referred to in subsection 16-5(4).

Section 14-10 – Application of requirements

Subsection 14-10(1) confirms that the requirements of section 14-5 apply to registered providers, aged care workers of registered providers, and responsible persons of registered providers in accordance with this section.

Subsection 14-10(2) confirms the requirements apply as if the reference to “I” is a reference to all registered providers, aged care workers of aged care providers, and responsible persons of registered providers.

Subsection 14-10(3) relates to the responsible person of a registered provider delivering funded aged care services to individuals. For the purpose of the application of requirements in relation to a responsible person, the requirements apply to the performance of the responsible person in respect of their responsibilities and functions as a responsible person in relation to the provision of funded aged care services.

The Note in this subsection outlines the provisions relevant to compliance with the Aged Care Code of Conduct, including the following:

- section 142 of the Act (civil penalties for non-compliance with conditions of registration of registered providers);
- section 145 of the Act (condition of registration of registered providers
- section 173 of the Act (civil penalties for aged care workers);
- section 174 of the Act (civil penalties for responsible persons)
- subparagraph 498(2)(d)(i) of the Act (grounds for banning orders against individuals who are or were aged care workers or responsible persons of a registered provider).

Part 6 – Quality Standards

Division 1 – Purpose and application

Section 15-1 – Purpose of this Division

Section 15-1 provides that for the purposes of subsection 15(1) of the Act, this division:

- Prescribes standards relating to the quality of funded aged care services delivered by a registered provider, and
- Provides for the application of the standards to registered providers in specified provider registration categories.

For the purposes of section 15 of the Act, section 15-1 confirms that this Part prescribes the Aged Care Quality Standards (the Standards) relating to the quality of funded aged care services delivered by a registered provider and provides for the application of the standards to registered providers in specified provider registration categories.

In response to recommendation 19 of the Royal Commission. The department completed a review of the existing Aged Care Quality Standards including a focus on key areas recommended by the Royal Commission (including dementia, diversity, governance, clinical care and food and nutrition).

Following significant consultations from December 2021, the review produced a final draft of the ‘strengthened’ Aged Care Quality Standards, published on the department’s website in December 2023. This December 2023 version of the Aged Care Quality Standards was used to draft the rules included as part of Release 3 of the Aged Care Act Rules. The Aged Care Quality Standards rules in this Part 6 have been finalised following the sector consultations on the draft rules in early 2025. A final version of the Aged Care Quality Standards has also been published on the department’s website

(<https://www.health.gov.au/resources/publications/strengthened-aged-care-quality-standards-august-2025> as accessible at September 2025).

The standards referred to in this Part are the (strengthened) Aged Care Quality Standards. There are 7 Aged Care Quality Standards:

- Standard 1: The individual (see section 15-10 below)
- Standard 2: The organisation (see section 15-15 below)
- Standard 3: The care and services (see section 15-20 below)
- Standard 4: The environment (see section 15-25 below)
- Standard 5: Clinical care (see section 15-30 below)
- Standard 6: Food and nutrition (see section 15-35 below)
- Standard 7: The residential community (see section 15-40 below).

Each Aged Care Quality Standard contains several outcomes with an ‘Outcome Statement’ and a number of ‘Actions’ sitting below each outcome.

- The ‘Outcome Statements’:
 - are the enforceable measure of the Standards
 - are what providers are required to demonstrate their conformance with during an audit conducted under section 110 of the Act and
 - are included in the rules in this Part.
- The ‘Actions’:
 - are not enforceable under the Aged Care Quality Standards
 - guide how providers can demonstrate compliance or conformance with the Outcomes for the purposes of an audit conducted under section 110 of the Act relating to an entity’s ability to conform with the Aged Care Quality Standards
 - are not included in the rules in this Part
 - are included in the published version of the Aged Care Quality Standards (<https://www.health.gov.au/resources/publications/strengthened-aged-care-quality-standards-august-2025>).

The Standards will be reviewed every 5 years following their implementation under the Act as outlined in subsections 15(4) to 15(8) of the Act.

Sector implementation of the Standards has been supported by a significant change and transition program led by the Aged Care Quality and Safety Commission (ACQSC). As part of this, the ACQSC has developed guidance materials to help providers, individuals and the sector understand their rights and obligations relating to the Standards. This guidance can be found on the ACQSC’s website at:

- Draft Strengthened Quality Standards guidance | Aged Care Quality and Safety Commission (<https://www.agedcarequality.gov.au/strengthened-quality-standards> as accessed September 2025).

For the purposes of the Standards in this Part, the term ‘supporters’ of older people has the same meaning as ‘supporters’ under section 7 of the Act.

Section 15-5 – Application of standards

The Aged Care Quality Standards were developed as part of broader aged care regulatory reforms. They have been designed to work together with other reforms under the Act, including the new model for regulating aged care. As part of this regulatory model, the Aged

Care Quality Standards are a condition of registration that a registered provider may need to comply with under section 146 of the Act.

- There are a number of other conditions of registration and obligations that may apply to registered providers under the Act. Some conditions of registration complement the requirements of the Aged Care Quality Standards. For example, the condition of registration on complaints, feedback and whistleblowers applies to all registered providers and prescribes further details than what is included in the Aged Care Quality Standards. Providers should reflect both requirements in a single complaints and feedback procedure to meet conditions of registration.
- Notes have been added under the relevant rules in this Part where there are related conditions of registration or related obligations under the Act.

For the purposes of section 15 of the Act, the Aged Care Quality Standards apply to registered providers based on the service types they provide under their registration category. Section 15-5 outlines which provider registration categories apply to each Aged Care Quality Standard.

Subsection (1) provides that Standards 1 to 4 (The individual; The organisation; The care and services; The environment) apply to a registered provider in any of the following provider registration categories:

- Personal and care support in the home or community
- Nursing and transition care
- Residential care

Subsection (2) provides that Standard 5 (Clinical care) applies to a registered provider in either of the following provider registration categories:

- Nursing and transition care;
- Residential care

Subsection (3) provides that subsections (1) and (2) under section 15-30 (Standard 5 – Outcome 5.1: Clinical governance) applies to a registered provider in the provider registration category personal and care support in the home or community that delivers, or intends to deliver, either of the following service types:

- Care management;
- Restorative care management

Subsection (4) provides that Standards 6 and 7 (Food and nutrition; The residential community) apply to a registered provider in the provider registration category residential care.

Alternatively, the strengthened Aged Care Quality Standards apply to each provider registration category as follows.

- For the purposes of subsection (1), registered providers in registration category 4 (Personal care and care support in the home or community (including respite)) are required to conform with Standards 1 to 4 (The individual; The organisation; The care and services; The environment).

- In addition, and for the purposes of subsection (3), registered providers in registration category 4 (Personal care and care support in the home or community (including respite)) who deliver ‘care management’ and ‘restorative care management’ service types, will also be required to demonstrate conformance with Outcome 5.1 (Clinical Governance) under Standard 5 for these service types only.
- For the purposes of subsection (2), registered providers in registration category 5 (Nursing and transition care) are required to conform with Standards 1 to 5 (The individual; The organisation; The care and services; The environment; Clinical care).
- For the purposes of subsection (4), registered providers in registration category 6 (Residential care) are required to conform with all 7 standards (The individual; The organisation; The care and services; The environment; Clinical care, Food and nutrition; The residential community).
- By exclusion, this means that registered providers in registration categories 1 to 3 (Home and community services; Assistive technology and home modifications; and Advisory and support services) are not required to conform with the Aged Care Quality Standards.
 - While registered providers in registration categories 1 to 3 are not required to conform with the Aged Care Quality Standards, they will be required to meet certain obligations and other conditions of registration as part of their registration. This includes compliance with the Aged Care Code of Conduct (under section 14 of these rules), worker screening (under section 7-5 of these rules), incident reporting requirements and obligations (under section 16 of these rules).

A summary table outlining how the Aged Care Quality Standards apply to each provider registration category is included on the department’s website here:
<https://www.health.gov.au/our-work/new-model-for-regulating-aged-care/how-it-works>

Division 2 – The standards

Section 15-10 – Standard 1—The individual

Section 15-10 provides for Standard 1 relating to the individual.

Standard 1 underpins the way that providers and aged care workers are expected to treat older people and is relevant to all standards. Standard 1 reflects important concepts about dignity and respect, older person individuality and diversity, independence, choice and control, culturally safe care and dignity of risk. These are all important in fostering a sense of safety, autonomy, inclusion and quality of life for older people.

It is expected that these key concepts under Standard 1 will be incorporated into every aspect of the older person’s care whether it be clinical care, food and nutrition or care assessment and planning.

Standard 1 also reflects that:

- Older people are valuable members of society, with rich and varied histories, characteristics, identities, interests and life experiences

- Older people can come from a diverse range of backgrounds and groups, including, but not limited to, Aboriginal or Torres Strait Islander persons, people from culturally and linguistically diverse backgrounds, people living in rural or remote areas, people who are financially or socially disadvantaged, people who are veterans, people experiencing homelessness or at risk of becoming homeless, people who are care leavers (i.e. a who spent time in care as a child), parents separated from their children by forced adoption or removal, people who are lesbian, gay, bisexual, transgender or intersex, people of various religions, people experiencing mental health problems and mental illness, people living with cognitive impairment including dementia, people living with disability.

Under Standard 1, a person's diversity does not define who they are, but it is critical that providers recognise and embrace each person's diversity and who they are holistically as a person, and that this drives how providers and aged care workers engage with older people and deliver their funded aged care service.

For Standard 1, older people can expect to have the right to be treated with dignity and respect and to live free from any form of discrimination. They can expect to make decisions about their funded aged care services, with support when they want or need it. Each older person's identity, culture and diversity are valued and supported and have the right to live the life they choose. The provider understands who older people are and what is important to them, and this determines the way their funded aged care services are delivered.

Standard 1 also directly links to the Statement of Rights under the Act by reflecting important concepts about person centred care, privacy, dignity and respect, older person individuality and diversity, independence, choice and control, culturally safe care and dignity of risk.

- References to 'cultural safety', 'culturally safe' or similar are not limited to Aboriginal or Torres Strait Islander persons' culture and includes spiritually, socially, emotionally and physically safe and respectful environments (refer to the ACQSC's Glossary here: <https://www.agedcarequality.gov.au/glossary>).

Standard 1 includes the following outcomes:

- Outcome 1.1: Person-centred care
- Outcome 1.2: Dignity, respect and privacy
- Outcome 1.3: Choice, independence and quality of life
- Outcome 1.4: Transparency and agreements

Standard 1 applies to registered providers in provider registration categories 4, 5 and 6 as outlined in section 15-5.

Outcome 1.1: Person-centred care

Outcome 1.1 comprises subsections (1), (2) and (3) under section 15-10.

Subsection (1) provides that the registered provider must demonstrate that the provider understands that the safety, health, wellbeing and quality of life of individuals is the primary consideration in the delivery of funded aged care services.

The note points the reader to the related condition of registration in subsection 144(2) of the Act regarding the Aged Care Rights and Principles.

Subsection (2) provides that the provider must demonstrate that the provider understands and values individuals including their identity, culture, ability, diversity, beliefs and life experiences.

The note points readers to section 23 of the Act regarding the Statement of Rights and to the related condition of registration in section 144 the Rights and Principles.

Subsection (3) provides that the provider must demonstrate that the provider develops funded aged care services with, and tailored to, individuals, taking into account their needs, goals and preferences.

Subsection (3) reflects that registered providers develop and deliver funded aged care services to individuals in accordance with their assessed needs, goals and preferences as outlined in a care and services plan where used. This can also mean the development of funded aged care services across the provider organisation's service offering. This is consistent with the commentary in section 6 of the Act (Simplified outline of this Act) and the definition of funded aged care services in section 9 of the Act.

Outcome 1.2: Dignity, respect and privacy

Outcome 1.2 comprises subsections (4) and (5) under section 15-10.

Subsection (4) provides that the provider must deliver funded aged care services to individuals in a way that:

- is free from all forms of discrimination, abuse and neglect; and
- treats individuals with dignity and respect; and
- respects the personal privacy of individuals.

The note points the reader to section 23 of the Act, the Statement of Rights, and to the related condition of registration in section 144 of the Act, the Rights and Principles.

Subsection (5) emphasises the importance of the rights of older people (under Outcome 1.2) and requires that providers demonstrate they understand the rights of older people set out in the Statement of Rights under the Act and that they have practices in place to ensure that they deliver care and services consistent with those rights being upheld.

Subsection (5) provides that the provider must:

- demonstrate that the provider understands the rights of individuals under the Statement of Rights; and
- must have practices in place to ensure that the provider acts compatibly with the Statement of Rights; and
- must have practices in place to ensure that the provider acts compatibly with the Statement of Rights, in accordance with subsection 24(2) of the Act (acting compatibly with the Statement of Rights).

The note points readers to the related condition of registration in section 144 of the Act, the Rights and Principles.

Outcome 1.3: Choice, independence and quality of life

Outcome 1.3 comprises subsections (6), (7) and (8) under section 15-10.

Subsection (6) provides that the provider must support individuals to exercise choice and make decisions about their funded aged care services, and provide them with support to exercise choice and make decisions when they want or need it.

Subsection (7) provides that the provider must provide individuals with timely, accurate, tailored and sufficient information about their funded aged care services, in a way that the individual understands.

The note points readers to the related condition of registration in section 155 of the Act, provision of information to individuals.

Subsection (8) provides that the provider must support individuals to exercise dignity of risk to achieve their goals and maintain independence and quality of life.

Outcome 1.4: Transparency and agreements

Outcome 1.4 comprises subsections (9) and (10) under section 15-10.

Subsection (9) provides that before entering into any agreements with individuals about the delivery of funded aged care services, the provider must provide individuals with:

- the opportunity to exercise autonomy, and
- the time they need to consider the agreement, and
- an opportunity to seek advice.

The amount of ‘time they need’ referred to in the second dot point under subsection (9) is relative to the needs of each individual. This reflects the person-centred care focus under the Act and these standards.

The note under subsection (9) points readers to refer to sections 148-65 and 148-70 of this instrument in relation to the requirements for entering into a service agreement, details and contents of such an agreement.

Subsection (10) provides that the provider must support individuals to understand and make informed decisions about their agreements, fees and invoices.

Section 15-15 – Standard 2—The organisation

Section 15-15 provides for Standard 2 relating to the organisation.

Standard 2 sets out the expectations of the governing body to meet the requirements of the Aged Care Quality Standards and deliver quality funded aged care services. The governing body sets the strategic priorities for the organisation and promotes a culture of safety and quality. The governing body is also responsible for driving and monitoring improvements to funded aged care services, including through the provider, informed by engagement with older people, their supporters and aged care workers, and data and information on care quality.

Under Standard 2, a registered provider’s governance systems and workforce are critical to the delivery of safe, quality, effective and person-centred care for every older person, and

continuous care and services improvement. Standard 2 ensures aged care workers are empowered to do their jobs well.

For Standard 2, older people can expect that the organisation is well run and can contribute to improvements to care and services. Older people can expect that their provider and aged care workers listen and respond to their feedback and concerns and that they receive funded aged care services from aged care workers who are knowledgeable, competent, capable and caring.

Standard 2 includes the following outcomes:

- Outcome 2.1: Partnering with individuals
- Outcome 2.2a: Quality, safety and inclusion culture to support aged care workers to deliver quality care
- Outcome 2.2b: Quality, safety and inclusion culture to support individuals
- Outcome 2.3: Accountability, quality system and policies and procedures
- Outcome 2.4: Risk management
- Outcome 2.5: Incident management
- Outcome 2.6a: Complaints and feedback management for aged care workers
- Outcome 2.6b: Complaints and feedback management for individuals
- Outcome 2.7: Information management
- Outcome 2.8: Workforce planning
- Outcome 2.9: Human resource management
- Outcome 2.10: Emergency and disaster management

Standard 2 applies to registered providers in provider registration categories 4, 5 and 6 as outlined in section 15-5.

Outcome 2.1: Partnering with individuals

Outcome 2.1 comprises subsection (1) under section 15-15.

Subsection (1) provides that the registered provider must engage in meaningful and active participation with individuals to inform organisational priorities and continuous improvement.

The note points readers to section 147 of the Act and Division 2 of Chapter 4 of these rules about conditions of registration relating to continuous improvement.

Outcome 2.2a: Quality, safety and inclusion culture to support aged care workers to deliver quality care

Outcome 2.2a comprises subsection (2) under section 15-15.

Subsection (2) provides that the governing body must lead a culture of quality, safety and inclusion that supports aged care workers to provide quality funded aged care services by:

- focussing on continuous improvement; and
- embracing diversity; and
- prioritising the safety, health and wellbeing of aged care workers.

The note points readers to section 147 of the Act and Division 2 of Chapter 4 of these rules about conditions of registration relating to continuous improvement.

Subsection (2) essentially mirrors the following subsection (3), where subsection (2) relates to ‘aged care workers’ and subsection (3) relates to ‘individuals’. This reflects the role of aged care workers in delivering safe and quality care and services for individuals.

Outcome 2.2b: Quality, safety and inclusion culture to support individuals

Outcome 2.2b comprises subsection (3) under section 15-15.

Subsection (3) essentially mirrors subsection (2), where subsection (3) relates to ‘individuals’ and subsection (2) relates to ‘aged care workers’.

Subsection (3) provides that the governing body must lead a culture of quality, safety and inclusion that supports individuals accessing quality funded aged care services by:

- focussing on continuous improvement; and
- embracing diversity; and
- prioritising the safety, health and wellbeing of aged care individuals.

The note points readers to section 147 of the Act and Division 2 of Chapter 4 of these rules about conditions of registration relating to continuous improvement.

Outcome 2.3: Accountability, quality system and policies and procedures

Outcome 2.3 comprises subsections (4), (5) and (6) under section 15-15.

Subsection (4) provides that the governing body is accountable for the delivery of quality funded aged care services and must maintain oversight of all aspects of the provider’s operations.

Subsection (5) provides that the provider must use a quality system to enable and drive continuous improvement of the provider’s delivery of funded aged care services.

The note points readers to section 147 of the Act and Division 2 of Chapter 4 of these rules about conditions of registration relating to continuous improvement.

Subsection (6) provides that the provider must:

- maintain current policies and procedures that guide the way aged care workers undertake their roles; and
- require aged care workers to follow the policies and procedures.

Outcome 2.4: Risk management

Outcome 2.4 comprises subsection (7) under section 15-15.

Subsection (7) provides that the provider must use a risk management system to identify, manage and continuously review risks to individuals, aged care workers and the provider’s operations.

The note points readers to section 147 of the Act and Division 2 of Chapter 4 of these rules about conditions of registration relating to continuous improvement.

Outcome 2.5: Incident management

Outcome 2.5 comprises subsection (8) under section 15-15.

Subsection (8) provides that the provider must use an incident management system to:

- safeguard individuals; and
- acknowledge, respond to, effectively manage and learn from incidents.

The note refers readers to section 164 of the Act and Division 1 of Part 10 of Chapter 4 of these rules about conditions of registration relating to incident management.

Outcome 2.6a: Complaints and feedback management for aged care workers

Outcome 2.6a comprises subsections (9) and (11) under section 15-15.

Subsection (9) provides that the provider must encourage and support aged care workers to make complaints and give feedback about the provider's delivery of funded aged care services without reprisal.

The note refers readers to section 165 of the Act and Division 2 of Part 10 of Chapter 4 of these rules about conditions of registration relating to complaints, feedback and whistleblowers.

Subsection (9) essentially mirrors the following subsection (10), where subsection (9) relates to 'aged care workers' and subsection (10) relates to 'individuals'. This reflects the role of aged care workers in delivering safe and quality care and services for individuals.

Subsection (11) below, applies to both complaints and feedback management for 'aged care workers' under outcome 2.6a (subsection (9)) and for 'individuals' under outcome 2.6b (subsection (10)). It provides that the provider must acknowledge and transparently manage all complaints and feedback and use complaints and feedback to contribute to the continuous improvement of funded aged care services.

The note refers readers to section 165 of the Act and Division 2 of Part 10 of Chapter 4 of these rules about conditions of registration relating to complaints, feedback and whistleblowers, and section 147 of the Act and Division 2 of Part 4 of these rules about conditions of registration relating to continuous improvement.

Providers are not expected to maintain 2 separate systems to manage complaints and feedback, i.e. one for aged care workers and a separate one for individuals. They are expected to reflect both requirements and can do so through in a single complaints and feedback management system to meet conditions of registration.

Outcome 2.6b: Complaints and feedback management for individuals

Outcome 2.6b comprises subsections (10) and (11) under section 15-15.

Subsection (10) provides that the provider must encourage and support individuals and others to make complaints and give feedback about the provider's delivery of funded aged care services without reprisal.

The note refers readers to section 165 of the Act and Division 2 of Part 10 of Chapter 4 of these rules about conditions of registration relating to complaints, feedback and whistleblowers.

Providers are not expected to maintain 2 separate systems to manage complaints and feedback, i.e. one for aged care workers and a separate one for individuals but are expected to reflect both requirements in a single complaints and feedback management system to meet conditions of registration.

Outcome 2.6a and 2.6b: Complaints and feedback management

Subsection (11) applies to both complaints and feedback management for ‘aged care workers’ under outcome 2.6a (subsection (9)) and for ‘individuals’ under outcome 2.6b (subsection (10)). It provides that the provider must acknowledge and transparently manage all complaints and feedback and use complaints and feedback to contribute to the continuous improvement of funded aged care services.

The note refers readers to section 165 of the Act and Division 2 of Part 10 of Chapter 4 of these rules about conditions of registration relating to complaints, feedback and whistleblowers, and section 147 of the Act and Division 2 of Part 4 of these rules about conditions of registration relating to continuous improvement.

Outcome 2.7: Information management

Outcome 2.7 comprises subsections (12) and (13) under section 15-15.

Subsection (12) provides that the provider must ensure that information recorded about an individual:

- is accurate and current, and
- is able to be accessed and understood by the individual, supporters of the individual, aged care workers, registered health practitioners, allied health professionals, allied health assistants and others involved in the individual’s care.

The note under subsection (12) points the reader to refer to section 155 of the Act relating to the provision of information which sets out conditions applicable to registered providers to allow records and information to individuals and explain those records and information to those individuals. It also refers readers to subsection 156(3) of the Act in specified circumstances which allows independent aged care advocates access to records and information held by a registered provider about an individual.

Subsection (13) provides that the provider must ensure that the information of individuals is kept confidential and is managed appropriately, in line with their informed consent. For providers to appropriately manage information, this includes adhering to any separate legislation that may compel data to be shared.

The note under subsection (13) points the reader to refer to the related provision in section 154 of the Act relating to personal information and record keeping that requires registered providers as a condition of their registration to keep and retain kinds of records in accordance with requirements set out in this instrument, and section 168 relating to the protection of personal information which requires registered providers to ensure the protection of personal information.

Outcome 2.8: Workforce planning

Outcome 2.8 comprises subsection (14) under section 15-15.

Subsection (14) provides that the provider must demonstrate that the provider understands and manages their workforce needs and plans for the future.

Outcome 2.9: Human resource management

Outcome 2.9 comprises subsections (15) and (16) under section 15-15.

Subsection (15) provides that the provider must deliver funded aged care services to individuals by aged care workers who:

- are skilled and competent in their roles; and
- hold relevant qualifications for their roles; and
- have expertise and experience relevant to delivering quality funded aged care services.

The note under subsection (15) points the reader to refer to the related provision in section 152 of the Act relating to workforce and aged care worker requirements that requires registered providers as a condition of their registration to comply with workforce screening and other requirements in relation to the employment of aged care workers.

Subsection (16) provides that the provider must provide aged care workers with training and supervision to enable them to effectively perform their roles.

Outcome 2.10: Emergency and disaster management

Outcome 2.10 comprises subsection (17) under section 15-15.

Subsection (17) provides that the provider must demonstrate that emergency and disaster management planning considers and manages risks to the health, safety and wellbeing of individuals and aged care workers.

Section 15-20 – Standard 3—The care and services

Section 15-20 provides for Standard 3, the care and services.

Standard 3 describes the way registered providers must deliver funded aged care services for all types of services being delivered (noting that other standards describe requirements relevant to specific service types). Effective assessment and planning, communication and coordination relies on a strong and supported workforce as described in Standard 2 and is critical to the delivery of quality funded aged care services that meet the older person's needs, are tailored to their preferences and support them to live their best lives.

Standard 3 also makes it clear that when delivering funded aged care services, registered providers and aged care workers must draw on all relevant standards, with particular reference to Standard 1, including to ensure care is tailored to the individual and what's important to them. Older people's supporters are recognised as having an important role in assisting or providing funded aged care services.

Under Standard 3, older people can expect that the funded aged care services they receive:

- are safe and effective
- optimise their quality of life, including through maximising independence and reablement
- meet their current needs, goals and preferences
- are well planned and coordinated
- respect their right to take risks.

Standard 3 includes the following outcomes:

- Outcome 3.1: Assessment and planning
- Outcome 3.2: Delivery of funded aged care services
- Outcome 3.3: Communicating for safety and quality
- Outcome 3.4: Planning and coordination of funded aged care services

Standard 3 applies to registered providers in provider registration categories 4, 5 and 6 as outlined in section 15-5.

Outcome 3.1: Assessment and planning

Outcome 3.1 comprises subsections (1), (2) and (3) under section 15-20.

Subsection (1) provides that the registered provider must actively engage with:

- the individuals to whom the provider delivers funded aged care services; and
- supporters of individuals (if any); and
- any other persons involved in the care of individuals;

in developing and reviewing the individual's care and services plan through ongoing communication.

The reference to 'other persons involved in the care of individuals' can include family, friends and/or carers of the individual who are not registered as a supporter of the individual under section 37 of the Act if the individual wishes for them to be involved.

Subsection (2) provides that care and services plans must:

- describe the current care needs, goals and preferences of individuals; and
- include strategies for risk management and preventative care.

Subsection (3) provides that the provider must ensure that care and services plans are regularly reviewed and are used by aged care workers to guide the delivery of funded aged care services. The frequency of the review of the care and services plans should be based on the needs of the individual. Reviews should be undertaken no less than once every 12 months.

The note under subsection (3) refers the reader to the related provision in section 148-80 of this instrument relating to requirements for care and services plans which provides details in relation to the development of care and services plans for individuals.

Outcome 3.2: Delivery of funded aged care services

Outcome 3.2 comprises subsections (4) and (5) under section 15-20.

Subsection (4) provides that the provider must ensure that individuals receive quality funded aged care services that:

- meet their care needs, goals and preferences; and
- optimise their quality of life, reablement and maintenance of function.

Subsection (5) provides that the provider must ensure that funded aged care services are delivered in a way that is culturally safe and culturally appropriate for individuals with specific needs and diverse backgrounds.

- References to ‘cultural safety’, ‘culturally safe’ or similar are not limited to Aboriginal or Torres Strait Islander persons’ culture and includes spiritually, socially, emotionally and physically safe and respectful environments (refer to the ACQSC’s Glossary here: <https://www.agedcarequality.gov.au/glossary>).

Outcome 3.3: Communicating for safety and quality

Outcome 3.3 comprises subsections (6) and (7) under section 15-20.

Subsection (6) provides that the provider must ensure that critical information relevant to the delivery of funded aged care services to individuals is communicated effectively:

- to the individuals; and
- between aged care workers delivering the services; and
- with supporters of the individuals and other persons supporting the individuals; and
- with registered health practitioners, allied health professionals, allied health assistants and others involved in the individual’s care.

The reference to ‘other persons supporting the individuals’ can include family, friends and/or carers of the individual who are not registered as a supporter of the individual under section 37 of the Act and the individual wishes for them to be involved.

Subsection (7) provides that the provider must ensure that risk to individuals, and changes and deterioration in the condition of the individuals, are escalated and communicated as appropriate.

Outcome 3.4: Planning and coordination of funded aged care services

Outcome 3.4 comprises subsection (8) under section 15-20.

Subsection (8) provides that the provider must ensure that individuals receive funded aged care services that are planned and coordinated, including where multiple health providers and registered providers, supporters of individuals and other persons supporting individuals are involved.

The reference to ‘other persons supporting individuals’ can include family, friends and/or carers of the individual who are not registered as a supporter of the individual under section 37 of the Act.

Section 15-25 – Standard 4—The environment

Section 15-25 provides for Standard 4, the environment.

Standard 4 is intended to ensure that older people receive funded aged care services in a physical environment that is safe, supportive and meets their needs. Effective infection prevention and control measures are a core component of service delivery to protect older people, their supporters and aged care workers.

Under Standard 4, older people should be able to feel safe when receiving funded aged care services. When funded aged care services are delivered through a service environment, the environment is clean, safe and comfortable and enables older people to move around freely. Equipment used in the delivery of funded aged care services is safe, appropriate and well-maintained and precautions are taken to prevent the spread of infections.

Standard 4 includes the following outcomes:

- Outcome 4.1a: Environment—services delivered in the individual’s home
- Outcome 4.1b: Environment—services delivered other than in the individual’s home
- Outcome 4.1a and 4.1b: Equipment
- Outcome 4.2: Infection prevention and control

Standard 4 applies to registered providers in provider registration categories 4, 5 and 6 as outlined in section 15-5.

Subsections (1) (for Outcome 4.1a) and (2) (for Outcome 4.1b), aim to clarify the expectation that in most cases, a registered provider will only be required to confirm with either Outcome 4.1a or 4.1b, but not both, unless they are registered in multiple registration categories. For example:

- A registered provider in registration categories 4 and/or 5 will be required to conform with Outcome 4.1a if they are registered to provide funded aged care services in the individual’s home.
- A registered provider in registration categories 5 and/or 6 will be required to confirm with Outcome 4.1b if they are registered to provide funded aged care services in environments other than in the individual’s home.
- Whereas a registered provider in registration categories 4, 5 and 6 will be required to conform with both Outcomes 4.1a and 4.1b as they are registered to provide funded aged care services delivered in any environment or setting.

Subsection (3) is intended to apply to all funded aged care services delivered in any environment or setting for registered providers in registration categories 4, 5 and/or 6.

Outcome 4.1a: Environment—services delivered in the individual’s home

Outcome 4.1a comprises subsections (1) and (3) under section 15.25.

Subsection (1) provides that when delivering funded aged care services to individuals in their homes, the registered provider must support the individuals to mitigate environmental risks relevant to the services.

Subsection (3) applies to both Outcome 4.1a and 4.1b and applies to the use of equipment where services are delivered in either the individual's home (subsection (1)) and/or other than in the individual's home (subsection (2)).

Outcome 4.1b: Environment—services delivered other than in the individual's home

Outcome 4.1b comprises subsections (2) and (3) under section 15.25.

Subsection (2) provides that where the provider delivers funded aged care services to individuals other than in their homes, the provider must ensure that individuals are able to access funded aged care services in a clean, safe and comfortable environment that optimises their sense of belonging, interaction and function.

Subsection (3) applies to both Outcome 4.1a and 4.1b and applies to the use of equipment where services are delivered in either the individual's home (subsection (1)) and/or other than in the individual's home (subsection (2)).

Outcome 4.1a and 4.1b: Equipment

Subsection (3) applies to both Outcome 4.1a and 4.1b and applies to the use of equipment where services are delivered in either the individual's home (subsection (1)) and/or other than in the individual's home (subsection (2)). It provides that where the provider uses equipment in the delivery of any funded aged care services to individuals, or provides equipment to individuals, the equipment must be safe and must meet the needs of individuals.

Outcome 4.2: Infection prevention and control

Outcome 4.2 comprises subsections (4) and (5) under section 15.25.

Subsection (4) provides that the provider must have an appropriate infection prevention and control system.

Subsection (5) provides that the provider must ensure that aged care workers use hygienic practices and take appropriate infection prevention and control precautions when delivering funded aged care services.

Section 15-30 – Standard 5—Clinical care

Section 15-30 provides for Standard 5 about clinical care.

Standard 5, Clinical care describes the responsibilities of registered providers to deliver safe and quality clinical care services to older people. The governing body has overall responsibility to ensure a clinical governance framework is implemented and to monitor its effectiveness in supporting aged care workers to deliver quality clinical care services. The governing body is also responsible to ensure providers operationalise the clinical governance framework and report on its performance.

Many older people who require clinical care services have multiple chronic co-morbidities and complex care needs. These people may be experiencing sickness, frailty, disability, cognitive impairment or be nearing the end of their life. Access to a range of registered health practitioners, allied health professionals and allied health assistants is crucial to address these complex needs. Quality clinical care services can optimise an older person's quality of life, reablement and maintenance of function. Improved health and wellbeing supports continued participation in activities that are enjoyable and give life meaning.

At all times, clinical care services provided should be person-centred, inclusive, safe, effective and coordinated. It should be planned and delivered in partnership with the older person, involving their supporters and others in line with the older person's needs and preferences. Delivering safe, quality clinical care services requires a multidisciplinary approach with a skilled workforce with clear accountabilities that are supported to deliver contemporary, evidence-based care. Allied health professionals have distinct roles in reablement and maintenance of an older person's functional capabilities.

Effective implementation of Standard 5 is reliant on the systems and processes from all of the Standards. Standard 5 does not seek to replicate the base expectation of understanding the person in Standard 1 or the base planning, assessment and delivery expectation of Standard 3.

- For example, implementation of processes for advance care planning in Action 3.1.6 is critical to quality clinical care, including at the end of life (Action 5.7.2). These systems and processes establish a baseline expectation which supports the delivery of person-centred and safe clinical care services, ensuring that risks of harm to older people from clinical care services are minimised and support continuous quality improvement.

Under Standard 5, older people can expect to receive person-centred, evidence-based, safe, effective, and coordinated clinical care services by health professionals and competent aged care workers that meet their changing clinical needs and is in line with their goals and preferences

Standard 5 includes the following outcomes:

- Outcome 5.1: Clinical governance
- Outcome 5.2: Preventing and controlling infections in delivering clinical care services
- Outcome 5.3: Safe and quality use of medicines
- Outcome 5.4: Comprehensive care
- Outcome 5.5: Safety of clinical care services
- Outcome 5.6: Cognitive impairment
- Outcome 5.7: Palliative care and end-of-life care

Standard 5 applies to registered providers in provider registration categories 5 and 6 as outlined in section 15-5.

- Outcome 5.1 (Clinical governance) under Standard 5 in subsection 15-30(1) also applies to registered providers in provider registration category 4 that are registered to deliver 'care management' and 'restorative care management' service types, and will be required to demonstrate conformance with Outcome 5.1 for these service types only.

Outcome 5.1: Clinical governance

Outcome 5.1 comprises subsections (1) and (2) under section 15-30.

Subsection (1) provides that the governing body must ensure that the governing body continuously improves the safety and quality of clinical care services to individuals; and that the provider delivers safe and quality clinical care services to individuals.

The note refers readers to section 147 of the Act and Division 2 of Part 4 of Chapter 4 of this instrument about conditions of registration relating to continuous improvement.

Subsection (2) provides that the registered provider must integrate clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care services delivered to individuals.

Outcome 5.2: Preventing and controlling infections in delivering clinical care services

Outcome 5.2 comprises subsections (3) and (4) under section 15-30.

Subsection (3) provides that the provider must ensure that individuals, aged care workers, registered health practitioners and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance.

Subsection (4) provides that the provider must ensure that infection risks are minimised and, if they occur, are controlled effectively.

Outcome 5.3: Safe and quality use of medicines

Outcome 5.3 comprises subsections (5), (6) and (7) under section 15-30.

Subsection (5) provides that the provider must encourage and support individuals, aged care workers, registered health practitioners and allied health professionals to use medicines in a way that maximises benefits and minimises the risks of harm.

Subsection (6) provides that the provider must ensure that:

- before administering medicine to an individual, the medicine has been prescribed for the individual; and
- medicines are appropriately and safely administered, monitored and reviewed by registered health practitioners, considering the clinical needs and informed decisions of the individual.

It is important to note that for the purposes of subsection (6) under section 15-30, it is not the registered providers responsibility to ensure that medicines have been ‘appropriately prescribed’ as that is the relevant (external) medical professional’s responsibility. Subsection (6) applies requirements on registered providers once medicines have been prescribed, and clarifies that a provider’s obligation only extends to ensuring the medication is prescribed to that individual before administering it and that it is administered as prescribed.

It is important to note that each jurisdiction has its own laws and regulations that specify who can administer medicines under what conditions. This depends on a number of factors such as the type of medicine, how it is administered, the setting and training/procedures in place. Aged care workers must perform medicines related tasks in accordance with state or territory legislation, regulations and provider policies and procedures for delegation and supervision. The provider's approach to ensuring safe administration of medicines should be incorporated into clinical governance frameworks.

Subsection (7) provides that the provider must ensure that medicines-related adverse events are monitored and reported, and are used to inform safety and quality improvement.

Outcome 5.4: Comprehensive care

Outcome 5.4 comprises subsections (8), (9), (10) and (11) under section 15-30.

Subsection (8) provides that the provider must ensure that individuals receive comprehensive, safe and quality clinical care services that are evidence—based, person-centred and delivered by registered health practitioners, allied health professionals, allied health assistants or nursing assistants.

- Providers should ensure that comprehensive clinical care is delivered by suitably qualified registered health practitioners, allied health professionals and other aged care workers working within their scope of practice and position description. Where provided for under relevant professional standards, and this could include students who are under appropriate supervision.

Subsection (9) provides that clinical care delivered by the provider must encompass clinical assessment, prevention, planning, treatment, management and review to minimise harm and optimise quality of life, reablement and maintenance of function.

Subsection (10) provides that the provider must have systems and processes that support coordinated, multidisciplinary clinical care services:

- that are delivered to individuals, in partnership with individuals, supporters of individuals and other persons supporting individuals; and
- that are aligned with the individuals' needs, goals and preferences.

The reference to 'other persons supporting individuals' can include family, friends and/or carers of the individual who are not registered as a supporter of the individual under section 37 of the Act if the individual wishes for them to be involved.

Subsection (11) provides that the provider must support early identification of, and response to, changing clinical needs.

Outcome 5.5: Safety of clinical care services

Outcome 5.5 comprises subsection (12) under section 15-30.

Subsection (12) provides that the provider must identify, monitor and manage high impact and high prevalence risks in the delivery of clinical care services:

- to ensure the delivery of safe, quality clinical care services; and
- to reduce the risk of harm to individuals.

Outcome 5.6: Cognitive impairment

Outcome 5.6 comprises subsections (13) and (14) under section 15-30.

Subsection (13) provides that the provider must ensure that individuals who experience cognitive impairment (whether acute, chronic or transitory) receive comprehensive funded aged care services that:

- optimise clinical outcomes; and
- are aligned with their needs, goals and preferences.

Subsection (14) provides that the provider identifies situations and events that may lead to changes in behaviours.

Outcome 5.7: Palliative care and end-of-life care

Outcome 5.7 comprises subsections (15), (16) and (17) under section 15-30.

Subsection (15) provides that the provider must recognise and address the needs, goals and preferences of individuals for palliative care and end -of -life care, and must preserve the dignity of individuals in those circumstances.

Subsection (16) provides that the provider ensures that the pain and symptoms of individuals are actively managed, with access to specialist palliative and end -of -life care when required.

Subsection (17) provides that the provider must ensure that supporters of individuals and other persons supporting individuals are informed and supported, including during the last days of life.

The reference to ‘other persons supporting individuals’ can include family, friends and/or carers of the individual who are not registered as a supporter of the individual under section 37 of the Act if the individual wishes for them to be involved.

The note refers readers to section 29 of the Act about giving information and documents to supporters.

Section 15-35 – Standard 6—Food and nutrition

Section 15-35 provides for Standard 6 about food and nutrition.

Standard 6 sets out the expectations of registered providers who deliver funded aged care services in residential care homes in relation to food and nutrition. Providers must partner with each older person to deliver a quality meals, refreshments and dining experience. Providers must also monitor and continuously improve food service.

Providers must assess and regularly reassess each older person’s nutrition, hydration and dining needs and preferences. This is supported by Standard 3’s general requirements in relation to effective assessment and planning, and the delivery of services in line with the needs, goals and preferences of each older person. It is also supported by Standard 5’s requirement to monitor each older person for malnutrition and dehydration and respond appropriately where concerns are identified.

The provider must provide each older person with food and drinks that meet their individual nutritional needs. Meals should be appetising, flavoursome and varied, and each older person should have choice about what and how much they eat and drink.

Under Standard 6, each older person can expect to receive:

- food and drinks that are enjoyable, nutritious, appetising and safe, and meets their needs and preferences; and
- a dining experience that is enjoyable, includes variety and supports a sense of belonging.

Standard 6 includes the following outcomes:

- Outcome 6.1: Partnering with individuals on food and drinks;
- Outcome 6.2: Assessment of nutritional needs and preferences;
- Outcome 6.3: Provision of food and drinks; and
- Outcome 6.4: Dining experience.

Standard 6 applies to registered providers in provider registration category 6 as outlined in section 15-5.

Outcome 6.1: Partnering with individuals on food and drinks

Outcome 6.1 comprises subsection (1) under section 15-35.

Subsection (1) provides that the registered provider must partner with individuals to deliver a quality food and drinks service that includes appetising and varied food and drinks and an enjoyable dining experience.

The note refers readers to item 9 of the table in section 8-145 of this instrument about residential everyday living services relating to meals and refreshments. This is the ‘meals and refreshments’ service on the age care service list, which describes the funded aged care service to be delivered in an approved residential care home.

Outcome 6.2: Assessment of nutritional needs and preferences

Outcome 6.2 comprises subsection (2) under section 15-35.

Subsection (2) provides that the provider must demonstrate that the provider understands the specific nutritional needs of individuals and assesses the current needs, abilities and preferences of individuals in relation to what and how they eat and drink. This subsection requires providers to demonstrate understanding the specific nutritional needs of individuals which refers to the cohort of individuals aged 65 years and older (or 50 years and older where referring to the needs of Aboriginal and Torres Strait Islander individuals).

Providers should consider that nutrition needs change as older people age, for example, requirements for nutrients such as protein and calcium are likely to be higher. This subsection also requires providers to assess each individual’s current needs, abilities and preferences in relation to what and how they like to eat and drink. This enables providers to build on their understanding of nutrition needs of individuals as a cohort to tailor services to meet each individual’s unique needs and preferences.

Outcome 6.3: Provision of food and drinks

Outcome 6.3 comprises subsection (3) under section 15-35.

Subsection (3) provides that the provider must provide individuals with:

- food and drinks that meet their nutritional needs and are appetising and flavoursome; and
- variation and choice about what they eat and drink; and
- choice about how much they eat and drink.

Outcome 6.4: Dining experience

Outcome 6.4 comprises subsections (4) and (5) under section 15-35.

Subsection (4) provides that the provider must support individuals to eat and drink.

Subsection (5) provides that the provider must ensure that the dining experience meets the needs and preferences of individuals to support social engagement, function and quality of life.

Section 15-40 – Standard 7—The residential community

Section 15-40 provides for Standard 7 about the residential community.

Standard 7 sets out the expectations of registered providers who deliver funded aged care services in residential care homes. It sets out requirements that registered providers must meet to ensure each older person feels safe in their residential care home and to support them to participate in meaningful activities and maintain personal and social relationships in ways that respect each older person's culture and unique background.

The requirements in Standard 7 are essential to the delivery of funded aged care services in a residential setting that optimise the older person's quality of life, promote their skills and strengths and enable them to do the things they want to do.

Reflecting the scope of responsibility in residential care, Standard 7 also sets out requirements that registered providers who deliver funded aged care services in residential care homes must meet to facilitate each older person's access to other services and to coordinate a planned transition to or from the service to maximise continuity of care for them.

Under Standard 7, older people can expect that the funded aged care services they receive:

- support them to do the things they want to do and to maintain their relationships and connections with their community; and
- give them confidence in the continuity of their care and security of their accommodation.

Standard 7 includes the following outcomes:

- Outcome 7.1: Daily living; and
- Outcome 7.2: Transitions.

Standard 7 applies to registered providers in provider registration category 6 as outlined in section 15-5.

Outcome 7.1: Daily living

Outcome 7.1 comprises subsections (1) and (2) under section 15-40.

Subsection (1) provides that the registered provider must ensure that individuals receive funded aged care services that optimise their quality of life, promote use of their skills and strengths and enable them to do the things they want to do.

Subsection (2) provides that the provider must ensure that individuals feel safe in their residential care home.

Outcome 7.2: Transitions

Outcome 7.2 comprises subsections (3) and (4) under section 15-40.

Subsection (3) provides that the provider must ensure that individuals experience a well-coordinated transition, whether planned or unplanned, to or from a provider.

The note refers the reader to section 149 of the Act. Section 149 of the Act provides for the obligations of registered providers in relation to starting and ceasing the delivery of funded aged care services to an individual, security of tenure for individuals accessing funded aged care services in an approved residential care home and continuity of funded aged care services for individuals.

Subsection (4) provides that the provider must set out clear responsibility and accountability for the delivery of funded aged care services to individuals between aged care workers, registered health practitioners, allied health professionals, allied health assistants and across organisations.

Part 7 – Reportable incidents and restrictive practices

Division 1 – Reportable incidents

Section 16-5 – Defining and clarifying expressions relating to reportable incidents

Section 16-5 provides that for the purposes of subsection 16(2) of the Act, this section prescribes the definitions or clarifications of expressions used in paragraphs 16(1)(a), (b), (c), (d), (e), (f) and (h) of the Aged Care Act, which deal with incidents that have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the delivery of funded aged care services to an individual by a registered provider.

Section 16-5 clarifies the meaning of the following expressions:

- Unreasonable use of force
- Unlawful sexual contact, or inappropriate sexual conduct
- Psychological or emotional abuse
- Unexpected death
- Stealing or financial coercion
- Neglect
- Unexplained absence

Unreasonable use of force

Subsection 16-5(2) provides that the expression “unreasonable use of force against the individual” includes conduct ranging from a deliberate and violent physical attack to use of unwarranted physical force. Examples may include kicking, hitting, pushing, shoving and rough handling.

Subsection 16-5(3) provides that, to avoid doubt, the expression unreasonable use of force against the individual does not cover gently touching the individual:

- for the purposes of providing a funded aged care service; or
- to attract their attention; or
- to guide them; or
- to provide comfort when they are distressed.

Unlawful sexual contact, or inappropriate sexual conduct

Subsection 16-5(4) provides that in paragraph 16(1)(b) of the Aged Care Act, the expression “unlawful sexual contact, or inappropriate sexual conduct, inflicted on the individual” includes the following:

- if the contact or conduct is inflicted by a person who is an aged care worker of the registered provider—the following:
 - any conduct or contact of a sexual nature inflicted on the individual, including (without limitation) sexual assault, an act of indecency and the sharing of an intimate image of the individual;
 - any touching of the individual’s genital area, anal area or breast in circumstances where this is not necessary to deliver funded aged care services to the individual
- any non-consensual contact or conduct of a sexual nature, including (without limitation) sexual assault, an act of indecency and the sharing of an intimate image of the individual;
- engaging in conduct relating to the individual with the intention of making it easier to procure the individual to engage in sexual contact or conduct.

Examples may include an aged care worker or other person (including another individual accessing funded aged care services):

- showing their own genitals to an individual;
- masturbating in front of an individual;
- using sexual innuendo, or explicit comments that are vulgar or would reasonably cause the individual discomfort;
- forcing an individual to view pornography;
- sexual grooming of an individual (preparatory process with an intent to be sexually abusive);
- crossing professional boundaries with an individual;
- touching an individual’s genitals, breasts or anus without a care need; or
- sexually penetrating an individual with a body part or an object.

In general, this includes sexual offences against the individual, including sexual assault, aggravated assault and indecent assault (noting that each state or territory may use a variety

of terms for these types of offences, and may have more specific categories of sexual offences).

However, subsection 16-5(5) provides that the expression “unlawful sexual contact, or inappropriate sexual conduct, inflicted on the individual” in paragraph 16(1)(b) of the Act does not include consensual contact or conduct of a sexual nature between an individual and a person who is not an aged care worker of the registered provider. This includes where the other individual is someone to whom the registered provider delivers funded aged care services.

To remove any doubt, it would not be a reportable incident for the existing partner of an individual accessing funded aged care services to have a consensual sexual relationship with the individual accessing funded aged care services. This is the case even if the partner is not themselves accessing aged care services and volunteers or works for the registered provider which is providing funded aged care services to the individual. This scenario may be particularly relevant in regional, rural or remote communities.

Psychological or emotional abuse

Subsection 16-5(6) provides that the expression “psychological or emotional abuse of the individual” in paragraph 16(1)(c) of the Act includes conduct that:

- has caused the individual psychological or emotional distress; or
- could reasonably have been expected to have caused an individual psychological or emotional distress.

The phrase ‘could reasonably have been expected to have caused’ is included to account for circumstances where an incident involves conduct that is not acceptable and would ordinarily cause psychological or emotional distress, even though the conduct may not have had such an effect in the circumstances of that specific incident. For example, where an individual is yelling at and threatening another individual and that individual does not display distress as their individual level of cognitive functioning did not allow them to recognise what was happening. Although that individual may not suffer psychological or emotional distress, it is intended that such incidents would be considered reportable incidents for the purposes of the Serious Incident Report Scheme (SIRS).

Subsection 16-5(7) clarifies that conduct covered by subsection (6) includes (without limitation) the following:

- taunting, bullying, harassment or intimidation;
- threats of maltreatment;
- humiliation;
- unreasonable refusal to interact with the individual or acknowledge the individual’s presence;
- unreasonable restriction of the individual’s ability to engage socially or otherwise interact with people;
- repetitive conduct or contact which does not constitute unreasonable use of force but the repetition of which:
 - has caused the individual psychological or emotional distress; or
 - could reasonably have been expected to have caused an individual psychological or emotional distress.

Examples may include yelling, name-calling, threatening gestures, making disparaging comments about a person's gender, sexual orientation, sexual identity, cultural identity or religious identity, or repeatedly flicking, tapping, or bumping of an individual.

The use of the term 'unreasonable' in relation to refusal to interact with an individual and restriction of their ability to engage socially or otherwise interact with people is used to exclude circumstances where this is done for a legitimate reason. For example, if an individual is being violent towards other individuals and is temporarily not permitted to attend a group activity in a common area of the service while their behaviour is being assessed and addressed. Another example may be not allowing an individual to leave the funded aged care service or have visitors during an outbreak, in order to protect the individual from the risk of disease.

Unexpected death

Subsection 16-5(8) provides that the expression "unexpected death of the individual" includes death in circumstances where:

- the individual was accessing funded aged care services in an approved residential care home of a registered provider and reasonable steps were not taken by the registered provider to prevent the death; or
- the death was a result of:
 - funded aged care services delivered by the registered provider; or
 - a failure of the registered provider to deliver funded aged care services.

For example, this would include circumstances where an individual has a fall while being moved or shifted and the individual sustains injuries during the fall resulting in their death. Other examples may include where a coronial inquest is being held in relation to an individual's death, or in a circumstance where an untreated pressure injury becomes infected, and appropriate medical assessment and or treatment was delayed or not given, which resulted in the death of the individual.

Stealing or financial coercion

Subsection 16-5(9) provides that the expression "stealing from, or financial coercion of, the individual by an aged care worker of the provider" in paragraph 16(1)(e) of the Aged Care Act includes the following:

- stealing from the individual by an aged care worker of the registered provider;
- conduct by an aged care worker of the registered provider that:
 - is coercive or deceptive in relation to the individual's financial affairs; or
 - unreasonably controls the individual's financial affairs.

For example, this includes an aged care worker of a registered provider coercing an individual to change their will in favour of the aged care worker, or an aged care worker stealing money or valuables from an individual. Another example may include an aged care worker influencing an individual to provide them with a large gift (expensive or of sentimental high value), or a circumstance where an aged care worker takes an individual's wallet and will not allow the individual to spend money, although the individual may have the cognitive function necessary to make decisions about the spending of their funds.

Neglect

Subsection 16-5(10) provides that the expression “neglect of the individual” means circumstances in which a registered provider, aged care worker, or responsible person of the registered provider:

- has delivered a funded aged care service to the individual that exposes the individual to the risk of serious injury or illness; or
- has caused or contributed (including through reckless or intentional behaviour) to:
 - a significant failure to deliver a funded aged care service to the individual; or
 - a systematic pattern of conduct; or
- has delivered a grossly inadequate funded aged care service to the individual; or
- has been reckless or intentionally negligent in delivering a funded aged care service to the individual.

The use of the term ‘grossly inadequate’ is intended to delineate between poor practice and deliberate or intentional neglect.

Examples of neglect of an individual may include:

- a reckless act or a failure to act by the registered provider, such as:
 - not providing a residential care recipient access to medical care or allied health
 - untreated wounds
 - failure to change soiled continence aids in a timely manner
- supervisory neglect by the registered provider;
- grossly inadequate care by the registered provider such as:
 - an aged care worker withholding personal care such as showering or oral care;
 - ongoing errors in the administration of essential medication;
 - lack of wound care resulting in maggots on or in the individual; or
 - an individual being left outside unprotected from the sun resulting in sunburn.

Other examples include where an individual’s meals are not appropriately modified to account for difficulty swallowing (dysphagia) as recorded on their meal plan, or insufficient assistance is given to an individual to eat their food, resulting in the individual either not being able to eat or choking on their food. Further examples may include where an individual is repeatedly not being given an appropriate meal, for example, where a registered provider refuses to supply kosher or halal food or vegetarian meals in accordance with the individual’s choice, or where other culturally appropriate care is not provided despite the opportunity to do so. In addition, this may include a circumstance where an aged care worker decides, against care directives, to move an individual without the use of a hoist because it would take too much time to set up and the individual has a fall and sustains injury.

It should be noted that under section 16-15 (explained below), an incident is not a reportable incident if the incident results from an individual deciding to refuse to receive funded aged care services offered by the registered provider, and the refusal has been documented in the care plan.

Unexplained absence

Subsection 16-5(11) provides that the expression “unexplained absence of the individual in the course of the delivery of funded aged care services to the individual” in paragraph 16(1)(h) of the Act means:

- for an individual accessing funded aged care services in an approved residential care home—an absence of the individual from the home in circumstances where there are reasonable grounds to report the absence to police; or
- for an individual accessing funded aged care services in a home or community setting—an absence of the individual from the setting during the delivery of a funded aged care service to the individual in circumstances where there are reasonable grounds to report the absence to police.

An absence is not unexplained merely because it is not authorised by the provider. Before reporting to the police the provider should take reasonable steps to determine the location of the individual, including considering cultural reasons for their absence.

The phrase ‘in the course of the delivery of funded aged care services’ is intended to capture situations where a registered provider has the individual in their physical care immediately prior to their absence. For example, where an individual goes missing while receiving transport services, while at a day therapy centre, in overnight respite or on a scheduled outing with the registered provider.

For paragraph 16-5(11)(b), the intended effect is not to require a registered provider delivering funded aged care services in a home or community setting to report incidents where the provider arrives for a scheduled visit and the individual is not present, as this would not be ‘in the course of the delivery of funded aged care services’. This recognises the limited control of registered providers who deliver funded aged care services in a home or community setting over the individual’s movement, living environment and safety, outside of when services are being delivered.

There must also be reasonable grounds to report the absence to the police. For example, where an individual who is accessing funded aged care services is not able to be located and does not have sufficient cognition to care for themselves or would miss a dose of essential medication as a result of them being missing. In this situation, this may be reasonable grounds for the registered provider to report the absence to the police given the potential risk to the individual’s health and safety.

Section 16-10 – Acts, omissions and events that are not reportable incidents—general

Section 16-10 provides that for the purposes of paragraph 16(3)(b) of the Aged Care Act, an act, omission or event covered by one of the following subsections is not a ***reportable incident***.

Approved residential care homes—incidents resulting from refusal by individuals of delivery of services

Subsection 16-10(2) provides that for approved residential care homes, an incident is not a reportable incident, if the incident results from an individual accessing funded aged care services in an approved residential care home deciding to refuse the delivery of funded aged care services.

For example, if an individual refuses to shower, or if an individual with diabetes refuses to eat a diabetic diet and as a result develops a wound with a poor healing prognosis.

It is important for registered providers and their aged care workers to maintain the rights of individuals accessing funded aged care services in line with the Statement of Rights, including their rights of autonomy and choice. However, a registered provider and its responsible persons and aged care workers remain responsible for ensuring choices made by individuals are informed, that any tension between refusal of funded aged care services and professional or legal obligations are managed, and that any relevant discussions and consideration are appropriately documented (for example, in the individual's care plan).

Home or community settings—incidents resulting from choices made by individuals about services to be delivered

Subsection 16-10(3) provides that for home or community settings, an incident is not a reportable incident if:

- the incident occurred, is alleged to have occurred, or is suspected of having occurred, in connection with the delivery of funded aged care services in a home or community setting to an individual by a registered provider; and
- apart from this subsection, the incident would be a reportable incident under paragraph 16(1)(f) of the Aged Care Act (neglect of the individual), but would not otherwise be a reportable incident; and
- the incident results from a choice made by the individual about the funded aged care services the registered provider is to deliver to the individual, or how the services are to be delivered by the provider; and
- before the incident occurred, is alleged to have occurred, or is suspected of having occurred, the individual had communicated the individual's choice to the provider, and the provider had recorded the individual's choice in writing.

As for residential care homes, it is important for registered providers delivering funded aged care services in home or community settings to respect the rights of autonomy and choice of the individuals accessing those services. Registered providers are responsible for ensuring these choices are informed, for managing professional and legal obligations, and for recording relevant discussions.

Section 16-15 – Acts, omissions and events that are not reportable incidents—use of restrictive practices in a home or community setting

Section 16-15 provides that for the purposes of paragraph 16(3)(b) of the Aged Care Act, the use of restrictive practices in relation to an individual is not a reportable incident if:

- the restrictive practice is used in connection with the delivery of funded aged care services to the individual in a home or community setting; and
- before the restrictive practice is used, the following matters were set out in the care and services plan for the individual:
 - the circumstances in which the restrictive practice may be used in relation to the individual, including the individual's behaviours of concern that are relevant to the need for the use;
 - the manner in which the restrictive practice is to be used, including its duration, frequency and intended outcome; and
- the restrictive practice is used:
 - in the circumstances set out in the plan; and
 - in the manner set out in the plan; and
 - in accordance with any other provisions of the plan that relate to the use; and

- details about the use of the restrictive practice are documented as soon as practicable after the restrictive practice is used.

This section provides the circumstances in which the use of a restrictive practice in a home or community setting will not be a reportable incident. Any use of a restrictive practice in a home or community setting which does not comply with the above requirements will be a reportable incident in accordance with paragraph 16(1)(g) of the Act.

Division 2 – Restrictive practices

Section 17-5 – Practices and interventions that are restrictive practices in relation to individuals

Section 17-5 sets out five types of restrictive practices in relation to individuals for the purposes subsection 17(2) of the Aged Care Act. These are:

- chemical restraint;
- environmental restraint;
- mechanical restraint;
- physical restraint;
- seclusion

The clarified definitions of the types of restraint described in section 17-5 are intended to ensure better understanding by registered providers on what constitutes a restrictive practice and the circumstances for the use of a restrictive practice. The proposed definitions align with the definitions applied under the National Disability Insurance Scheme (NDIS), bringing aged care sector practice into line with the disability sector.

All forms of restrictive practices defined are practices or interventions that are used for the primary purpose of influencing an individual's behaviour.

Chemical restraint

Subsection 17-5(2) sets out what constitutes a chemical restraint. Chemical restraint is a practice or intervention that is, or that involves, the use of medication or a chemical substance for the primary purpose of influencing an individual's behaviour, but does not include the use of medication prescribed for:

- a diagnosed mental disorder; or
- a physical illness; or
- a physical condition; or
- end of life care for the individual.

The most common type of chemical restraint used in aged care is psychotropic medicine. Psychotropic medications are any drug capable of affecting the mind, emotions and behaviour. The three main classes of psychotropic medicines prescribed are antidepressants, anxiolytic/ hypnotics (mostly benzodiazepines to manage anxiety and insomnia) and antipsychotics. Other psychotropic classes include anticonvulsants and stimulants. The Aged Care Quality and Safety Commission's resource 'Psychotropic medications used in Australia information for aged care' includes details of the types of medications used in aged care settings. The definition excludes medication prescribed for a diagnosed mental disorder, a physical illness or physical condition or end of life care. This allows for the continued use of these medications where there is a genuine and clear medical need. Where medication is

prescribed for the medical treatment of a diagnosed mental disorder, a physical illness or physical condition or end of life care, registered providers need to ensure they are using the medication as prescribed. If medication is prescribed as a chemical restraint, an approved provider must meet the additional requirements for the use of restrictive practices that are a chemical restraint listed under section 162-25 (see below). This includes documenting the medical or nurse practitioner's decision to use chemical restraint and the individual's behaviours that are relevant to the need for the chemical restraint.

Environmental restraint

Subsection 17-5(3) defines what restrictive practices will be taken to be an environmental restraint. Environmental restraint is a practice or intervention that restricts, or that involves restricting, an individual's free access to all parts of the individual's environment (including items and activities) for the primary purpose of influencing the individual's behaviour.

The individual's environment is taken to include the individual's room, any common areas within an approved residential care home, and the common grounds outside of the approved residential care home. It does not include areas within the approved residential care home where an individual would not normally be permitted, such as the kitchen, meal preparation areas, laundry, maintenance areas or medication storage areas. Additionally, it does not include other individual's rooms.

Environmental restraint may involve restricting an individual from accessing a room or area within their environment, or an item or activity. For example, locking away cutlery, tea/coffee, or mobile phones, in cupboards and/or drawers, or restricting an individual from accessing activities such as watching television, or making tea or coffee is environmental restraint. Number keypads on doors are a restrictive practice if it prevents an individual from accessing a part of their environment or limits their movements. While keypads are commonly used within facilities for the safety of individuals, they are a restrictive practice if an individual cannot leave freely. If facilities provide codes to individuals or aged care workers are available to open doors when required, this would not be considered an environmental restraint. However, when a keypad code is given to an individual, but they are unable to remember it or have cognitive impairments, this is an environmental restraint. While environmental restraints are commonly used for the safety of individuals, they can have unanticipated effects on other individual's rights. Therefore, any environmental restraint should not only consider the impact for the individual but for all individuals that have access to that environment and/or item or activity.

Mechanical restraint

Subsection 17-5(4) defines what restrictive practice will be taken to be a mechanical restraint. Mechanical restraint is a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue an individual's movement for the primary purpose of influencing the individual's behaviour, but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the individual.

Examples of potential mechanical restraints include bed rails, tray tables, belts, harnesses, restrictive clothing, and the use of straps to restrain any part of the body, splints or gloves. Devices used for therapeutic purposes or non-behavioural purposes are not considered to be mechanical restraints, such as splints/casts for broken bones, or wheelchairs for someone

unable to walk long distances. Devices used for safety purposes or to prevent harm, even if consented to by the care recipient, are considered to be a mechanical restraint if not used for therapeutic or non-behavioural purposes.

Physical restraint

Subsection 17-5(5) defines what restrictive practices will be taken to be a physical restraint. Physical restraint is a practice or intervention that is or involves the use of physical force to prevent, restrict or subdue movement of an individual's body, or part of an individual's body, for the primary purpose of influencing the individual's behaviour. However, this does not include the use of a hands-on technique in a reflexive way to guide or redirect the individual away from potential harm or injury if it is consistent with what could reasonably be considered to be the exercise of care towards the individual.

An example of the use of a hands-on technique in a reflexive way to guide or redirect the individual away from harm may be where a person holds an individual back from crossing the road where the individual began to move forward without consideration of the oncoming traffic. Another example may be where a person catches an individual when they begin to fall down.

However, examples of physical restraint include pulling a care recipient in a direction they do not wish to go or holding a care recipient down to administer medication.

Assisting individuals during activities of daily living and therapeutic activities where the individual is unable to perform these tasks themselves or has requested assistance, for example, assisting during dressing, shaving, teeth brushing, or assisting to complete physiotherapy activities, are not considered to be physical restraint.

Seclusion

Subsection 17-5(6) defines what restrictive practices will be taken to be seclusion. Seclusion is a practice or intervention that is, or that involves, the sole confinement of an individual in a room or a physical space at any hour of the day or night where:

- voluntary exit is prevented or not facilitated; or
- it is implied that voluntary exit is not permitted;

for the primary purpose of influencing the individual's behaviour.

Examples of seclusion are locking an individual in their room or other area of an approved residential care home, ordering an individual to a specific area within the approved residential care home with them believing they are not permitted to leave, or aged care workers and other individuals retreating to other rooms while the individual is unable to follow.

An individual choosing to go to their own room or bathroom and locking the door is not seclusion, provided they are free to leave when they wish to. Additionally, individuals required to isolate for the purpose of complying with state and territory public health directives would not be considered to be seclusion, as the primary purpose for such an action is not to influence the individual's behaviour.

Part 8 – Supporters

Division 1 – Actions and duties of supporters

Section 28-5 – Role of guardians etc – prescribed classes of persons

Section 28-5 prescribes that for the purposes of paragraph 28(2)(d) of the Act, a class of persons includes restrictive practices substitute decision-makers.

Division 2 – Registration of supporters

Section 37-5 – Registration of supporters – matters the System Governor must take into consideration

Section 37-5 prescribes, for the purposes of paragraph 37(6)(c) of the Act, additional matters that the System Governor must take into consideration when deciding whether to register a person as a supporter of an individual under subsection 37(1) of the Act.

Subsection 37-5(1) confirms that this section applies to decisions about registering a person as a supporter.

Subsection 37-5(2) provides that, for a person who is covered by subsection 28(2) of the Act, the System Governor must consider the nature of the person's decision-making authority for an individual, including the extent to which that person's decision-making authority extends to decisions relevant to the delivery of funded aged care services to the individual.

For example, when considering the nature of a person's decision-making authority, the System Governor may consider while the authority relates to an aspect of the delivery of funded aged care services, it is so narrow or exclusive to one element of this that the authority does not extend far enough across the delivery of funded aged care services to support registration as a supporter. This recognises that supporters may assist an individual to do a thing under, or for the purposes of, the Act other than Part 5 of Chapter 4 of the Act, and a supporter covered by subsection 28(2) of the Act will receive any information or documents that is required or authorised under, or for the purposes of, this Act to be given to the individual, regardless of the consent of the individual.

Chapter 2 – Entry to the Commonwealth aged care system

Part 1 – Introduction

Section 55-5 – Simplified outline of this Chapter

Section 55-5 provides a simplified outline of Chapter 2. This chapter comprises matters relating to entry to the Commonwealth aged care system under Chapter 2 of the Act, including how an older individual can apply for, and access funded aged care services.

It provides for the rules which implement the new processes that provide a single point for individuals entering the Commonwealth aged care system.

Part 2 of this chapter relates to eligibility of individuals for entry to the Commonwealth aged care system, and deals with:

- applying for access to funded aged care services; and

- the assessment tool for aged care needs assessments and circumstances in which reassessments are required;
- approval of access to funded aged care services.

Part 3 of this chapter relates to classification, and deals with:

- requirements for classification assessments; and
- the period for making classification decisions and the period of effect of classification levels for classification types for service groups for individuals; and
- prescribing classification levels for classification types for service groups, including criteria used to establish certain classification levels and methods or procedures for deciding certain classification levels.

Part 4 of this chapter relates to prioritisation, and deals with:

- priority category decisions; and
- priority categories for classification types for service groups and eligibility criteria for those priority categories; and
- circumstances in which urgency ratings will apply to individuals in relation to the classification type ongoing or short-term for the service group residential care.

Part 5 of this chapter relates to place allocation, and deals with:

- allocation of places to individuals, including methods that the System Governor must follow in deciding the order of allocation of places to individuals for certain classification types and service groups; and
- allocation of places to registered providers for certain specialist aged care programs.

Part 2 – Eligibility for entry

Division 1 – Applying for access to funded aged care services

Section 56-5 – Classes of persons who may apply on behalf of individuals

Section 56-5 lists the classes of people who may apply to the System Governor on behalf of the individual for access to funded aged care services. The individual must not have an existing eligibility determination in effect. The classes of people are:

- supporters of the individual;
- registered health practitioners;
- allied health professionals;
- aged care workers of registered providers;
- registered providers;
- social workers (however described);
- individuals employed or engaged as care finders under the care finder program funded by the Department;
- individuals employed or engaged as elder care supporters under the elder care support program funded by the Department;
- family members, friends, advocates and carers of the individual;
- independent aged care advocates.

Having a class of persons be able to apply to the System Governor for access to funded aged care services on behalf of the individual is important. At this stage in the assessment process, an individual may not be able to apply for access to funded aged care services themselves.

Section 57-5 – Period for deciding whether to make eligibility determinations

Section 57-5 provides that, for the purposes of subsection 57(2) of the Act, the System Governor, after receiving an application for access to funded aged care services, must decide within 28 days whether to make an eligibility determination for an aged care needs assessment for the individual.

Section 58-5 – Information to be provided for eligibility determinations

Section 58-5 provides that for the purposes of paragraph 58(b) of the Act, each of the following is prescribed as the kinds of information that the System Governor must consider when making an eligibility determination for an individual in relation to their care needs. The kinds of information prescribed are:

- a declaration by the individual, made orally or in writing, that the individual has care needs;
- a written statement by a person in a class of persons referred to in Section 56-5 of the rules that sets out the individual's care needs;
- written medical records of the individual's care needs.

The term care needs used in this section is defined in section 7 of the Act. The note following section 58-5 highlights this.

The eligibility determination for an aged care needs assessment is separate to the assessment of an individual's need for funded aged care services. The assessment of an individual's need for funded aged care services is arranged after the System Governor makes the eligibility determination.

Division 2 – Aged care needs assessments and reassessments

Subdivision A – Aged care needs assessments

Section 62-5 – Assessment tool

Section 62-5 prescribes that aged care needs assessments must be carried out by an approved needs assessor using the Integrated Assessment Tool. The Integrated Assessment Tool provides for a single, consistent tool to assess an individual's need for all Commonwealth-funded aged care services.

The Integrated Assessment Tool is used by needs assessors to determine an individual's care needs and help the needs assessor determine the appropriate type of care under the Act, including the individual's need to access services under specialist aged care programs.

Subdivision B – Aged care needs reassessments

Section 64-5 – Significant changes in circumstances

Section 64-5 prescribes what is considered a significant change in circumstances in relation to an individual who is accessing funded aged care services (other than residential care). The significant changes in circumstances are:

- a carer for the individual has permanently ceased to provide some or all care to the individual;
- the individual has experienced an event, or a decline in their condition, that is likely to mean that the individual will require:
 - more frequent access to a funded aged care service that is covered by the individual's access approval and that the individual has been accessing; or
 - access to a funded aged care service that is covered by the individual's access approval but that the individual has not been accessing (for example, because the individual's budget is exhausted); or
 - access to a funded aged care service that is not covered by the individual's access approval (for example, the individual's existing classification level does not include services that are now required because of a significant change in their condition).

If the System Governor is satisfied that one of the above significant changes in circumstances applies in relation to an individual and decides that a reassessment of the individual's needs for aged care services is required under subsection 64(1) of the Act, the reassessment must be conducted in accordance with section 61 of the Act – the section which governs the undertaking of a full assessment of an individual's need for funded aged care services.

Section 64-10 – Other circumstances

Section 64-10 prescribes other circumstances the System Governor should consider when deciding whether a reassessment of an individual's needs for funded aged care services (other than the service group residential) is required. This section provides for the process that is described as a 'Support Plan Review' in the Aged Care Assessment Manual. The circumstances where a Support Plan Review is undertaken is described below.

One circumstance is that a carer for the individual has temporarily ceased to provide some or all care to the individual. Another is that the individual has experienced an event, or a decline in their condition, that is likely to mean that the individual will require access to a funded aged care service that is not covered by the individual's access approval (but can, for example, be accommodated within their existing classification). These circumstances are intended to provide for the ability for the System Governor to carry out a reassessment when an individual has had a change in circumstances that does not meet the definition of significant change in circumstance in section 64-5 of the rules. In these circumstances it is also likely that an individual may require additional services or service types resulting from their change of circumstances. The addition of services or service types to an individual's access approval also requires a reassessment.

Another circumstance is when all the following apply to an individual:

- the individual has an access approval in effect for the classification type ongoing or short-term for the service group home support;
- on the date of the application for the reassessment, the individual has a prognosis of a life expectancy of 3 months or less;
- on the date of the application for the reassessment, the individual has an AKPS score of 40 or less;
- the individual has not previously had the classification level SAH end-of-life pathway in effect;
- a notice in the approved form containing evidence of the matters referred to in subparagraphs (ii) and (iii) has been given to the System Governor (above points relating to life expectancy and AKPS score);

These circumstances are prescribed here to allow for the System Governor to carry out a reassessment based on information provided to them (a type of information prescribed in section 64-15) when an individual is accessing funded aged care services in the service group home support already but is now eligible for the SAH end-of-life pathway.

Another circumstance is when both of the following apply to an individual:

- the individual has an access approval in effect for the classification type short-term for the service group home support;
- the individual has previously had the classification level SAH end-of-life pathway in effect;

These circumstances are prescribed here to allow for the System Governor to carry out a reassessment based on information provided to them (a type of information prescribed in section 64-15) when an individual previously had or currently has the SAH end-of-life pathway in effect yet still has a need for access to funded aged care services.

Another circumstance is when both of the following apply to an individual:

- the classification level SAH end-of-life pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;
- the individual will require access to funded aged care services in the service group assistive technology;

These circumstances are prescribed here to allow for the System Governor to carry out a reassessment based on information provided to them (a type of information prescribed in section 64-15 of the rules) when an individual is accessing the SAH end-of-life pathway but would benefit from the addition of assistive technology to meet their needs.

Another circumstance is when both of the following apply to an individual:

- the classification level SAH restorative care pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;
- the individual will require access to funded aged care services in the service group assistive technology or home modifications;

These circumstances are prescribed here to allow for the System Governor to carry out a reassessment based on information provided to them (a type of information prescribed in section 64-15 of the rules) when an individual is accessing the SAH restorative care pathway

but would benefit from the addition of assistive technology or home modifications to meet their needs.

Another circumstance is when both of the following apply to an individual:

- the individual has an access approval in effect for the classification type ongoing for the service group home support;
- repairs or maintenance are required for an included AT-HM item or a conditionally included AT-HM item that the individual owns or has been loaned or rented under a Commonwealth aged care program (including under the old Act);

These circumstances are prescribed here to allow for the System Governor to carry out a reassessment based on information provided to them (a type of information prescribed in section 64-15) when an individual is accessing the SAH ongoing but would benefit from the addition of assistive technology funding to meet their assistive technology repair and maintenance needs.

Another circumstance is when both of the following apply to an individual:

- the individual has an access approval in effect for the classification type ongoing for the service group home support;
- the individual has a progressive condition as outlined in subsection 211-10(2) of the rules.

These circumstances are prescribed here to allow for the System Governor to carry out a reassessment based on information provided to them (a type of information prescribed in section 64-15 of the rules) when an individual is accessing the SaH ongoing but would benefit from the addition of assistive technology or home modifications to meet their needs.

Another circumstance is when both of the following apply to an individual:

- the individual has an access approval in effect for the classification type ongoing for the service group home support;
- the individual has an assistance dog.

These circumstances are prescribed here to allow for the System Governor to carry out a reassessment based on information provided to them (a type of information prescribed in section 64-15) when an individual is accessing the SaH ongoing but would benefit from the addition of ongoing assistive technology funding for essential assistance dog maintenance costs.

If the System Governor is satisfied that any of the above circumstances apply in relation to an individual and decides that a reassessment of the individual's needs for aged care services is required under subsection 64(1) of the Act, the System Governor can make the reassessment based on of the kind of information prescribed in section 64-15 (Information for reassessments in other circumstances) of the rules below. This will allow a new access approval decision to be made, without the individual undergoing a whole new needs assessment. For example, an individual accessing funded aged care services through the home support service group, may not have been approved to access meals at the time of their original assessment - the individual could provide information to show they need this service as part of their access approval.

Further information relating to this process can be found in the Aged Care Assessment Manual on the department's website.

Section 64-15 – Information for reassessments in other circumstances

Section 64-15 lists the kinds of information in relation to an individual that the System Governor could use as the basis of a reassessment decision. The kinds of information prescribed are:

- information in the application for the aged care needs reassessment;
- information provided, orally or in writing, by any of the following about the individual's need for funded aged care services:
- a registered health practitioner;
- an allied health professional;
- a registered provider delivering the funded aged care service home support care management or home support restorative care management to the individual;
- information provided, orally or in writing, by an approved needs assessor following a review by the assessor of the report of the most recent aged care needs assessment for the individual;
- information in the most recent application for a classification reassessment for the individual.

Division 3 – Approval of access to funded aged care services

Subdivision A – General

Section 65-5 – Approval of services in service types for individuals

Section 65-5 prescribes the service types *allied health and therapy* and *therapeutic services for independent living* for the purposes of subparagraph 65(2)(b)(ii) of the Act. Accordingly, the System Governor must decide which of the services within these service groups to approve for the individual.

The service types identified in this section are ones where the services within that service type meet different needs or interact with different barriers. For example, within the service type *allied health and therapy*, an individual could be approved services for podiatry, social work and speech pathology. While an individual may need all three services, these services interact with the barriers an individual may experience in different ways, and as such must be approved separately.

Section 65-10 – Eligibility requirements—service group home support

Section 65-10 provides the eligibility requirements for the service group home support for the purposes of paragraph 65(3)(b) of the Act. These are included to help ensure that individuals are approved for the service group that best meets the individual's personal situation.

The eligibility requirements for the service group home support set out in the section for an individual are:

- the individual has a total score of less than 20 for the questions in the Integrated Assessment Tool with the following headings:
 - “Climb stairs”;
 - “Eating”;
 - “Dressing”;

- “Take a bath or shower”;
- “Grooming”;
- “Transfers”;
- “Toilet use”;
- “Toileting – bladder”;
- “Toileting – bowels”;
- “Walk”; or
- the individual has a total score of less than 14 for the questions in the Integrated Assessment Tool with the following headings:
 - “Get to places out of walking distance”;
 - “Undertake housework (heavy/moderate)”;
 - “Go shopping (assuming transportation)”;
 - “Prepare meals”;
 - “Take medicine”;
 - “Handle money”;
 - “Use the telephone”; or
- the individual has a score of greater than zero for the questions in the sections of the Integrated Assessment Tool headed “Cognition” and “Medical and Medications”; or
- the individual has a score of greater than zero for the questions in the sections of the Integrated Assessment Tool headed “Psychological”; or
- the individual has a score of greater than zero for the questions in the section of the Integrated Assessment Tool headed “Physical, Personal Health and Frailty”.

The above scores are based on responses to specific questions in the Integrated Assessment Tool (IAT) that fall across the “Function”, “Medical and Medications”, “Psychological” and “Physical, Personal Health and Frailty” domains of the Tool. If, during the needs assessment, the individual’s responses to the questions in the IAT indicate the individual has very few or no care needs, then the individual is likely to be ineligible for funded aged care services.

These questions can be viewed in the IAT, which is published on the department’s website

Section 65-15 – Eligibility requirements—service groups assistive technology and home modifications

Section 65-15 prescribes the eligibility requirement for the service groups assistive technology and home modifications for the purposes of paragraph 65(3)(b) of the Act. The eligibility requirement is that the individual has been approved for the service group home support.

Section 65-20 – Eligibility requirements—service group residential care

Section 65-20 prescribes the eligibility requirement for the service group residential care for the purposes of paragraph 65(3)(b) of the Act. The eligibility requirement is that the individual is not able to live in a home or community setting without support.

Section 65-30 – Period for making decisions

Section 65-30 prescribes that the period for making the access approval decision for an individual’s access to funded aged care services under subsections 65(1) and (2) of the Act is 14 days after receiving an assessment report for the individual provided under section 63 of

the Act, or information relating to the individual that is provided to the System Governor in accordance with paragraph 64(2)(b) of the Act, as applicable.

The intention is that this will ensure timely access to funded aged care services for individuals.

Subdivision B – Period of effect of approval

Section 71-5 – Alternative entry—when access approval takes effect—circumstances and period for making application

Section 71-5 prescribes for the purposes of paragraph 71(3)(b) of the Act when access approvals take effect in special circumstances. The circumstance prescribed for an individual is that a registered provider that delivers funded aged care services under the MPSP or the NATSIFACP is delivering aged care services to the individual then the period is 30 days after the first day an aged care service covered by the individual's access approval was delivered to the individual by the provider.

The 30-day period takes into account the particular settings relating to these specialist services (for example, geographic, cultural or technological barriers to making an application within the 30-day period).

This subsection only applies in specific circumstances as detailed in section 71(4) of the Act.

Part 3 – Classification

Division 1 – Classification assessments

Section 75-5 – Circumstances in which classification assessment not required

Section 75-5 prescribes circumstances for the purposes of paragraph 75(5)(a) of the Act when classification assessments under paragraph 75(1)(b) or subsection 75(2) of the Act are not required. These are when the assessment:

- the classification type is ongoing or short-term for the service group residential care; and
- the individual is accessing funded aged care services under a specialist aged care program in an approved residential care home.

This section is appropriate as deciding a classification level for an individual for the service group residential care for a specialist aged care program classification type does not require performance of a classification assessment.

Section 76-10 – Assessment tools and other requirements for classification assessments required under subsection 75(1) or (2) of the Act and carried out by approved needs assessors

Section 76-10 prescribes the assessment tools and other requirements for classification assessments required under subsection 75(1) or (2) of the Act. These assessment tools and requirements are different depending on the service group.

Subsection 76-10(1) explains that this section is made for the purposes of subparagraphs 76(1)(a)(i) and (b)(i) of the Act.

Subsection 76-10(2) prescribes the assessment tool and other requirements for an assessment for an individual which establishes a classification type for the service group home support, assistive technology or home modifications which are:

- the assessment tool is the Integrated Assessment Tool; and
- the other requirements are that the assessment must be carried out in accordance with the Aged Care Assessment Manual.

Subsection 76-10(3) prescribes the assessment tool and other requirements for an assessment for an individual for the classification type ongoing for the service group residential care which are:

- the assessment tool is the AN-ACC Assessment Tool; and
- the other requirements are that the assessment must be carried out in accordance with the AN-ACC Reference Manual.

Subsection 76-10(4) prescribes the assessment tool and other requirements for an assessment for an individual for the classification type short-term for the service group residential care which are:

- the assessment tool is the De Morton Mobility Index assessment item; and
- the other requirements are that the assessment must be carried out in accordance with the part of the AN-ACC Reference Manual that relates to that item.

Section 76-15 – Circumstances and information for classification assessments required under paragraph 75(1)(a) or subsection 75(2) of the Act and carried out by the System Governor

Section 76-15 prescribes the circumstances and information for classification assessments required under paragraph 75(1)(a) or subsection 75(2) of the Act and carried out by the System Governor.

Subsection 76-15(1) outlines that section 76-15 is made for the purposes of subparagraph 76(1)(a)(ii) of the Act for an assessment for an individual for a classification type for a service group. The circumstances and information required differs depending on the classification type, the service group and the circumstance.

Classification type short-term for service groups home support and assistive technology—end-of-life

Subsection 76-15(2) prescribes the circumstances and kind of information required for a classification assessment required under 75(1)(a) or subsection 75(2) of the Act and carried out by the System Governor for the classification type short-term for the service groups home support and assistive technology.

These are:

- the individual has an access approval in effect for the classification type short-term for the service group home support

- on the date of the individual's application for access to funded aged care services, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less
- the individual has not previously had the classification level SAH end-of-life pathway in effect and
- the kind of information is information that provides evidence of the matters mentioned above.

Subsection 76-15(3) prescribes the circumstances and kind of information required for a classification assessment required under paragraph 75(1)(a) or subsection 75(2) of the Act for the classification type short-term for the service groups assistive technology and home modifications as well as the classification type ongoing for the service group home support. These are:

- the individual has an access approval in effect for the classification type short-term for the service group home support and
- the individual has previously had the classification level SAH end-of-life pathway in effect;
- the kind of information is information that provides evidence of the matters mentioned above.

Subsection 76-15(4) prescribes the circumstances and kind of information required for a classification assessment required under paragraph 75(1)(a) or subsection 75(2) of the Act for the classification type short-term for the service group assistive technology. These are:

- the classification level SAH end-of-life pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;
- the individual will require access to funded aged care services in the service group assistive technology;
- the kind of information is information that provides evidence of the matters mentioned above.

Classification type short-term for service group assistive technology or home modifications—restorative care pathway

Subsection 76-15(5) prescribes the circumstances and kinds of information required for a classification assessment required under paragraph 75(1)(a) or subsection 75(2) of the Act for the classification type short-term for the service group assistive technology and home modifications. These are:

- the classification level SAH restorative care pathway for the classification type short-term for the service group home support has been established for the individual by a classification decision;
- the individual will require access to funded aged care services in the service group assistive technology or home modifications;

- the kind of information is information that provides evidence of the matters mentioned above.

Classification type short-term for service group assistive technology—repairs or maintenance for included and conditionally included AT-HM items

Subsection 76-15(6) prescribes the circumstances and kinds of information required for a classification assessment required under paragraph 75(1)(a) or subsection 75(2) of the Act for the classification type short-term for the service group assistive technology. These are:

- a classification level for the classification type ongoing for the service group home support has been established for the individual by a classification decision; and
- repairs or maintenance are required for an included AT-HM item or a conditionally included AT-HM item that the individual owns or has been loaned or rented under a Commonwealth aged care program (including under the old Act);
- the kind of information is information that provides evidence of the matters mentioned above.

Classification type short-term for service groups assistive technology and home modifications—progressive conditions

Subsection 76-15(7) prescribes the circumstances and kinds of information required for a classification assessment required under paragraph 75(1)(a) or subsection 75(2) of the Act for the classification type short-term for the service group assistive technology and home modifications. These are:

- a classification level for the classification type ongoing for the service group home support has been established for the individual by a classification decision; and
- the individual has a condition referred to in subsection 211-10(2) of the rules;
- the kind of information is information that provides evidence of the matters mentioned above.

Classification type ongoing for service group assistive technology—assistance dog

Subsection 76-15(8) prescribes the circumstances and kinds of information required for a classification assessment required under paragraph 75(1)(a) or subsection 75(2) of the Act for the classification type short-term for the service group assistive technology. These are:

- the individual has an access approval in effect for the classification type ongoing for the service group home support;
- the individual has an assistance dog;
- the kind of information is information that provides evidence of the matters mentioned above.

Classification type short-term for service groups assistive technology and home modifications—aged care needs reassessments in certain circumstances

Subsection 76-15(9) prescribes the circumstances and kinds of information required for a classification assessment required under paragraph 75(1)(a) or subsection 75(2) of the Act for

the classification type short-term for the service group assistive technology and home modifications. These are:

- a classification level for the classification type short-term for the service group home support has been established for the individual by a classification decision; and
- the circumstances referred to in paragraph 64-10(b) of the rules (aged care needs reassessments in certain circumstances) apply to the individual
- the kinds of information are the kinds of information referred to in paragraphs 64-15(a), (b) and (c) of the rules.

Classification type ongoing for service group residential care—palliative care pathway

Subsection 76-15(10) prescribes the circumstances and kind of information are required for a classification assessment required under paragraph 75(1)(a) or subsection 75(2) of the Act for the classification type ongoing for the service group residential care, for an individual accessing funded aged care services in the form of palliative care in an approved residential care home of a registered provider. These are:

- the circumstances are that:
 - on and after the individual's start day for the home, the provider has delivered funded aged care services in the form of palliative care to the individual in the home; and
 - on the individual's start day for the home, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less; and
 - the provider gives the System Governor a notice in the approved form containing the kind of information referred to in paragraph (b) within 14 days, or such longer period as is agreed in writing between the System Governor and the provider, after the provider gives the System Governor a start notification for the individual;
- the kind of information is information that provides evidence of the matters mentioned above.

The effect of the subsection is to provide for a simple, expedited classification assessment for individuals with short life expectancy and limited ability to perform activities of daily living when entering residential care homes to receive palliative care at end of life.

Section 76-20 – Circumstances and information for classification assessments required under paragraph 75(1)(b) of the Act (on application for classification reassessment) and carried out by the System Governor

Section 76-20 prescribes the circumstances and information for classification assessments required under paragraph 75(1)(b) of the Act (on application for classification reassessment) and carried out by the System Governor.

Subsection 76-20(1) prescribes that section 76-20 is made for the purposes of subparagraph 76(1)(b)(ii) of the Act for an assessment for an individual for a classification type for a service group.

Classification type short-term for service group assistive technology—increased needs

Subsection 76-20(2) prescribes the circumstances and kind of information required for a classification assessment required under paragraph 75(1)(b) of the Act for the classification type short-term for the service group assistive technology. These are:

- a classification level for the classification type short-term for the service group assistive technology, other than the classification level AT high, has been established for the individual by a classification decision; and
- the individual needs an increased amount of assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community;
- the kind of information is information that provides evidence of the circumstances mentioned above.

Classification type short-term for service group assistive technology—individuals with classification level AT transitional

Subsection 76-20(3) prescribes circumstances and kind of information required for a classification assessment required under paragraph 75(1)(b) of the Act for the classification type short-term for the service group assistive technology. These are:

- the classification level AT transitional for the classification type short-term for the service group assistive technology has been established for the individual by a classification decision; and
- subsection 76-20(4) applies to the individual;
- the kind of information is information that provides evidence of the circumstances mentioned above.

Subsection 76-20(4) adds additional information for when 76-20(3) applies to an individual. These include that the individual has a condition referred to in subsection 211-10(2) of the rules or the System Governor has reviewed the report of the most recent aged care needs assessment for the individual and considers that the individual needs assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community (see paragraph (a) in column 2 of items 1 to 3 of the table in subsection 81-25(1) of the rules (criteria for the classification levels AT low, AT medium and AT high)).

Classification type short-term for service group home modifications—increased needs

Subsection 76-20(5) prescribes the circumstances and kind of information required for a classification assessment required under paragraph 75(1)(b) of the Act for the classification type short-term for the service group home modifications. These are:

- a classification level for the classification type short-term for the service group home modifications, other than the classification level HM high, has been established for the individual by a classification decision; and
- the individual needs an increased amount of home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community;
- the kind of information is information that provides evidence of the circumstances mentioned above.

Classification type short-term for service group home modifications—individuals with classification level HM transitional

Subsection 76-20(7) prescribes the circumstances and kind of information required for a classification assessment required under paragraph 75(1)(b) of the Act for the for the classification type short-term for the service group home modifications These are:

- the classification level HM transitional for the classification type short-term for the service group home modifications has been established for the individual by a classification decision; and
- the System Governor has reviewed the report of the most recent aged care needs assessment for the individual and considers that the individual needs home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community (see paragraph (a) in column 2 of items 1 to 3 of the table in subsection 81-30(1) of the rules (criteria for the classification levels HM low, HM medium and HM high));
- the kind of information is information that provides evidence of the circumstances mentioned above.

Classification type ongoing for service group residential care—palliative care pathway

Subsection 76-20(9) prescribes the circumstances and kinds of information required for a reclassification decision for the classification type ongoing for the service group residential care, for an individual accessing funded aged care services in the form of palliative care in an approved residential care home of a registered provider. These are:

- the circumstances are that:
 - on and after the individual's start day for the home, the provider has delivered funded aged care services in the form of palliative care to the individual in the home; and
 - on the individual's start day for the home, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less; and
 - the provider gives the System Governor a notice in the approved form containing the kind of information referred to in paragraph (b) within 14 days, or such longer period as is agreed in writing between the System Governor and the provider, after the date of the application for classification reassessment for the individual;
- the kind of information is information that provides evidence of the matters mentioned above.

The effect of the subsection is to provide for a simple, expedited classification assessment for individuals with short life expectancy and limited ability to perform activities of daily living when entering residential care homes to receive palliative care at end of life.

Section 76-25 – Classification assessments for classification type ongoing for service group residential care—skills, qualifications and other requirements for approved needs assessors

Section 76-25 prescribes for the purpose of paragraph 76(2)(a) of the Act the skills, qualifications and other requirements that approved needs assessors must have to carry out a classification assessment, for the classification type ongoing for the service group residential care. The skills, qualifications and prior experience required are proportionate to the complexity and sensitivities of assessing frail aged individuals against clinical assessment items in the AN-ACC Assessment Tool (see subsections 76-10(3) and (4)).

Subsection 76-25(1) outlines the skills and qualifications required for someone carry out a classification assessment for the classification type ongoing for the service group residential care. Subsection 76-25(1) prescribes that the approved needs assessors must be a registered nurse, occupational therapist or physiotherapist.

Subsection 76-25(2) prescribes the other requirements for an approved needs assessor to carry out a classification assessment for the classification type ongoing for the service group residential care for the purposes of 76(2)(b) of the Act. These are:

- the assessor has at least 5 years of clinical experience in the delivery of aged care services or related health services as a registered nurse, occupational therapist or physiotherapist (as the case requires);
- a police certificate issued for the assessor within the last 3 years does not record that the assessor has a serious offence conviction in Australia;
- if, at any time after turning 16, the assessor has been a citizen or permanent resident of a country other than Australia—the assessor has made a statutory declaration that the assessor does not have a serious offence conviction in that country.

The legislative note clarifies that approved needs assessors must carry and produce identity cards issued under subsection 343A(1) of the Act when performing functions or exercising powers under the Act as approved needs assessors (see section 343A-10 of the rules).

Division 2 – Classification decisions

Subdivision A – Period for making classification decisions

Section 78-5 – Period for making classification decisions

Section 78-5 prescribes that for the purposes of subsection 78(4) of the Act, the period for making a decision under subsection 78(1) of the Act to establish a classification level for an individual for a classification type for a service group is 14 days after the occurrence of whichever of the events referred to in subsection 78(1) of the Act is applicable for the individual. This is intended to ensure timely access for an individual to their classification level and therefore the funded aged care services for which they have been approved.

Subdivision B – Period of effect of classification levels

Section 80-5 – Purpose of this Subdivision

Section 80-5 prescribes that the following sections within this subdivision of the rules provides the period of effect for a classification level for a classification type for a service group that has been established under section 78 of the Act for an individual. This section also prescribes that the sections in this subdivision are made for the purpose of subsection 80(1) of the Act and is subject to subsection 80(3) of the Act.

The legislative note adds that for the period of effect for classification levels taken to be established for an individual by the *Aged Care (Consequential and Transitional Provisions) Determination 2025*, see the *Aged Care (Consequential and Transitional Provisions) Rules 2025*.

Section 80-10 – Service group home support—classification type ongoing

Section 80-10 prescribes the periods of effect for classification levels in the classification type ongoing, for the service group home support. The period of effect is different depending on the classification level.

CHSP class

Subsection 80-10(1) prescribes that for the classification level CHSP class for the classification type ongoing for the service group home support, established for an individual by a classification decision, the period of effect:

- starts at the start of the day the individual's access approval for the classification type for the service group was given; and ends at the end of the earlier of the following (as applicable):
 - the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
 - the day the individual dies.

SAH class 1, 2, 3, 4, 5, 6, 7 or 8

Subsection 80-10(2) prescribes that for the classification level SAH class 1, 2, 3, 4, 5, 6, 7 or 8 for the classification type ongoing for the service group home support, established for an individual by a classification decision, the period of effect:

- starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act and ends at the end of the earlier of the following (as applicable):
 - the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
 - the day the individual dies.

Section 80-15 – Service group home support—classification type short-term

Section 80-15 prescribes the period of effect of classification levels for the classification type short-term in the service group home support. The period of effect provisions differs depending on the classification level, as different classification levels serve different purposes.

SAH restorative care pathway

Subsection 80-15(1) prescribes the period of effect for the classification level SAH restorative care pathway. The period of effect starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act and ends at the earliest of the following as applicable:

- the end of the day a classification decision is made to establish a classification level (other than CHSP class) for the classification type ongoing for the service group home support for the individual;
- the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
- the end of the maximum period of effect for the classification level (see section 80-55);
- the end of the day the individual dies.

SAH end-of-life pathway

Subsection 80-15(3) prescribes the period of effect for the classification level SAH end-of-life pathway for the classification type short-term for the service group home support. The period of effect starts the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act and ends at the earliest of the following (as applicable):

- the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
- the end of the maximum period of effect for the classification level (see section 80-57);
- the end of the day the individual dies.

Section 80-20 – Service group assistive technology—classification type ongoing

Section 80-20 prescribes that for the classification level assistance dogs for the classification type ongoing for the service group assistive technology. The period of effect starts at start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act and ends at the earliest of the following (as applicable):

- the day that the individual ceases to have an assistance dog;
- the day the individual dies.

Section 80-25 – Service group assistive technology—classification type short-term

Section 80-25 prescribes the period of effect of the classification levels in the classification type short-term for the service group assistive technology.

AT CHSP

Subsection 80-25(1) prescribes that for the classification level AT CHSP for the classification type short-term for the service group assistive technology the period of effect starts at the start of the day the individual's access approval for the classification type for the service group was given and end the earlier of the following:

- the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
- the day the individual dies.

AT low, AT medium and AT high

Subsection 80-25(2) prescribes that for the classification level AT low, AT medium or AT high for the classification type short-term for the service group assistive technology, the period of effect starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act and ends at the earlier of the following:

- the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
- the end of the account period for the individual's notional assistive technology account established in respect of that classification level;
- the end of the day the individual dies.

Section 80-30 – Service group home modifications—classification type short-term

Section 80-30 prescribes the period of effect for the classification type short-term for the service group home modifications. Different classification levels under this classification type have different period of effects as they serve different purposes.

HM CHSP

Subsection 80-30(1) prescribes that for the classification level HM CHSP for the classification type short-term for the service group home modifications the period of effect starts at the start of the day the individual's access approval for the classification type for the service group was given and ends at the earlier of the following:

- the later of the following:
 - the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
 - if the System Governor determines a later time than the time mentioned above for the individual under subsection 80-30(3), then that later time;
- the day the individual dies.

HM low, HM medium and HM high

Subsection 80-30(2) prescribes that for the classification levels HM low, HM medium or HM high for the classification type short-term for the service group home modifications, established for an individual by a classification decision, the period of effect starts at the start of the day a place allocated under subsection 92(1) of the Act to the individual for the classification type for the service group takes effect under section 92A of the Act.

Paragraph (b) prescribes that the period of effect of the classification levels HM low, HM medium or HM high for the classification type short-term for the service group home modifications ends either at the end of the day the individual dies or the latest of the following:

- the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
- the end of the account period for the individual's notional home modifications account established in respect of that classification level;
- if the System Governor approves a later time than the time mentioned in subparagraph (A) or (B) for the individual under subsection (3)—that later time.

Approval of later time for services scheduled for delivery

Subsection 80-30(3) and (4) prescribes that if there is evidence that a service in the service group home modifications to be delivered by the registered provider to the individual has been scheduled for delivery, and is in progress, but will not be delivered before the end of the period of effect of the classification levels level HM low, HM medium or HM high for the classification type short-term for the service group home modifications, then the System Governor must approve an extension to the period of effect for an additional 12 months.

Evidence must be in the approved form and provided to the System Governor within the account period for the individual's notional home modifications account established in respect of that classification level.

Section 80-35 – Service group residential care—classification type ongoing

Class 0

Subsection 80-35(1) prescribes that the period of effect for the classification level class 0 for the classification type ongoing for the service group residential care starts on the day the individual first enters a residential care home. The classification ends either at the earlier of the day the individual dies or the day a classification level among classes 1 to 13 (inclusive) for the classification type ongoing for the service group residential care takes effect in accordance with the rules in subsection 80-35(2).

Classes 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13

Subsection 80-35(2) prescribes that, generally, the period of effect for the first time an individual gets a classification level from among classes 1 to 13 (inclusive) for the classification type ongoing for the service group residential care takes effect on the day the individual first enters a residential care home. The exception is that if the individual has a 'break period' of more than 28 days before they are first classified in any of classes 1 to 13

(inclusive) then the class 1 to 13 (inclusive) classification takes effect when that break period ends. In either case the classification ends at the end of the day the individual dies.

A break period is a period which starts when the individual ceases to receive ongoing residential care at a residential care home and ends when the individual next enters a residential care home and receives ongoing residential care. For example, if an individual enters one residential care home, then leaves the home for 5 days, and then enters another home, the break period would be 5 days, being the period from the individual leaving the first home and entering the next home.

The effect is that the first instance of a class 1 to class 13 (inclusive) classification made for an individual who enters a residential care home usually has effect (including on payment of subsidy) on and from the day the recipient first enters a residential care home. That day will usually be earlier than the day the classification decision is made. This arrangement ensures that the rate of subsidy appropriate for the individual's classification is paid on and from the individual's first day of residential care (including by replacing the prior class 0 classification – see subsection 80-35(1)) regardless of when the decision about the class 1 to 13 (inclusive) classification decision is made.

However, when an individual moves between two (or more) homes before the class 1 to class 13 (inclusive) classification decision is made, then the day of effect of the classification will be either:

- the day the individual entered the first home if they have not taken a break in care of more than 28 days while moving between homes before the classification is made; or
- the day the individual re-enters a home after their break, if the individual has a break in care for more than 28 days.

This arrangement is appropriate as the classification made of an individual who has moved between residential care homes with a break of more than 28 days cannot be assumed to reflect their circumstances at earlier homes.

Subsection 80-35(2) also prescribes that where a classification level of class 1 to class 13 (inclusive) is the result of a classification reassessment then that classification level takes effect from the date of request for the classification reassessment, replacing any prior ongoing residential classification level on and from that date.

This ensures that a new classification level takes effect from the date it was first identified, through a reclassification request, that the individual's condition had changed such that a change in classification level (and associated subsidy) might be indicated.

Section 80-40 – Service group residential care—classification type short-term

Respite class 0

Subsection 80-40(1) prescribes that the period of effect for the classification level class 0 for the classification type short-term for the service group residential care starts on the day the individual first enters a residential care home. The classification ends either at the earlier of the day the individual dies or the day a classification level among respite classes 1 to 3 (inclusive) for the classification type short-term for the service group residential care takes effect in accordance with the rules in subsection 80-40(2).

Respite classes 1, 2 and 3

Subsection 80-40(2) also prescribes that where a classification level of respite class 1 to 3 (inclusive) is the result of a classification reassessment then that classification level takes effect from the date of request for the classification reassessment, replacing any prior respite classification level on and from that date.

This ensures that a new classification level takes effect from the date it was first identified, through a reclassification request, that the individual's condition had changed such that a change in classification level (and associated subsidy) might be indicated.

Section 80-45 – Service group home support, assistive technology or residential care—classification type hospital transition

Section 80-45 provides the period of effect for the classification type hospital transition for the service groups home support, assistive technology or residential care.

Service group home support

Subsection 80-45(1) prescribes the start and end of the period of effect of the classification level HS HT class for the classification type hospital transition for the service group home support.

Firstly, it provides that the classification level does not take effect if a start day for the individual for the classification type for the service group does not occur within 28 days from the day the access approval that is in effect for the individual took effect.

Paragraph (b) prescribes that the period of effect for the classification level HS HT consists of each day on or after the start day for the individual for the classification level on which a registered provider delivers funded aged care services to the individual for the classification type for the service group; and the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group is less than the maximum period of effect for the classification level (see section 80-65).

Paragraph (c) adds that the period of effect for the classification level HS HT ends at the earlier of the following (as applicable):

- the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual
- if, after the start of the period of effect and before the end of the maximum period of effect for the classification level (see section 80-65), the individual does not access funded aged care services for the classification type for the service group for a total of 7 days—the end of the most recent day on which the individual accessed funded aged care services for the classification type for the service group;
- end of the maximum period of effect for the classification level (see section 80-65);
- the end of the day the individual dies.

Service group assistive technology

Subsection 80-45(2) prescribes the start and end of the period of effect of the classification level AT HT class for the classification type hospital transition for the service group home support.

Paragraph (a) prescribes that the classification level AT HT does not take effect if a start day for the individual for the classification type for the service group does not occur within 28 days from the day the access approval that is in effect for the individual took effect.

Paragraph (b) prescribes that the period of effect for the classification level consists of each day on or after the start day for the individual for the classification level on which a registered provider delivers funded aged care services to the individual for the classification type for the service group and the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group is less than the maximum period of effect for the classification level (see section 80-65).

Paragraph (c) prescribes the period of effect for the classification level AT HT ends at the earliest of the following:

- the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
- if, after the start of the period of effect and before the end of the maximum period of effect for the classification level (see section 80-65), the individual does not access funded aged care services for the classification type for the service group for a total of 7 days—the end of the most recent day on which the individual accessed funded aged care services for the classification type for the service group;
- the end of the maximum period of effect for the classification level (see section 80-65);
- the end of the day the individual dies.

Service group residential care

Subsection 80-45(3) prescribes the start and end of the period of effect of the classification level RC HT class for the classification type hospital transition for the service group residential care.

The subsection ensures that in the event an individual moves from an episode of hospital transition care to residential care that the residential care classification level and associated subsidy replaces the hospital transition classification level and associated subsidy. It also appropriately reflects that hospital transition is a time-limited form of care.

Paragraph (a) prescribes the classification level RC HT does not take effect if a start day for the individual for the classification type for the service group does not occur within 28 days from the day the access approval that is in effect for the individual took effect.

Paragraph (b) prescribes that the period of effect for the classification level RC HT consists of each day on or after the start day for the individual for the classification level on which a registered provider delivers funded aged care services to the individual for the classification type for the service group and the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group is less than the maximum period of effect for the classification level (see section 80-65).

Paragraph (c) prescribes that the period of effect for the classification level RCHT ends at the earliest of the following:

- the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual.
- if, after the start of the period of effect and before the end of the maximum period of effect for the classification level (see section 80-65), the individual does not access funded aged care services for the classification type for the service group for a total of 7 days—the end of the most recent day on which the individual accessed funded aged care services for the classification type for the service group;
- the end of the maximum period of effect for the classification level (see section 80-65);
- the end of the day the individual dies.

Subdivision C – Maximum period of effect of classification levels

Section 80-50 – Purpose of this Subdivision

Section 80-50 describes that this subdivision is made for the purposes of section 80(1) of the Act and prescribes for certain classification levels, the maximum period of effect for the classification level.

The sections in this subdivision cover classification levels in certain classification types which are, by nature of the services provided, time limited. This includes short-term and hospital transition classification types, which must be accessed within a certain amount of time or the classification for those services will lapse. This is necessary given the time-sensitive nature of the needs affecting older people who would be approved for those kinds of services.

Section 80-55 – Service group home support—classification type short-term—classification level SAH restorative care pathway

Section 80-55 provides that for the classification level SAH restorative care pathway for the classification type short-term for the service group home support, the maximum period of effect for an individual is 112 days.

This is a short-term and time limited classification type, intended to focus on early intervention through intensive clinical care, support and monitoring. The Restorative Care Pathway aims to maintain or regain function and to reduce or prevent functional decline, particularly after a setback.

Section 80-57 – Service group home support—classification type short-term—classification level SAH end-of-life pathway

Section 80-57 provides that for the classification level SAH end-of-life pathway for the classification type short-term for the service group home support, the maximum period of effect for an individual is 112 days.

This is a short-term and time limited classification type, intended to provide support to participants with less than 3 months to live.

Section 80-60 – Service group residential care—classification type short-term

Section 80-60 prescribes the maximum period of effect for a classification level for the classification type short-term, for the service group residential care. This is a short-term and therefore time limited classification type intended to provide temporary support to individuals and their carers for short periods of time, for example to give both individual and carer a break or to allow carers to undertake necessary personal travel.

Subsection 80-60(1) provides that for classification level for the classification type short-term for the service group residential care, the maximum period of effect is 63 days or if the System Governor has increased the number of days for the classification level for the individual under subsection 80-60(5) then the number of days as so increased (or as most recently increased).

The legislative note clarified that the maximum period of effect for the classification type short-term for the service group residential care relates to a financial year (see section 80-40).

Increase in number of days for classification levels for individuals

Subsection 80-60(2) provides that a registered provider may apply to the System Governor for a determination of an increased number of days for the classification level for an individual under subsection 80-60(5). Subsection (3) adds that the application must be made in the approved form. Subsection (4) provides that the System Governor must consider any applications under (3) and decide whether to determine an increased number of days under subsection (5).

Subsection 80-60(5) provides that the System Governor may increase the number of days for the classification level for the individual by up to 21 days if the System Governor is satisfied that an increase in the number of days is necessary because of any of the following:

- carer stress;
- severity of the individual's condition;
- absence of the individual's carer;
- any other relevant matter.

These grounds appropriately reflect common circumstances in which additional residential respite care is an appropriate way to meet an individual's needs.

Subsection 80-60(6) provides that the System Governor must give written notice to the registered provider of the System Governor's decision within 28 days after the application was made.

Subsection 80-60(7) provides that the increase in number of days for the classification level under subsection 80-60(5) can be made more than once. This appropriately reflects that respite care needs can be unpredictable and that, on a case-by-case basis, granting more than one extension to the maximum number of subsidised residential respite care days during a financial year can be necessary for an individual's needs to be met.

Section 80-65 – Service group home support, assistive technology or residential care—classification type hospital transition

Section 80-65 prescribes the maximum period of effect for the classification type hospital transition in the service groups home support, assistive technology or residential care. The hospital transition classification type is intended for post-hospital rehabilitation and is therefore time limited and has a maximum period of effect.

Subsection 80-65(1) provides that for a classification level for the classification type hospital transition for the service group home support, assistive technology or residential care, the maximum period of effect is 84 days. Paragraph (b) adds that if the System Governor determines one or more additional periods for the classification level for the individual under subsection 80-65(5) then the maximum period of effect is 84 days plus those additional periods.

Extension of maximum period of effect for classification levels for individuals

Subsection 80-65(2) provides that a registered provider may apply to the System Governor for a determination of an additional period for the classification level for an individual.

Subsection 80-65(3) adds that the application to the System Governor must be made in the approved form. Paragraph (3)(b) prescribes that the application must be made within the 84 days (as provided for by paragraph (1)(a)) or if an additional period is determined for the classification level for the individual under subsection (5), then the application must be made within that period.

Subsection 80-65(4) provides that the System Governor must consider an application under subsection (2) and decide whether to determine an additional period under subsection (5).

Subsection 80-65(5) is the section which allows the System Governor to extend the maximum period of effect for the classification level. It provides that the System Governor may determine one or more additional periods, together totalling not more than 42 days, for the classification level for the individual if the System Governor is satisfied that the individual requires access to funded aged care services for that level for the additional periods.

Subsection 80-65(6) prescribes that the System Governor must give written notice to the registered provider of a decision under subsection 80-65(5) within 28 days after the application was made.

Division 3 – Classification levels and procedures

Subdivision A – Introduction

Section 81-5 – Purpose of this Division

Section 81-5 outlines the purpose of ‘Division 3 – Classification levels and procedures’. It provides that for the purpose of section 81 of the Act, this Division prescribes:

- classification levels for classification types for service groups; and
- for certain classification levels—criteria that are to be used in establishing the classification level of an individual for a classification type for a service group; and
- for certain classification levels—methods or procedures that the System Governor must follow in deciding classification levels for an individual for a classification type for a service group; and
- for the service groups home support, assistive technology and home modifications—compounding factors (based on results against relevant assessment items mentioned in subsection 77(2) of the Act) that will be used to establish an individual’s classification level; and
- for the service group residential care:
 - compounding factors (based on results against relevant assessment items mentioned in subsection 77(2) of the Act) that will be used to establish an individual’s classification level; and
 - the scientific population study that will be used by the System Governor to derive a method for establishing when these compounding factors, taken together, are significant because they indicate the individual has significantly higher care needs relative to the needs of other individuals.

Section 81-7 – Meaning of home support compounding factors

Section 81-7 provides that the home support compounding factors, for an individual, means the individual’s scores for the following groups of questions in the Integrated Assessment Tool:

- questions in the sections headed “Cognition” and “Medical and Medications”;
- questions in the section headed “Social”;
- questions under the headings “Toileting Bladder” and “Toileting Bowels”;
- questions in the section headed “Carer Profile”;
- questions in the section headed “Psychological”;
- questions in the section headed “Physical, Personal Health and Frailty”.

Section 81-8 – Meaning of *residential care compounding factors*

Section 81-8 provides that the following are *residential care compounding factors* for individuals.

Item 1 provides that for an individual who is independently mobile, the residential care compounding factors are as follows:

- the individual’s AFM cognition score;
- the individual’s agitation score;
- the individual’s AKPS score;

- the individual's RUG total score;
- whether the individual requires daily injections.

Item 2 provides that for an individual who is mobile only with assistance and has higher cognitive ability, the residential care compounding factors are as follows:

- the individual's AFM motor score;
- the individual's AFM social cognition score;
- the individual's AKPS score;
- the individual's Braden activity score;
- whether the individual has fallen in the last 12 months;
- whether the individual requires daily injections.

Item 3 provides that for an individual who is mobile only with assistance and has medium cognitive ability, the residential care compounding factors are as follows:

- the individual's AFM communication score;
- the individual's disruptiveness score;
- the individual's Rockwood Frailty Score;
- the individual's RUG total score;
- whether the individual requires complex wound management;
- whether the individual requires daily injections.

Item 4 provides that for an individual who is not mobile and has higher function, the residential care compounding factors are as follows:

- the individual's AFM transfers score;
- the individual's Braden total score;
- the individual's disruptiveness score;
- whether the individual requires complex wound management;
- whether the individual requires daily injections.

Item 5 provides that for an individual who is not mobile and has lower function and higher pressure sore risk, the residential care compounding factors are as follows:

- the individual's AFM eating score;
- the individual's disruptiveness score;
- whether the individual has fallen in the last 12 months;
- whether the individual has lost more than 10% of their body weight in the last 12 months;
- whether the individual requires daily injections.

Residential care compounding factors are used in determining the appropriate classification level for the service group residential care classification type ongoing (see section 81-35).

Section 81-9 – Scientific population study for residential care compounding factors

Section 81-9 provides that the scientific population study to be used as mentioned in paragraph 81(4)(b) of the Act is the Resource Utilisation and Classification Study undertaken by the Australian Health Services Research Institute at the University of Wollongong.

The note following adds that the reports of the Resource Utilisation and Classification Study could in 2025 be viewed on the Department's website (<https://www.health.gov.au>).

Subdivision B – Classification levels and criteria

Section 81-10 – Service group home support—classification type ongoing

Section 81-10 prescribes the classification levels and criteria for the classification type ongoing for the service group home support. This includes both transitional and non-transitional classification levels.

Subsection 81-10(1) prescribes the non-transitional classification levels for the classification type "ongoing" within the service group "home support" and outlines the criteria for these classification levels. These are presented in a table for ease of reference.

Item 1 in the table provides the CHSP class classification level and its criteria, which are any of the following:

- The individual has a functional independence score of 42-48 and a needs met score of 35 or 36.
- The individual has a functional independence score of 42-48 and a needs met score of 0-34.
- The individual has a functional independence score of 35-41 and a needs met score of 31-36.
- The individual has a functional independence score of 35-41, a needs met score of 0-30 and does not have significant compounding factors.

Item 2 in the table provides the SAH classification level 1 and its criteria, which are either:

- The individual has a functional independence score of 35-41, a needs met score of 0-30 and has significant compounding factors.
- The individual has a functional independence score of 30-34, a needs met score of 30-36 and does not have significant compounding factors.

Item 3 in the table provides the SAH classification level 2 and its criteria, which are either:

- The individual has a functional independence score of 30-34, a needs met score of 30-36 and has significant compounding factors.
- The individual has a functional independence score of 30-34, a needs met score of 0-29 and does not have significant compounding factors.

Item 4 in the table provides the SAH classification level 3 and its criteria, which are either:

- The individual has a functional independence score of 30-34, a needs met score of 0-29 and has significant compounding factors.
- The individual has a functional independence score of 25-29, a needs met score of 28-36 and does not have significant compounding factors.

Item 5 in the table provides the SAH classification level 4 and its criteria, which are either:

- The individual has a functional independence score of 25-29, a needs met score of 28-36 and has significant compounding factors.
- The individual has a functional independence score of 25-29, a needs met score of 0-27 and does not have significant compounding factors.

Item 6 in the table provides the SAH classification level 5 and its criteria, which are either:

- The individual has a functional independence score of 25-29, a needs met score of 0-27 and has significant compounding factors.
- The individual has a functional independence score of 0-24, a needs met score of 29-36 and does not have significant compounding factors.

Item 7 in the table provides the SAH classification level 6 and its criteria, which are either:

- The individual has a functional independence score of 0-24, a needs met score of 29-36 and has significant compounding factors.
- The individual has a functional independence score of 0-24, a needs met score of 23-28 and does not have significant compounding factors.

Item 8 in the table provides the SAH classification level 7 and its criteria, which are either:

- The individual has a functional independence score of 0-24, a needs met score of 23-28 and has significant compounding factors.
- The individual has a functional independence score of 0-24, a needs met score of 0-22 and does not have significant compounding factors.

Item 9 in the table provides the SAH class 8 classification level and its criteria, which is that:

- the individual has a functional independence score of 0-24, a needs met score of 0-22 and has significant compounding factors.

Subsection 81-10(2) provides the transitional classification levels for the classification type ongoing for the service group home support which are:

- HCP class 1;
- HCP class 2;
- HCP class 3;
- HCP class 4.
- CHSP transitional;
- HSO NATSIFACP;

- HSO MPSP.

The legislative note adds that transitional classification levels for the classification type ongoing for the service group home support are established for classes of individuals to whom subsection 2(2) of Schedule 2 to Transitional Act applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

Section 81-15 – Service group home support—classification type short-term

Section 81-15 prescribes the criteria for the classification levels in the classification type short-term for the service group home support.

Subsection 81-15(1) includes a table that sets out the non-transitional classification levels for the classification type short-term for the service group home support and the criteria for the classification levels. There are 2 classification levels listed in column 1, SAH restorative care pathway and SAH end-of-life pathway.

Item 1 provides the criteria for the SAH restorative care pathway classification level which are that the individual:

- does not meet the criteria for the classification level CHSP class for the classification type ongoing for the service group home support; and
- does not meet the criteria for the classification level SAH end of life pathway for the classification type short-term for the service group home support; and
- is not accessing, and does not have the potential to benefit from accessing, funded aged care services delivered through the service group home support under the TCP; and
- is residing in a home or community setting; and
- needs restorative care to prevent or delay the individual from needing to access ongoing funded aged care services in the service group home support in circumstances mentioned in paragraph 64-5(b); and
- has goals in line with restorative care outcomes (for example improving function and being independent); and
- either:
 - has not had the classification level SAH restorative care pathway in effect in the previous 90 days; or
 - has not had an amount determined for the individual under section 195-3 during a period of effect for the classification level SAH restorative care pathway that includes a day in the previous 12 months

To be eligible for the Restorative Care Pathway, at their aged care needs assessment the individual must not meet the criteria for a CHSP classification through the Integrated Assessment Tool. In these cases, reablement services or allied health/nursing services through the Commonwealth Home Support Programme (CHSP) may be considered.

As the Restorative Care Pathway is suitable for individuals seeking to regain function and independence to continue to live at home, the individual must also not be eligible for, or have recently received, the End-of-Life Pathway, and must be residing in a home or community

setting (i.e. not in permanent residential aged care). Where the individual is in hospital and more suitable for the TCP, this must be accessed instead.

Under the Restorative Care Pathway, an individual can access two separate episodes of restorative care or two units of funding in a 12-month period. If accessing two separate episodes (consisting of one unit of funding each), there must be 90 days in between episodes.

Item 2 provides the criteria for the SAH end-of-life pathway classification level which are that the individual:

- has a prognosis of a life expectancy of 3 months or less; and
- has an AKPS score of 40 or less
- has not previously had the classification level SAH end-of-life pathway in effect and
- a notice in the approved form containing evidence of the matters referred to in paragraphs above has been given to the System Governor.

The End-of-Life Pathway provides support to individuals with less than 3 months to live.

The Australian-modified Karnofsky Performance Status (AKPS) is a measure of an individual's overall performance status or ability to perform their daily activities. It is a single score assigned by a clinician based on observations of a patient's ability to perform common tasks relating to activity, work and self-care. The AKPS requirements for accessing the End-of-Life Pathway are consistent with the current palliative care entry pathway for residential aged care.

To access the End-of-Life Pathway, a medical or nurse practitioner is required to complete the department's End-of-Life Pathway form. This sets out systematically the eligibility requirements for confirmation.

Transitional classification level

Subsection 81-15(2) provides the transitional classification levels for the classification type short-term for the service group home support are the following:

- STRC class;
- HSST NATSIFACP;
- HSST MPSP.

The note adds that the transitional classification level for the classification type short-term for the service group home support is established for classes of individuals to whom subsection 2(2) of Schedule 2 to the Transitional Act applies—see *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

Section 81-17 – Service group home support—classification type hospital transition

Section 81-17 prescribes the classification levels for the classification type hospital transition for the service group home support and the criteria for the classification levels.

There is a single classification level in the classification type hospital transition named HS HT class. The criteria for this classification level as prescribed in column 2 of item 1 is that the individual:

- has an access approval that includes the service type assistance with transition care; and
- is in the concluding stage of a hospital episode; and
- is medically stable; and
- has the potential to benefit from accessing funded aged care services delivered through the service group home support under the TCP; and
- was admitted to a hospital at the time the aged care needs assessment was carried out

Section 81-20 – Service group assistive technology—classification type ongoing

Section 81-20 provides the classification levels for the classification type ongoing for the service group assistive technology and the criteria for the classification levels.

The classification level is assistance dogs. The criteria is that the individual has an assistance dog and is unable to access assistance under the Assistance Dogs Australia program for people with physical disabilities.

Section 81-25 – Service group assistive technology—classification type short-term

Subsection 81-25(1) prescribes the non-transitional classification levels for the classification type short-term within the service group assistive technology and outlines the criteria for these classification levels. These are presented in a table for ease of reference.

Item 1 in the table prescribes the AT low classification level and its criteria, which are:

- The individual needs low-cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and
- The individual has had any of the following classification levels established:
 - The classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7, or 8.
 - The classification type short-term for the service group home support—SAH restorative care pathway or SAH end of life pathway.

Item 2 in the table prescribes the AT medium classification level and its criteria, which are:

- The individual needs medium-cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and
- The individual has any of the following classification levels established:
 - The classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7, or 8.
 - The classification type short-term for the service group home support—SAH restorative care pathway or SAH end-of-life pathway.

Item 3 in the table prescribes the AT high classification level and its criteria, which are:

- The individual needs high-cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and
- The individual has any of the following classification levels established:

- the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7, or 8.
- the classification type short-term for the service group home support—SAH restorative care pathway.

Item 4 in the table provides the AT CHSP classification level and its criteria, which is that the classification level CHSP class has been established for the individual for the classification type ongoing for the service group home support.

Transitional classification levels

Subsection 81-25(2) provides that the transitional classification level for the classification type short-term for the service group assistive technology is AT transitional.

The note provides that the transitional classification levels for the classification type short-term for the service group assistive technology are established for classes of individuals to whom subsection 2(2) of Schedule 2 to the Transitional Act applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

Section 81-27 – Service group assistive technology—classification type hospital transition

Section 81-27 prescribes the classification levels for the classification type hospital transition for the service group assistive technology and the criteria for the classification levels.

There is a single classification level called AT HT class and the criteria as set out in Column 2 of Item 1 is that the individual:

- has an access approval that includes the service type assistance with transition care; and
- is in the concluding stage of a hospital episode; and
- is medically stable; and
- has the potential to benefit from accessing funded aged care services delivered through the service group assistive technology under the TCP; and
- was admitted to a hospital at the time the aged care needs assessment was carried out.

Section 81-30 – Service group home modifications—classification type short-term

Subsection 81-30(1) prescribes the non-transitional classification levels for the classification type short-term within the service group home modifications and outlines the criteria for these classification levels. These are presented in a table for ease of reference.

Item 1 in the table prescribes the HM low classification level and its criteria, which are:

- The individual needs low-cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and
- The individual has any of the following classification levels established:
 - The classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7, or 8.
 - The classification type short-term for the service group home support—SAH restorative care pathway

Item 2 in the table prescribes the HM medium classification level and its criteria, which are:

- The individual needs medium-cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and
- The individual has any of the following classification levels established:
 - The classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7, or 8.
 - The classification type short-term for the service group home support—SAH restorative care pathway

Item 3 in the table provides the HM high classification level and its criteria, which are:

- The individual needs high-cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and
- The individual has any of the classification levels SAH class 1, 2, 3, 4, 5, 6, 7 or 8 established.

Item 4 in the table provides the HM CHSP classification level and its criteria, which is the classification level CHSP class has been established for the individual for the classification type ongoing for the service group home support

Transitional classification levels

Subsection 81-30(2) provides that the transitional classification level for the classification type short-term for the service group home modifications is HM transitional.

The note provides that the transitional classification levels for the classification type short-term for the service group home modifications are established for classes of individuals to whom subsection 2(2) of Schedule 2 to the Transitional Act applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

Section 81-35 – Service group residential care—classification type ongoing

Subsection 81-35(1) provides that the classification levels for the classification type ongoing for the service group residential care class 0, and the classification levels 1 - 13 set out in the table in subsection 81-35(2).

Item 1 in the table prescribes the Class 1 classification level and its criteria, which are:

- The circumstances referred to in paragraph 76-15(10)(a) of the Rules (palliative care pathway) apply to the individual.

Item 2 in the table prescribes the Class 2 classification level and its criteria, which are:

- The individual is independently mobile.
- The individual does not have significant compounding factors.

Item 3 in the table prescribes the Class 3 classification level and its criteria, which are:

- The individual is independently mobile.
- The individual has significant compounding factors.

Item 4 in the table prescribes the Class 4 classification level and its criteria, which are:

- The individual is mobile only with assistance.
- The individual has higher cognitive ability.

- The individual does not have significant compounding factors.

Item 5 in the table prescribes the Class 5 classification level and its criteria, which are:

- The individual is mobile only with assistance.
- The individual has higher cognitive ability.
- The individual has significant compounding factors.

Item 6 in the table prescribes the Class 6 classification level and its criteria, which are:

- The individual is mobile only with assistance.
- The individual has medium cognitive ability.
- The individual does not have significant compounding factors.

Item 7 in the table prescribes the Class 7 classification level and its criteria, which are:

- The individual is mobile only with assistance.
- The individual has medium cognitive ability.
- The individual has significant compounding factors.

Item 8 in the table prescribes the Class 8 classification level and its criteria, which are:

- The individual is mobile only with assistance.
- The individual has lower cognitive ability

Item 9 in the table prescribes the Class 9 classification level and its criteria, which are:

- The individual is not mobile.
- The individual has higher function.
- The individual does not have significant compounding factors.

Item 10 in the table prescribes the Class 10 classification level and its criteria, which are:

- The individual is not mobile.
- The individual has higher function.
- The individual has significant compounding factors.

Item 11 in the table prescribes the Class 11 classification level and its criteria, which are:

- The individual is not mobile.
- The individual has lower function.
- The individual has lower pressure sore risk.

Item 12 in the table prescribes the Class 12 classification level and its criteria, which are:

- The individual is not mobile.
- The individual has lower function.
- The individual has higher pressure sore risk.
- The individual does not have significant compounding factors.

Item 13 in the table prescribes the Class 13 classification level and its criteria, which are:

- The individual is not mobile.
- The individual has lower function.
- The individual has higher pressure sore risk.
- The individual has significant compounding factors.

An individual has significant compounding factors if their compounding factors, considered together, indicate the care recipient has significantly higher care needs relative to the needs of the other individuals mentioned in the relevant item in the table under section 81-8 of the rules (see definitions to the rules).

Transitional classification levels

Subsection 81-35(3) provides that the transitional classification levels for the classification type ongoing for the service group residential care are as follows:

- (a) RCO MPSP
- (b) RCO NATSIFACP

The Note provides that the transitional classification levels for the for the classification type ongoing for the service group residential care are established for certain classes of individuals to whom subsection 3(2) of Schedule 2 to the Transitional Act applies—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

Section 81-40 – Service group residential care—classification type short-term

Subsection 81-40(1) prescribes that the non-transitional classification levels for the classification type short-term for the service group residential care are respite class 0 and respite classes 1-3 as set out in the table in subsection 81-40(2).

Item 1 in the table prescribes the respite class 1 classification level and its criteria which is that the individual is independently mobile.

Item 2 in the table prescribes the respite class 2 classification level and its criteria which is that the individual is mobile only with assistance.

Item 3 in the table prescribes the respite class 1 classification level and its criteria which is that the individual is not mobile.

Subsection 81-40(3) provides that the transitional classification levels for the classification type short-term for the service group residential care are as follows:

- (a) RCST MPSP
- (b) RCST NATSIFACP

The Note provides that the transitional classification levels for the for the classification type short-term for the service group residential care are established for certain classes of individuals to whom subsection 3(2) of Schedule 2 to the Transitional Act—see the *Aged Care (Consequential and Transitional Provisions) Determination 2025*.

Section 81-42 – Procedure for deciding initial classification levels for individuals for the classification types ongoing and short-term for the service group residential care

Classification type ongoing

Subsection 81-42(1) provides that the procedure for establishing a classification level for an individual to whom paragraph 78(1)(c) of the Act applies for the classification type ongoing for the service group residential care is to establish the classification level class 0 for the individual.

The classification level class 0 will be replaced by a classification level 1 to 13 after a classification assessment is performed (see section 80-35).

Classification type short-term

Subsection 81-42(2) provides that the procedure for establishing a classification level for an individual to whom paragraph 78(1)(c) of the Act applies for the classification type ongoing for the service group residential care is to establish the classification level respite class 0 for the individual.

The classification level class 0 will be replaced by a classification level respite class 1 to respite class 3 after a classification assessment is performed (see section 80-40).

Section 81-45 – Service group residential care—classification type hospital transition

Section 81-45 prescribes the classification levels for the classification type hospital transition for the service group residential care and the criteria for the classification levels.

There is a single classification level called RC HT class to which the criteria are that the individual:

- has an access approval that includes the service type assistance with transition care; and
- is in the concluding stage of a hospital episode; and
- is medically stable; and
- has the potential to benefit from accessing funded aged care services delivered through the service group residential care under the TCP; and
- was admitted to a hospital at the time the aged care needs assessment was carried out

Part 4 – Prioritisation

Division 1 – Prioritisation assessments

Section 84-5 – When prioritisation assessments not required for classification type ongoing for service group home support

Section 84-5 prescribes that for individuals classed in the classification level CHSP class for the classification type ongoing for the service group home support, a prioritisation assessment is not required because a classification decision has been made for an individual. This is because individuals do not require a place to access the specialist aged care program CHSP as it is grant funded.

Division 2 – Priority category decisions

Section 86-5 – Service groups—period in which priority category decisions must be made

Section 86-5 prescribes that the period in which priority category decisions must be made for service groups. This period is 14 days after the day on which the System Governor is given a prioritisation report (under section 85 of the Act) for an individual.

Section 86-10 – Service group residential care—priority category 1—areas

Section 86-10 describes that, for the purposes of subparagraph 86(5)(a)(ii) of the Act, an area with a 2023 MM category known as MM 5, MM 6 or MM 7 is prescribed.

Division 3 – Priority categories for classification types for service groups

Subdivision A – Service group home support

Section 87-5 – Priority categories and eligibility criteria for classification type ongoing

Section 87-5 prescribes the priority categories and eligibility criteria for the classification type ongoing for the service group home support (for the purposes of subsection 87(1) of the Act).

These categories and criteria are set out in a table.

- column 1 of the table prescribes the priority categories for the classification type ongoing for the service group home support; and
- column 2 of the table prescribes eligibility criteria for each of those priority categories.

Item 1 in the table prescribes the priority category as urgent and the eligibility criteria as the individual having 5 or more points determined in accordance with an individual's points determination.

Item 2 in the table prescribes the priority category as high and the eligibility criteria as the individual having 4 points determined in accordance with an individual's points determination.

Item 3 in the table prescribes the priority category as medium and the eligibility criteria as the individual having 2 or 3 points determined in accordance with an individual's points determination.

Item 4 in the table prescribes the priority category as standard and the eligibility criteria as the individual having 1 point, or no points, determined in accordance with an individual's points determination.

Section 87-5 also prescribes that, for the purpose of column 2 as described above, that an individual's points are determined by adding together the points specified in column 2 of each item of the table in which column 1 specifies circumstances that apply to the individual (if any).

These categories and criteria are set out in a table.

- column 1 of the table prescribes the priority circumstances for the classification type ongoing for the service group home support; and
- column 2 of the table prescribes the points assigned for each of those circumstances.

Item 1 of the table prescribes the circumstances as the individual living alone and column 2 prescribes the points as 1.

Item 2 of the table prescribes the circumstances as the individual having a cognitive impairment and column 2 prescribes the points as 1.

Item 3 of the table prescribes the circumstances as the individual being an Aboriginal or Torres Strait Islander person and column 2 prescribes the points as 1.

Item 4 of the table prescribes the circumstances as the individual being homeless, or at risk of homelessness and column 2 prescribes the points as 1.

Item 5 of the table prescribes the circumstances as the individual has a need for urgent access to ongoing funded aged care services through the service group home support and column 2 prescribes the points as 2.

Item 6 of the table prescribes the circumstances as the individual:

- Having waited more than 6 months from:
 - the day on which the individual applied for access to funded aged care services; or
 - if the individual applied for the reassessment of the individual's need for funded aged care services—the day on which the individual applied for the reassessment; and
- Residing in an area with a 2023 MM category known as MM 5, MM6 or MM 7 and column 2 prescribes the points as 1

Subdivision B – Service groups assistive technology and home modifications

Section 87-7 – Priority categories and eligibility criteria

Section 87-7 prescribes the priority categories and their eligibility criteria for the service groups assistive technology and home modifications

For the classification type ongoing or short-term for service group assistive technology (for the purposes of subsection 87(1) of the Act) these categories and eligibility criteria are set out in a table

- column 1 of the following table prescribes the priority categories for the classification types ongoing and short-term for the service group assistive technology; and
- column 2 of the following table prescribes eligibility criteria for each of those priority categories.

Item 1 of the table prescribes the priority category as immediate and column 2 prescribes the eligibility criteria as an approved needs assessor considering the classification type short-term for the service group home support should be approved for the individual

Item 2 of the table prescribes the priority category as high and column 2 prescribes the eligibility criteria as two or more of the following circumstances applying to the individual:

- the individual lives alone;
- the individual has a mobility impairment;
- the individual is an Aboriginal or Torres Strait Islander person;
- the individual's current place of residence poses a moderate or severe risk to the individual's health or safety;
- both of the following apply:
 - the individual has waited more than 6 months from the day on which the individual made the application to which the priority assessment relates;
 - the individual resides in an area with a 2023 MM category known as MM 5, MM 6 or MM 7
- The table notes in column 2 that the application referred to in the above 2 dot points could be an application for access to funded aged services under section 56 of the Act or an application for an aged care needs reassessment under section 64 of the Act.

Item 3 of the table prescribes the priority category as medium and column 2 prescribes the eligibility criteria as one of the circumstances referred to in column 2 of item 2 applying to the individual.

Item 4 of the table prescribes the priority category as standard and column 2 prescribes the eligibility criteria as none of the circumstances referred to in column 2 of item 2 applying to the individual.

For the classification type short-term for service group home modifications (for the purposes of subsection 87(1) of the Act) these categories and eligibility criteria are set out in a table

- column 1 of the following table prescribes the priority categories for the classification type short-term for the service group home modifications; and
- column 2 of the following table prescribes eligibility criteria for each of those priority categories.

Item 1 of the table prescribes the priority category as immediate and column 2 prescribes the eligibility criteria as an approved needs assessor considering the classification type short-term for the service group home support should be approved for the individual

Item 2 of the table prescribes the priority category as high and column 2 prescribes the eligibility criteria as two or more of the following circumstances apply to the individual:

- the individual lives alone;
- the individual has a mobility impairment;
- the individual is an Aboriginal or Torres Strait Islander person;
- the individual's current place of residence poses a moderate or severe risk to the individual's health or safety;
- both of the following apply:
 - the individual has waited more than 6 months from the day on which the individual made the application to which the priority assessment relates;
 - the individual resides in an area with a 2023 MM category known as MM 5, MM 6 or MM 7
- The table notes in column 2 that the application referred to in the above 2 dot points could be an application for access to funded aged services under section 56 of the Act or an application for an aged care needs reassessment under section 64 of the Act.

Item 3 of the table prescribes the priority category as medium and column 2 prescribes the eligibility criteria as one circumstance referred to in column 2 of item 2 applying to the individual.

Item 4 of the table prescribes the priority category as standard and column 2 prescribes the eligibility criteria as none of the circumstances referred to in column 2 of item 2 apply to the individual.

Division 4 – Circumstances for urgency ratings—service group residential care

Section 87-10 – Classification type ongoing

Section 87-10 (for the purposes of subsection 87(2) of the Act) prescribes the circumstances in which an urgency rating of low, medium or high will apply to an individual in relation to the classification type ongoing for the service group residential care. A high urgency rating will apply to an individual if the individual has a need for immediate access to ongoing funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk.

A medium urgency rating will apply to an individual if:

- the circumstances described above regarding a safety, health or wellbeing risk do not apply to the individual; and

- taking into account the individual's circumstances and preferences, the individual is expected to seek access to ongoing funded aged care services delivered in an approved residential care home within the next 6 months.

A low urgency rating will apply to an individual if:

- the circumstances described above regarding a safety, health or wellbeing risk do not apply to the individual do not apply to the individual; and
- the circumstances described above regarding the expectation that the individual will seek access to ongoing funded aged care services in approved residential care do not apply to the individual.

Part 5 – Place Allocation

Division 1 – Allocation of places to individuals

Subdivision A – Allocation of places to individuals

Section 92-5 – When allocation of places to individuals does not apply for classification type ongoing for service group home support

Section 92-5 provides for circumstances in which allocation of places to individuals does not apply. This occurs when individuals have been assigned (by classification decision) the classification level CHSP class, for the classification type ongoing for the service group home support

Section 92A-5 – When a place is in effect—period for start day

Subsection 92A-5 provides the period of time required under subsection 92A(2) of the Act, being the period within which a start day for an individual included in a start notification given by a registered provider to the System Governor for the classification type for the service group must occur in order for the place to take effect. These periods are:

- 56 days from the day the individual's access approval for the classification type comes into effect
- if, within the 56 days, the individual notifies the System Governor that the individual needs an extension to that period—84 days from the day the notice of the allocation of the place is given to the individual under subsection 92(3) of the Act.

Section 92A-10 – When a place ceases to have effect

Subsection 92A-10 provides for when a place ceases to be in effect. This occurs when:

- for a place for the classification type ongoing for the service group home support or assistive technology—the end of the day the individual dies; or
- for a place for the classification type short-term for the service group home support, assistive technology or home modifications, allocated to an individual for whom a classification level has been established for the classification type for the service group by a classification decision—the end of the earlier of the following (as applicable):

- the period of effect for the classification level;
- the day the individual dies.

Subdivision B – Method for allocation

Section 93-5 – Purpose of this Subdivision

Section 93-5 sets out the purpose of subdivision B as prescribing the methods that the System Governor must follow in deciding the order of allocation of a place under subsection 93(1) of the Act for the following circumstances:

- the classification type ongoing for the service group home support; and
- the classification types ongoing and short-term for the service group assistive technology; and
- the classification type short-term for the service group home modifications.

Section 93-10 – Classification type ongoing for the service group home support—method for deciding order of allocation

Section 93-10 sets out the method for deciding the order of allocation of a place to an individual for the classification type ongoing for the service group home support in the following steps:

Step 1: Identify the individuals (if any) to whom the circumstances referred to in paragraph 64-10(d) of this instrument apply.

Step 2: Allocate the place to the individual who has the longest current wait time.

Step 3. Using the method in section 93-12, identify if a place is assigned to a priority category for the classification type for the service group.

Step 4. Identify whether the place is a full place or an interim place.

Step 5. Identify the individuals (if any) who have that priority category for the classification type for the service group and whether those individuals have an interim place in effect for the classification type for the service group.

Step 6. If the place is a full place, allocate the place to the individual who, of the individuals to whom a place has not already been allocated under step 2, has the longest current wait time.

Step 7. If the place is an interim place, allocate the place to the individual who, of the individuals who do not have an interim place in effect for the classification type for the service group and to whom a place has not already been allocated under step 2, has the longest current wait time.

Steps 1 and 2 of the method statement ensure that individuals who require home services beyond the classification period for home support short-term classification type end of life pathway classification level can get immediate access to services in the home support ongoing classification type without waiting for a place to be allocated.

Steps 3 to 7 set out the method for allocation places to individuals based on their priority category and whether the place being allocated is a full place or an interim place.

Section 93-12 – Classification type ongoing for the service group home support— method for assigning places to priority categories

Section 93(3)(a) of the Act sets out that a method for allocating a place may have consideration of an individual's priority category. Section 93-12 of the rules prescribes the method for distributing the places to be allocated across each of the priority categories for the classification type ongoing for the service group home support on a day. The allocation method is as follows:

Step 1. For each priority category for the classification type for the service group, identify the number of waiting individuals for whom the current wait time is equal to or greater than the target priority category wait time for that priority category on the day.

Step 2. Add up the numbers identified for each priority category under Step 1.

Step 3. Identify the number of places that are available to be allocated to individuals for that service group on the day (as worked out in accordance with the method determined under subsection 91(1) of the Act).

Step 4. If the number worked out under Step 2 is less than or equal to the number identified at Step 3, divide the number worked out under Step 2 by the number identified at Step 3.

Step 5. If the number worked out under Step 2 is greater than the number identified at Step 3, divide the number identified at Step 3 by the number worked out under Step 2.

Step 6. For each priority category:

- (a) multiply the number identified under step 1 by the result of Step 4 or 5 (as applicable) and round down to the nearest whole number; and
- (b) if the result under paragraph (a) is a number greater than zero, that number of places are assigned to that priority category on the day; and
- (c) if the result under paragraph (a) is zero, no places are assigned to that priority category on the day.

Section 93-13 – Classification type ongoing for the service group home support— method for working out wait time factor

Section 93-13 prescribes the method for working out the wait time factor for the classification type ongoing for the service group home support. The method is as follows:

Step 1. Reduce the target classification type wait time most recently determined by the System Governor under section 93-14 by the priority category waiting proportion for the priority category urgent.

Step 2. For each remaining priority category, multiply the priority category waiting proportion by the queue rate.

Step 3. Add up the results of step 2 for each priority category.

Step 4. Divide the result of step 1 by the result of step 3.

Section 93-14 – Classification type ongoing for the service group home support—method for System Governor determination of target classification type wait time

Section 93-14 prescribes the method for the System Governor to determine the target classification type wait time (in months) for the classification type ongoing for the service group home support. The need to determine the wait time may arise from time to time. In these instances, the System Governor must consider the following:

- on the first occasion the System Governor does so—the average of the old Act wait times; or
- on any subsequent occasion:
 - the weighted average of the current wait times for individuals who have been assigned priority categories for the classification type for the service group; and
 - what change needs to be made to the previous target classification type wait time to ensure that, on and after 1 November 2027, the weighted average mentioned above is not more than 3 months.

Section 93-15 – Classification types ongoing and short-term for the service group assistive technology—method for deciding order of allocation

Section 93-15 sets out the method for deciding the order of allocation of places to people for the classification types ongoing and short-term for the service group assistive technology. The method is as follows:

Step 1. Identify the individuals (if any) who have, or have had, the classification level SAH end-of-life pathway for the classification type short-term for the service group home support in effect.

Step 2. Allocate the place to the individual who has the longest current wait time.

Step 3. Identify the waiting individuals (if any) who have the priority category immediate for the classification type for the service group and to whom a place has not already been allocated under step 2.

Step 4. Of those individuals, allocate the place to the individual who has the longest current wait time.

Step 5. If no individuals are identified under step 3, identify the waiting individuals (if any) who have the priority category medium-high for the classification type for the service group and to whom a place has not already been allocated under step 2.

Step 6. Of those individuals, allocate the place to the individual who has the longest current wait time.

Step 7. If no individuals are identified under step 5, identify the waiting individuals (if any) who have the priority category medium for the classification type for the service group and to whom a place has not already been allocated under step 2.

Step 8. Of those individuals, allocate the place to the individual who has the longest current wait time.

Step 9. If no individuals are identified under step 7, identify the waiting individuals who have the priority category standard for the classification type for the service group and to whom a place has not already been allocated under step 2.

Step 8. Of those individuals, allocate the place to the individual who has the longest current wait time.

Section 93-20 – Classification type short-term for the service group home modifications—method for deciding order of allocation

Section 93-20 prescribes the method for deciding the order of allocations of places to people for the classification type short-term for the service group home modifications. The method is as follows:

Step 1. Identify the individuals (if any) who have had the classification level SAH end-of-life pathway for the classification type short-term for the service group home support in effect.

Step 2. Allocate the place to the individual who has the longest current wait time.

Step 3. Identify the waiting individuals (if any) who have the priority category immediate for the classification type for the service group and to whom a place has not already been allocated under step 2.

Step 3. Of those individuals, allocate the place to the individual who has the longest current wait time.

Step 4. If no individuals are identified under step 1, identify the waiting individuals (if any) who have the priority category high for the classification type for the service group.

Step 5. Of those individuals, allocate the place to the individual who has the longest current wait time.

Step 6. If no individuals are identified under step 3, identify the waiting individuals (if any) who have the priority category medium high for the classification type for the service group and to whom a place has not already been allocated under step 2.

Step 7. Of those individuals, allocate the place to the individual who has the longest current wait time.

Step 8. If no individuals are identified under step 5, identify the waiting individuals (if any) who have the priority category medium for the classification type for the service group and to whom a place has not already been allocated under step 2.

Step 9. Of those individuals, allocate the place to the individual who has the longest current wait time.

Step 10. If no individuals are identified under step 7, identify the waiting individuals who have the priority category standard for the classification type for the service group and to whom a place has not already been allocated under step 2.

Step 11. Of those individuals, allocate the place to the individual who has the longest current wait time.

Division 2 – Allocation of a place to registered providers for certain specialist aged care programs

Section 95-5 – Allocation of a place—System Governor may invite application for allocation of TCP place

Section 95-5 provides for the System Governor to invite applications for allocation of TCP places from an entity to apply on its own behalf or on behalf of another entity (the *nominated entity*). These places are for the delivery of funded aged care services under the TCP in a State or Territory. Applications may only be made by an entity (or the nominated entity) by invitation.

Section 95-10 – Allocation of a place—application for allocation of a TCP place

Section 95-10 sets out the requirements for applications made for the allocation of a place for delivering funded aged care services under the TCP in a State or Territory. The application must specify the following:

- whether the application is being made:
 - on an entity's own behalf; or
 - on behalf of a nominated entity to which the place is to be allocated;
 - the number of places applied for;
 - the number of those places that will be used to prioritise delivery of funded aged care services to Aboriginal or Torres Strait Islander persons;
 - the area or areas in which the places will be used to deliver funded aged care services.
- For each area in which the places will be used to deliver funded aged care services, the application must also specify the following:
 - the estimated number of persons residing in the area or areas who are aged at least 70, other than Aboriginal or Torres Strait Islander persons;
 - the estimated number of Aboriginal or Torres Strait Islander persons residing in the area or areas who are aged at least 50;
 - the estimated number of persons mentioned in paragraph (a) or (b) who are expected to be discharged from hospital;
 - the estimated number of persons expected to be discharged from hospital as mentioned in paragraph (c) annually, or within another relevant time period, who are expected to benefit from funded aged care services delivered under the TCP after discharge;
 - if the application is made on behalf of one or more nominated entities to which the places are to be allocated—the nominated entity or entities that will deliver funded aged care services under each place applied for.
- The number of persons for an area specified in an application is to be expressed as a whole number per thousand of the total number of persons residing in the area.
- To avoid doubt:
 - For each area in which the places will be used to deliver funded aged care services, an area may be the whole or a part of a State or Territory; and
 - an application made on behalf of a nominated entity is made by the nominated entity for the purposes of the Act.

The Section notes that the System Governor may request further information which must be given within 14 days of the request (see section 588 of the Act and section 588-5 of the rules).

Section 95-15 – Allocation of a place—matters of which System Governor must be satisfied before allocating TCP place

Section 95-15 provides for the need for the System Governor to be satisfied of certain conditions before allocation a Transition Care Place to a state or territory entity for the delivery of funded aged care services

The conditions of which the System Governor must be satisfied are as follows:

- that the place, if allocated, will be used by the entity to which the place is allocated to deliver funded aged care services in accordance with an agreement between the Commonwealth and the State or Territory made under the Act
- that, if the place is allocated to a nominated entity (i.e. nominated on an entity's behalf by another entity), the entity was nominated bearing in mind the community's needs.

Section 97-5 – When a place is in effect—basic rules

Section 97-5 provides for the conditions that must be met by an entity for a place to come into effect for a specialist aged care program. The place will come into effect on the day after the first day on which the entity satisfies the prescribed conditions.

These conditions are as follows:

- the entity is a registered provider that is registered for a registration category for one or more service groups through which the entity will deliver funded aged care services under the specialist aged care program;
- if the place is to be used to deliver funded aged care services under the MPSP—an agreement with the entity is in force under paragraph 247(1)(a) of the Act;
- if the place is to be used to deliver funded aged care services under the TCP in a State or Territory—an agreement with the State or Territory covering the arrangements for the delivery of those services is in force under paragraph 247(1)(b) of the Act;
- if the place is to be used to deliver funded aged care services in an approved residential care home—the System Governor is satisfied that a bed in the approved residential aged care home is ready to be used for the delivery of funded aged care services under the place.

This provision notes that under certain circumstances, a place can be transferred in accordance with the Act under section 97-25.

Section 97-5 also prescribes the period of time for which a place is in effect. A place begins being in effect starting from the day after the conditions above are met. A place ceases to be in effect if the place is permanently ceased under 97-15 or the place has not come into effect within 5 years of it being allocated.

A place can be temporarily ceased under 97-10. If the place is temporarily ceased under subsection 97-10, the place will not be in effect for that period of time.

Section 97-5 prescribes that a nominated entity may be required to complete an application that confirms that a bed is already in use. The System Governor may require an entity to complete this application via the Department's website.

Section 97-10 – When a place is in effect—temporary cessation

Section 97-10 prescribes the rules for instances in which a place in effect is *temporarily* ceased. When it is agreed by the system governor and the entity that an entity does not have the capacity to deliver funded aged care services, the place is not in effect for an agreed period of time between the entity and the System Governor.

This section notes that under section 167 of the Act (and rules made under that section) certain registered providers are required to notify the System Governor of certain changes in circumstances

Section 97-10 also prescribes that, if an entity's registration is suspended, the place is not in effect during any period of suspension.

Section 97-10 also prescribes the conditions in which it is impractical to deliver funded aged care services, and therefore a place is not in effect for a period. These conditions are as follows:

- a condition is placed on the entity; and
- the condition makes it impracticable for the entity to deliver funded aged care services under the place for that period.
- A place that is not in effect for a period comes back into effect immediately after the end of the period.

Section 97-15 – When a place is in effect—permanent cessation

Section 97-15 provides for instances where a place in effect permanently ceases to be in effect and can never resume being in effect. These circumstances are as follows:

- the entity ceases to be a registered provider; or
- the System Governor and the entity agree that the entity may relinquish the place; or
- the System Governor revokes the place.

This section notes that an allocated place may be brought back into effect for allocation to another entity in certain circumstances

This section also prescribes that (in relation to dot point 2) the System Governor must not agree to the relinquishment of a place unless the System Governor is satisfied that the entity (to which the place was allocated) has complied with the prescribed requirements in chapter 4 of the rules, which deals with continuity of delivery of funded aged care services.

This Section also prescribes that the System Governor can revoke a place if the entity has not used the place to deliver funded aged care services for a period of 12 months or more.

Section 97-25 – When a place is in effect—reallocation of TCP place

Section 97-25 prescribes for instances in which a reallocation of a Transition Care Program place may occur.

A State or Territory specified in the determination may apply to the System Governor for the place to be allocated to another entity if:

- the Minister determines under paragraph 94(1)(a) of the Act that a place is available for allocation for use in a specified State or Territory; and
- the place is allocated to an entity under subsection 95(1) of the Act; and
- the place would, apart from this section, cease permanently to be in effect under section 97-15;

If the State or Territory makes an application to the System Governor for a TCP place to be re-allocated, then the System Governor may decide to allocate the place to the other entity under subsection 95(1) of the Act. If the System Governor decides to re-allocate, the place comes into effect (in accordance with section 97-5).

Section 98-5 – Transfer of places

Section 98-5 prescribes circumstances in which an allocated place (under subsection 95(1) of the Act) to the first entity may be transferred to the second entity.

The circumstances in which this may occur are as follows:

- the place is for delivering funded aged care services under the TCP in a State or Territory; and
- the State or Territory makes an application to the System Governor for the place to be transferred to the second entity; and
- the second entity is a registered provider delivering funded aged care services under the TCP in the State or Territory.
- the place is for delivering funded aged care services under the MPSP in a State or Territory; and
- the State or Territory makes an application to the System Governor for the place to be transferred to the second entity; and
- the second entity is a registered provider delivering funded aged care services under the MPSP in the State or Territory; and
- the first entity and second entity agree to the transfer.

Section 99-5 – Conditions that apply to an allocated place

Section 99-5 prescribes the conditions that apply in relation to a place allocated by the System Governor to an entity.

The conditions are as follows:

- the entity must notify the System Governor if the entity will not be able to, or does not intend to, use the place to deliver funded aged care services for a period of 12 months or more;
- for a place allocated for the MPSP:
 - if the place is used for the delivery of funded aged care services through the service group residential care—the place must only be used by the entity at the approved residential care home specified in the notice given (under subsection 96(1) of the Act) in relation to the allocation of the place; and
 - if the place is used for the delivery of funded aged care services through a service group that is not the service group residential care—the place must only be used by the entity at a location specified in the notice given (under subsection 96(1) of the Act) in relation to the allocation of the place.

This Section notes that section 167 of the Act and the rules allow have the effect that this condition of place allocation can be met by giving the Commissioner and the System Governor a notice under that section.

Section 101-5 – System Governor decision on whether to vary a condition—matters to which System Governor must have regard

Section 101-5 prescribes that the System Governor must consider certain matters in deciding whether or not to vary a condition that applies to a place allocated to an entity (under subsection 95(1) of the Act)

The matters that the System Governor must consider are:

- the objectives of the specialist aged care program for which the place is allocated;
- the needs of the communities of which individual members are expected to be able to access funded aged care services delivered under the place;
- the Statement of Principles;
- any information or documents given by the entity in relation to the variation of the condition.

Chapter 3 – Provider registration

Part 1 – Introduction

104-1 – Simplified outline of this Chapter

Section 104-1 provides an outline of this Chapter about provider registration and the approval of a residential care home including variations, suspensions and revocations of registration and variations of approvals of residential care homes.

It states that Part 2 of this Chapter relates to provider registration and residential care home approval processes and deals with:

- applications for registration as a registered provider and applications for renewal of registration; and
- requirements for audits or assessments of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category; and

- applications for approval of a residential care home; and
- matters that must be included in a notice of a decision to register an entity as a registered provider or renew an entity's registration; and
- deeming certain classes of entities to be registered providers and matters that must be included in a determination that an entity is taken to be a registered provider.

Part 3 of this Chapter relates to variations, suspensions and revocations of the registration of a registered provider and variations of approvals of a residential care home, and deals with:

- the appointment by a registered provider of an eligible adviser to assist the provider to comply with the provider's conditions and obligations under Part 4 of Chapter 3 of the Act; and
- variations of approvals of residential care homes on the Commissioner's own initiative and on application by a registered provider; and
- matters that the Provider Register must include in relation to the registration of a registered provider.

Part 2 – Provider registration and residential care home approval process

Division 1 – Applications for registration and registration decisions

Subdivision A – Application fees, information for applications and decision making periods

Section 104-5 – Application for registration—application fee

Section 104-5 provides that for the purposes of paragraph 104(2)(b) of the Act, the application fee for an application by an entity to be registered as a registered provider is the sum of:

- \$3,270.00; and
- the sum of the amounts specified in the table in section 104-5, for each provider registration category specified in the application as a provider registration category that the entity is applying to be registered in.

The table in section 104-5 provides for the following amounts by registration category:

- Item 1, Home and community services, the amount is \$1,270.00
- Item 2, Assistive technology and home modifications, the amount is \$1,270.00
- Item 3, Advisory and support services, the amount is \$1,270.00
- Item 4, Personal and care support in the home and community, the amount is \$3,800.00
- Item 5, Nursing and transition care, the amount is \$3,800.00
- Item 6, Residential care, the amount is \$5,070.00.

The note provides that exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

Cost recovery by the Commissioner aligns with the Government's overarching Cost Recovery Policy that, where appropriate, non-government recipients of specific government activities should be charged some or all of the costs of those activities. The Cost Recovery Policy also notes that if the same cost recovered activity is provided to both government and non-government stakeholders, charges should be set on the same basis for all

stakeholders. The objective of regulatory charging activities (fees) is to ensure the efficiency, productivity and responsiveness of the registration, renewal and variations processes, and the quality of applications submitted for decision. The fees and exemptions in these provisions were consulted on and are reflected in the cost recovery implementation statement (CRIS) for activities of the Commissioner under this Act. Charging models and fees levels will be reviewed annually before the new financial year begins and changes reflected in the CRIS before they can commence. Any change will also be reflected in these rules. Further information is available at the Aged Care Quality and Safety Commission website: <https://www.agedcarequality.gov.au/cost-recovery-consultation>.

For registration and renewal, the fees have been calculated for both provider-level activities and category specific activities, with activities for the registration categories personal and care support in the home or community, nursing and transition care, and residential care requiring more effort due to the higher level of risk associated with the delivery of these service types. The difference in fees across all the registration categories is reflective of the different effort (time taken and level of APS staff) required to complete the activity.

Section 104-15 – Application for registration—other information

Section 104-15 provides that for the purposes of paragraph 104(3)(i) of the Act, the application must also specify each local government area in which the entity intends to deliver funded aged care services in the home or community setting. This section does not apply to entities intending to only deliver funded aged care services in a residential care setting. The information required is related to the provider register which includes, if the provider delivers funded aged care services in a home or community setting, each local government area in which the provider delivers those services under paragraph 141(3)(j).

The note provides that for provider registration categories, see subsection 11(3) of the Act and section 11-5 of the rules.

Section 105-5 – Application for registration—period for making decision

Section 105-5 provides that for the purposes of subsection 105(2) of the Act, the period within which the Commissioner must make a decision on an application by an entity for registration is 90 days from the later of the following:

- the day the Commissioner receives the application;
- if an audit finding referred to in subparagraph 109(2)(d)(i) of the Act is required in relation to one or more provider registration categories specified in the application—the day the Commissioner gives a copy of the final audit report to the entity under section 110-38 of this instrument.

This means entities can have some assurance that a decision will be made within 90 days of the later of the above instances which is important to manage entities' expectations. As set out in section 588 of the Act, the period for making the decision will change where the Commissioner requests further information or a document from the registered provider before making a decision on the application.

The note provides that for provider registration categories prescribed for the purposes of paragraph 109(2)(d) of the Act, see section 109-5 of this instrument. For circumstances

prescribed for the purposes of subparagraph 109(2)(d)(ii) of the Act, see section 109-10 of this instrument.

Section 107-5 – Application for renewal of registration—application fee

Section 107-5 provides that for the purposes of paragraph 107(2)(b) of the Act, the application fee for an application by a registered provider to renew the provider's registration is the sum of:

- \$295.00; and
- The sum of the amounts specified in the table below for each provider registration category specified in the application as a provider registration category that the registered provider is applying to be registered in.

The note provides that exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

The table provides for the following amounts by registration category:

- Item 1, Home and community services, the amount is \$770.00
- Item 2, Assistive technology and home modifications, the amount is \$770.00
- Item 3, Advisory and support services, the amount is \$770.00
- Item 4, Personal and care support in the home or community, the amount is \$4,040.00
- Item 5, Nursing and transition care, the amount is \$4,040.00
- Item 6, Residential care, the amount is \$5,380.00.

Cost recovery by the Commissioner aligns with the Government's overarching Cost Recovery Policy that, where appropriate, non-government recipients of specific government activities should be charged some or all of the costs of those activities. The Cost Recovery Policy also notes that if the same cost recovered activity is provided to both government and non-government stakeholders, charges should be set on the same basis for all stakeholders. The objective of regulatory charging activities (fees) is to ensure the efficiency, productivity and responsiveness of the registration, renewal and variations processes, and the quality of applications submitted for decision. The fees and exemptions in these provisions were consulted on and are reflected in the cost recovery implementation statement (CRIS) for activities of the Commissioner under this Act. Charging models and fees levels will be reviewed annually before the new financial year begins and changes reflected in the CRIS before they can commence. Any change will also be reflected in these rules. Further information is available at the Aged Care Quality and Safety Commission website: <https://www.agedcarequality.gov.au/cost-recovery-consultation>.

For registration and renewal, the fees have been calculated for both provider-level activities and category specific activities, with activities for the registration categories personal and care support in the home or community, nursing and transition care, and residential care, requiring more effort due to the higher level of risk associated with the delivery of these service types. The difference in fees across all the registration categories is reflective of the different effort (time taken and level of APS staff) required to complete the activity.

Section 108-5 – Application for renewal of registration—period for making decision

Section 108-5 provides that for the purposes of subsection 108(2) of the Act, the period within which the Commissioner must make a decision on an application by a registered provider for renewal of registration is 90 days from the later of the following:

- the day the Commissioner receives the application for renewal;
- if an audit finding referred to in subparagraph 109(2)(d)(i) of the Act is required in relation to one or more provider registration categories specified in the application—the day the Commissioner gives a copy of the final audit report to the registered provider under section 110-38 of this instrument.

This means providers can have some assurance that a decision will be made within 90 days of the later of the above instances which is important to manage provider expectations. As set out in section 588 of the Act, the period for making the decision will change where the Commissioner requests further information or a document from the registered provider before making a decision on the application.

The note provides that for provider registration categories prescribed for the purposes of paragraph 109(2)(d) of the Act, see section 109-5 of this instrument. For circumstances prescribed for the purposes of subparagraph 109(2)(d)(ii) of the Act, see section 109-10 of this instrument.

Subdivision B—Provider registration category specific requirements

Section 109-5 – Provider registration categories for which audit findings or prescribed circumstances are required

Section 109-5 provides that for the purposes of paragraph 109(2)(d) of the Act, the following provider registration categories are prescribed:

- personal and care support in the home or community;
- nursing and transition care;
- residential care.

This aligns with the registered provider of a kind that the Quality Standards apply to under section 146-5 of the rules. An audit against the Quality Standards are only required for these categories to provide a proportionate regulatory approach.

Section 109-10 – Circumstances in which audit findings are not required—health service standards assessments

Section 109-10 provides for circumstances in which an entity applying for registration (or renewal) does not need undergo an audit against the Quality Standards that apply to a provider registration category. It enables recognition of specified equivalent audit processes conducted by other regulators. It ensures registered providers are not, where appropriate alternative arrangements are in place, subject to duplicative regulation.

Subsection 109-10(1) provides that for the purposes of subparagraph 109(2)(d)(ii) of the Act, the prescribed circumstances for an application by an entity for registration, or renewal of registration, in the following provider registration categories are:

- for residential care, in relation to the delivery, or proposed delivery, by the entity of funded aged care services through that provider registration category as part of an integrated service arrangement—that the entity satisfies subsection (2);
- for personal and care support in the home and community, and nursing or transition care, in relation to the delivery or proposed delivery, by the entity of funded aged care services through those provider registration categories as part of an integrated service arrangement—that the entity satisfies subsection (3).

Prescribed circumstances—residential care

Subsection 109-10(2) provides that an entity satisfies this subsection if:

- during the 3 years immediately preceding the date of the entity’s application, a health service standards assessment was conducted; and
- the health service standards assessment assessed the entity’s ability to comply with the Australian Health Service Safety and Quality Accreditation Scheme requirements for:
 - the National Safety and Quality Health Service Standards; and
 - the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time);
 that are equivalent to the Aged Care Quality Standards that apply to the provider registration category residential care, in relation to each residential care home in which the entity delivers or proposes to deliver funded aged care services as part of an integrated service arrangement; and
- the assessment:
 - covers all the residential care homes in which the entity delivers, or proposes to deliver, funded aged care services as part of an integrated service arrangement; and
 - found that the entity is able to comply with those Standards and that Module for each residential care home.

The note under paragraph 109-10(2)(c)(ii) provides that the effect of this subsection is that an audit is not required for residential care homes of an entity in an integrated service arrangement for which a health service standards assessment has been conducted and has found that the entity is able to comply with those Standards and that Module.

The reference to a substantially equivalent module that was in force before transition time is to capture the Multi-Purpose Services Aged Care Module, which was in place at commencement of this Act. As this section allows recognition of the assessment in the prior three years, this reference allows for the recognition of those assessments where the renewal of the registered provider is before the next assessment under the Australian Health Service Safety and Quality Accreditation Scheme.

Prescribed circumstances – personal and care support in the home or community and nursing or transition care

Subsection 109-10(3) provides that an entity satisfies this subsection if:

- during the 3 years immediately preceding the date of the application, a health service standards assessment was conducted; and
- the assessment assessed the entity’s ability to comply with the Australian Health Service Safety and Quality Accreditation Scheme requirements for:
 - the National Safety and Quality Health Service Standards; and

- the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time); that are equivalent to the Aged Care Quality Standards that apply to the provider registration category personal and care support in the home or community, or nursing and transition care (as applicable); and
- the assessment covers the provider registration categories personal and care support in the home and community, or nursing or transition care, through which the entity delivers, or proposes to deliver funded aged care services as part of an integrated service arrangement; and
- the assessment found that the entity is able to comply with those Standards and that Module for all of the funded aged care services delivered, or proposed to be delivered, through those provider registration categories.

The note under paragraph 109-10(3)(d) provides that the effect of this subsection is that an audit is not required for funded aged care services provided through the registration categories personal and care support in the home or community, or nursing and transition care, as part of an integrated service arrangement for which a health service standards assessment has been conducted and has found that the entity is able to comply with those Standards and that Module.

The reference to a substantially equivalent module that was in force before transition time is to capture the Multi-Purpose Services Aged Care Module, which was in place at commencement of this Act. As this section allows recognition of the assessment in the prior three years, this reference allows for the recognition of those assessments where the renewal of the registered provider is before the next assessment under the Australian Health Service Safety and Quality Accreditation Scheme.

Meaning of health service standards assessment

Subsection 109-10(4) provides that a **health service standards assessment** means an assessment conducted:

- in accordance with Australian Health Service Safety and Quality Accreditation Scheme formulated and coordinated by the Australian Commission on Quality and Safety in Health Care; and
- by an accrediting agency approved by the Australian Commission on Quality and Safety in Health Care to assess health service organisations against the National Safety and Quality Health Service Standards and the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time).

From 1 November 2025, a health service standard assessment will only be conducted where entities deliver integrated health and aged care services at the one location, including residential care services. This includes where such providers deliver services under the MPSP or are integrated service providers of a kind specified on the website of the Department and the Aged Care Quality and Safety Commission.

The reference to a substantially equivalent module that was in force before transition time is to capture the Multi-Purpose Services Aged Care Module, which was in place at commencement of this Act. As this section allows recognition of the assessment in the prior three years, this reference allows for the recognition of those assessments where the renewal

of the registered provider is before the next assessment under the Australian Health Service Safety and Quality Accreditation Scheme.

Section 109-15 – Circumstances if audit finds nonconformance

Section 109-15 provides that for the purposes of subparagraph 109(2)(d)(ii) of the Act, circumstances for an application by an entity for registration or renewal of registration are that:

- an audit referred to in subparagraph 109(2)(d)(i) of the Act has found that the entity has not conformed with one or more of the Aged Care Quality Standards that apply to a provider registration category specified in the application; and
- the nonconformance:
 - has been addressed; or
 - can be addressed through an update to a continuous improvement plan that outlines how the nonconformance will be addressed within a specified period; or
 - can be addressed by the imposition of a condition under section 143 of the Act.

This section enables the Commissioner to register, or renew the registration of a provider into a registration category notwithstanding nonconformance has been identified during an audit. It provides the Commissioner with a mechanism to manage nonconformance and, where appropriate, allow a provider to enter, or continue in, the sector. For example, the Commissioner might impose a condition restricting the service types within a registration category that a provider can deliver or require that a continuous improvement plan outline how the provider will implement professional training on a specific topic within a set timeframe.

Section 109-25 – Other requirements—delivery of funded aged care services in certain circumstances

Section 109-25 provides for other requirements relating to the delivery of funded aged care services in certain circumstances.

Subsection 109-25(1) provides that for the purposes of paragraph 109(2)(e) of the Act, this section prescribes other requirements for an application by an entity for registration, renewal of registration or variation of registration in a provider registration category other than residential care.

Delivery to certain individuals through the service group home support

Subsection 109-25(2) provides that if the entity delivers, or intends to deliver, funded aged care services to an individual:

- who has an access approval in effect for the classification type ongoing for the service group home support; or
- who has the classification level SAH end-of-life pathway in effect for the classification type short-term for the service group home support;

another requirement is that the entity:

- also delivers, or intends to deliver, the service type care management to the individual; and

- has applied for, and satisfies the requirements for, registration in the provider registration category personal and care support in the home or community.

Delivery of services in service type restorative care management

Subsection 109-25(3) provides that if the entity delivers, or intends to deliver, funded aged care services in the service type restorative care management, another requirement is that the entity delivers, or intends to deliver, funded aged care services in the service type allied health and therapy.

These requirements relating to the service types of care management and restorative care management are prescribed to ensure that funded aged care services are integrated and adequately coordinated and monitored.

An entity seeking to deliver the Restorative Care Pathway must be able to deliver allied health services to meet the objectives and intent of restorative care.

Section does not apply to specialist aged care programs

Subsection 109-25(4) provides that this section does not apply if the entity delivers, or intends to deliver, funded aged services only under a specialist aged care program.

By removing the application against specialist aged care programs via 109-25(4) these requirements only apply to entities seeking to deliver Support at Home. This is to make sure that entities seeking registration can deliver services in line with the needs of older people accessing funded aged care services through the program as older people can only engage a single provider to deliver the services they need at commencement.

Division 2—Audit requirements

Subdivision A—Purpose of this Division

Section 110-5 – Purpose of this Division

Section 110-5 provides that for the purposes of subsection 110(1) of the Act, this Division prescribes requirements relating to conducting an audit of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category. Section 109-5 outlines which registration categories are subject to an audit for registration and renewal purposes.

Subdivision B—How audits must be conducted—general

Section 110-13 – Audit must be conducted

Subsection (1) provides that an audit of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category must be conducted by the Commissioner.

Subsection (2) provides that the Commissioner must gather evidence relevant to the scope of the audit being conducted and may be assisted by persons with the technical knowledge or skill required to collect and interpret information relevant to the scope of the audit.

Subsection (3) provides that before the audit is undertaken, the Commissioner must give a notice to the entity that includes the following information:

- a general description of the audit process;
- that an audit is proposed to be conducted in accordance with the audit process;
- the purpose of the audit, and the decision or decisions it will inform;
- the scope of the audit, including the applicable Aged Care Quality Standards;
- the period during which the audit is proposed to occur;
- the applicable fees for the proposed audit;
- advice on how individuals (if any) should be notified about opportunities to contribute to the audit;
- a copy of the audit methodology;
- any other information the Commissioner considers relevant.

Subdivision C—How audits must be conducted—assessments of approved residential care homes

Section 110-26 – Assessments—approved residential care homes

Section 110-26 provides for home assessments in relation to each approved residential care home. Note where a residential care home has been the subject of alternative arrangements under section 109-10 it will not be required to have a home assessment.

Subsection (1) provides that this section applies if an audit of a registered provider's ability to conform with the Aged Care Quality Standards relates to an application for renewal of the registered provider's registration in the provider registration category residential care.

Assessments of approved residential care homes

Subsection (2) provides that the Commissioner must, for each of the approved residential care homes included in the registered provider's registration, either:

- conduct a home assessment of the residential care home; or
- if the residential care home is covered by an integrated service arrangement, be satisfied that a health standards assessment has found it complies with the National Safety and Quality Health Service Standards and the Integrated Health and Aged Care Services Module (or a substantially equivalent module that was in force before the transition time).

This means that each of the approved residential care homes attached to a provider's registration will be subject to an assessment.

Scope of home assessment

Subsection (3) provides that a home assessment of an approved residential care home must assess whether the registered provider delivering funded aged care services in the approved residential care home conforms with the applicable Quality Standards. This means that each of the assessments undertaken of the approved residential care home will consider whether service delivery in each home is conforming with the Quality Standards.

Subsection (4) provides that a home assessment of an approved residential care home must, to the extent possible, consider the following matters as part of the home assessment:

- the experience of individuals to whom funded aged care services are delivered in the approved residential care home to, for example, understand from the resident's point

of view whether the provider is acting in conformance with applicable Quality Standards;

- documents and records relevant to the home assessment, which may include policies and procedures relevant to assessing against applicable Aged Care Quality Standards;
- feedback from the following to holistically assess a provider's conformance with applicable Aged Care Quality Standards:
 - aged care workers of the registered provider;
 - responsible persons of the registered provider;
 - the governing body of the registered provider;
 - third parties with relevant knowledge or experience;
- observations at the approved residential care home which are critical to understanding a provider's conformance with the applicable Aged Care Quality Standards;
- care outcomes relating to the approved residential care home which refers to the funded aged care services delivered to each of the residents within the approved residential care home.

It is expected that each approved residential care home's assessment will include interviews with residents to gauge their experiences living within the home. This is important for the assessment to understand from the resident's point of view whether the provider is conforming with the relevant Quality Standards that affect their experience. It is also expected that the Commissioner will seek the consent of any residents as part of this activity at the time of the assessment.

Attendance at approved residential care homes

Subsection (5) provides that a home assessment of an approved residential care home must include the following:

- attendance by the Commissioner at the approved residential care home, meaning that each approved residential care home will require a person to physically visit the home to conduct at least part of the assessment;
- such other means of assessment as are appropriate, meaning, for example, that an assessment of documents and records may be conducted off-site.

Notice of home assessment

Subsection (6) provides that before a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must give written notice to the registered provider:

- specifying each approved residential care home included in the registered provider's registration, and stating that a home assessment of each approved residential care home is to be conducted; and
- requiring the registered provider to notify each individual to whom funded aged care services are delivered in each approved residential care home:
 - that the home assessment is going to be conducted; and
 - that the person or persons conducting the home assessment will attend the approved residential care home as part of the home assessment, and the day or days on which this will occur; and

- that the person or persons attending the approved residential care home will seek the individual's consent before engaging with the individual, or entering a part of the approved residential care home that comprises the individual's personal space (for example, the individual's room).

Rule if consent not obtained from individuals

Subsection (7) provides that if an individual to whom funded aged care services are delivered at an approved residential care home does not give consent as mentioned in subparagraph (6)(b)(iii), the persons conducting the home assessment will not enter any part of the approved residential care home that comprises the individual's personal space. It is imperative that the persons conducting the home assessment seek consent before engaging with residents or entering their personal spaces. Consent requires positive indication and cannot be presumed in the absence of a clear, positive indication. In circumstances where a person is unable to communicate – whether by speech, gesture, or other means, consent must not be inferred or presumed. The absence of objection does not equate to permission; only an affirmative, voluntary, and informed expression of consent constitutes valid consent. It cannot be assumed that they have consented to another person entering their personal space.

The note provides that subsection (7) means that if none of the individuals accessing funded aged care services in the approved residential care homes included in a registered provider's registration give consent, the person or persons conducting the home assessments will not enter any parts of the approved residential care homes that comprises the personal space of an individual, such as, for example, the individual's room.

Section 110-28 – Preliminary assessment report of home assessment

Section 110-28 provides for preliminary assessment reports of home assessments. A home assessment examines an entity's conformance with the Aged Care Quality Standards applicable to registration category residential care at the approved residential care home. The preliminary assessment report presents the draft findings of the assessment, including the attendance at the residential care home which is the 'on-site' element of the assessment, and the underlying reasons or evidence that informed these conclusions. A copy of this report will then be provided to the registered provider for their review to allow them an opportunity to respond to any of the findings and/or the underlying reasons or evidence used to inform the findings.

Subsection (1) provides that if a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must prepare a preliminary assessment report setting out the findings of the home assessment.

Subsection (2) provides that the preliminary assessment report must assign a grade for conformance with the Aged Care Quality Standards for the registered provider's delivery of funded aged care services in the approved residential care home as outlined in the audit methodology mentioned in paragraph 110-13(3)(h).

Audit grades replace the 'pass or fail' system for conformance with the Aged Care Quality Standards and support an entity's continuous improvement. The audit grades used by the Commission will be outlined in their methodology but at commencement are expected to be:

- major non-conformance,
- minor non-conformance,

- conformance, and
- exceeding conformance.

An approved residential care home's conformance with the Aged Care Quality Standards will affect its Star Rating. The incorporation of graded assessment of an approved residential care home against the Aged Care Quality Standards gives effect to one of the Royal Commission's recommendations for star ratings (Recommendation 24).

It is important that entities have a chance to review the preliminary report and audit grade of the residential care home as the audit grade may be published by the Commissioner and/or used for star ratings.

Subsection (3) provides that the Commissioner must:

- give a copy of the preliminary assessment report to the registered provider within 14 days from the attendance at the approved residential care home for the home assessment; and
- give the registered provider the opportunity to respond in writing to the report within 14 days from the day the Commissioner gave the preliminary assessment report to the registered provider.

Section 110-30 – Final assessment report of home assessment

Section 110-30 provides for final assessment reports of home assessments. Once the registered provider has had the opportunity to respond to the draft findings and the underlying reasons or evidence used to inform the findings, the Commissioner will provide a copy of the final assessment report of each of the home assessments undertaken at the approved residential care homes. Where a provider has provided a response to the Commissioner on the preliminary assessment, the Commissioner must take the response into account when finalising the assessment report. Subsection (1) provides that if a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must prepare a final assessment report setting out the findings of the home assessment.

Subsection (2) provides that the final assessment report must assign a grade for conformance with the Aged Care Quality Standards for the registered provider's delivery of funded aged care services in the approved residential care home as outlined in the audit methodology mentioned in paragraph 110-13(3)(h).

Subsection (3) provides that in preparing the final assessment report, the Commissioner must consider any response received from the registered provider as mentioned in paragraph 110-28(3)(b).

Subsection (4) provides that the Commissioner must give a copy of the final assessment report to the registered provider within 28 days from:

- if the registered provider responded in writing to the preliminary report within the period mentioned in paragraph 110-28(3)(b)—the day the Commissioner received the response; or
- if the registered provider did not respond in writing to the preliminary report within the period mentioned in paragraph 110-28(3)(b)—the last day of that period.

Subsection (5) provides that the registered provider must, within 14 days from receiving the final assessment report, notify the following of the findings of the home assessment (including the grade):

- responsible persons and aged care workers of the registered provider who deliver funded aged care services in the approved residential care home;
- individuals to whom funded aged care services are delivered in the approved residential care home.

The Commissioner may publish final assessment reports as outlined in section 546-10.

Subdivision D—How audits must be conducted— attendance at a service delivery location for home or community setting

Section 110-32 Attendance at a service delivery location —home or community setting

Section 110-32 provides for the attendance at a service delivery location in relation to home or community settings.

Subsection (1) provides that this section applies if:

- an audit of a registered provider's ability to conform with the Aged Care Quality Standards relates to an application for renewal of the registered provider's registration; and
- the scope of the audit includes funded aged care services delivered by the registered provider in a home or community setting.

This attendance is an on-site activity that may occur as part of an audit of an entity's conformance with the Aged Care Standards applicable to registration categories:

- personal and care support in the home or community;
- nursing or transition care.

Funded aged care services in the home or community setting can be delivered in a variety of physical locations, including, but not limited to, the home of individual who is receiving funded aged care services, a private business or a public shared location like a community hall. To capture all possibilities the term 'service delivery location' is used.

This activity is similar to the attendance element of a home assessment of a residential care home with a focus on gathering information and evidence onsite. It is not intended to replicate the entire home assessment for the home and community setting as it would be impractical and disproportionate, given the variety of locations at which services are delivered.

Attendance at a service delivery location will occur only where it is in the scope of audit. This means that some entities will not have an attendance as part of their audit even if seeking registration in registration categories:

- personal and care support in the home or community;
- nursing or transition care.

This again is in recognition of differences between the residential, where attendance is required for all assessments at approved residential care homes, and home and community setting.

Notice of attendance at a service delivery location

Subsection (2) provides that if the scope of the audit includes attendance at a service delivery location, the Commissioner must give written notice to the registered provider:

- stating that attendance at a service delivery location is to be conducted; and
- stating whether or not one or more persons propose to attend individuals' residences or the premises of a community setting in conducting the attendance at the service delivery location; and
- if the Commissioner proposes to attend the residence of one of more individuals—requiring the registered provider to notify the individuals:
 - that attendance at the service delivery location is going to be conducted; and
 - that the Commissioner will attend individuals' residences as part of the assessment, and the day or days on which this will occur; and
 - that if the Commissioner proposes to attend the residence of a particular individual, the person will seek consent to enter the residence from the individual and any other person at their residence; and
- if the Commissioner proposes to attend the premises of a community setting—stating that the person will seek consent from the owner or occupier to enter the premises.

It is imperative that consent is sought before engaging with individuals or entering their personal spaces and/or private property. Consent requires positive indication and cannot be presumed in the absence of clear and positive permission. In circumstances where a person is unable to communicate – whether by speech, gesture, or other means, consent must not be inferred or presumed. The absence of objection does not equate to permission; only an affirmative, voluntary, and informed expression of consent constitutes valid consent. It cannot be assumed that an individual has consented to another person entering their personal space, home or private property.

Subsection (3) provides that if:

- an individual to whom funded aged care services are delivered at their residence does not give consent as mentioned in subparagraph (2)(c)(iii), attendance at the service delivery location must not include their residence; and
- if no such individuals give consent, attendance at the service delivery location must not be included in the scope of the audit.

Subsection (4) provides that if it is not reasonably practicable to obtain consent from the owner or occupier of the premises where funded aged care services are delivered in a community setting, attendance at the service delivery location must not include those premises.

Subdivision E—How audits must be conducted—final audit report

Section 110-38 – Final audit reports

Section 110-38 provides for final audit reports.

Subsection (1) provides that if an audit of an entity's ability to conform with the Aged Care Quality Standards is conducted, the Commissioner must prepare a final audit report.

Subsection (2) provides that the final audit report must include the following:

- the period to which the audit relates;

- the scope of the audit;
- the audit outcomes;
- an assessment of the entity's conformance, or ability to conform, with the Aged Care Quality Standards;
- if the final audit report identifies nonconformance with the Aged Care Quality Standards—whether the entity has the ability to conform and the things the entity must do, or has done, to conform;
- the outcomes of the following (if any):
 - each home assessment of an approved residential care home conducted in accordance with section 110-26(2) for the purposes of the audit;
 - each attendance at the service delivery location of residences or other premises conducted in accordance with section 110-32 for the purposes of the audit.

The final audit report incorporates the outcomes of the home assessments (if any) and attendances at service delivery locations (if any) and provides a summary of the entity's conformance with the Aged Care Quality Standards in relation to the registration categories the entity is seeking registration for. This report will inform the decision by the Commissioner to register or renew registration in a registration category. Where relevant, it will also inform which mechanisms the Commissioner might use to manage non-conformance such as, for example, through the imposition of conditions on the registration of the entity or a requirement that specific information be included in a continuous improvement plan.

As part of a relational regulatory approach, entities will receive feedback throughout the audit and there should be 'no surprises' in the final audit report. Audits are forward-looking and consider whether the organisation is set up to deliver consistently with the Aged Care Quality Standards. This forward-looking focus is intended to support continuous improvement in aged care services and will be different to the monitoring or enforcement approach the Commission will use when it is identified that a provider may not be complying with some of its obligations.

Subsection (3) provides that the Commissioner must:

- give a copy of the final audit report to the entity within 28 days of the completion of the audit; and
- give the entity the opportunity to respond in writing to the final audit report within 14 days from the day the final audit report was given to the entity, or such longer period as the Commissioner agrees with the entity.

The final audit report and the response from the entity will be used to inform the decision by the Commissioner to register or renew registration in a registration category as highlighted above. This provides the opportunity for the entity's response to be considered by the decision maker and may be reflected in the notice of decision. Decisions to not register, renew or vary a registration are reviewable under section 556 of the Act.

Subsection (4) provides that an entity that is a registered provider must, within 28 days from receiving the final audit report, notify the following of the outcomes of the audit:

- responsible persons and aged care workers of the registered provider;
- if the audit relates to an approved residential care home—any individuals to whom funded aged care services are delivered in the approved residential care home.

The Commissioner may publish final audit reports as outlined in section 546-15.

Subdivision F—Type and scope of audits and other matters

Section 110-40 – Type and scope of audits for provider registration categories

Provider registration categories

Subsection (1) provides that this section prescribes the types and scope of audits that can be conducted for the following provider registration categories:

- personal and care support in the home or community;
- nursing and transition care;
- residential care.

Types of audit

Subsection (2) provides that the types of audit that may be conducted in respect of the provider registration categories referred to in subsection (1) are as follows:

- registration of an entity;
- renewal of an entity's registration;
- variation of an entity's registration.

Note that a decision to approve a variation into a new registration category will require consideration of the registration requirements for that specific category.

Scope of audit

Subsection (3) provides that the scope of an audit is to include (as applicable):

- whether the audit relates to registration of an entity, or the renewal or variation of an entity's registration; and
- the applicable Aged Care Quality Standards in respect of:
 - the provider registration category or categories for which the audit is being conducted; and
 - service types to which the audit relates; and
- whether or not the audit will include any home assessments or attendance at any service delivery locations.

Note 1 provides that for the provider registration category residential care, a home assessment of all approved residential care homes must be conducted for renewal of registration (see subsection 110-26(2)), except in certain circumstances specified in subsection 109-10(2), where there has been a health service standards assessment in the previous 3 years.

Note 2 provides that for the provider registration categories personal and care support in the home or community, and nursing and transition care, attendance at a service delivery location on renewal of registration may be conducted (see subsection 110-32(2)).

There will also be consideration of whether any residential care homes do not require a home assessment due to the alternative arrangements outlined in section 109-10.

Subsection (4) provides that the Commissioner must consider the following when determining the scope of the audit:

- matters or risks that are identified as requiring specific examination;
- in the case of renewal or variation of an entity's registration:
 - the time that has elapsed since the most recent audit of the entity was conducted; and
 - the scope of any previous audits of the entity; and
 - the outcomes of previous audits of the entity; and
 - the history of compliance with the Act of the entity;
- any guidelines relating to audit matters made for the purposes of subsection 348(2) of the Act.

The note provides that, in considering the scope of an audit, the Commissioner may consider an audit undertaken by another person or body, which the Commissioner recognises as equivalent to meeting the Aged Care Quality Standards, despite the audit not having been undertaken by the Commissioner.

Subdivision G—Fees payable for an audit

Cost recovery by the Commissioner aligns with the Government's overarching Cost Recovery Policy that, where appropriate, non-government recipients of specific government activities should be charged some or all of the costs of those activities. The Cost Recovery Policy also notes that if the same cost recovered activity is provided to both government and non-government stakeholders, charges should be set on the same basis for all stakeholders. The objective of regulatory charging activities (fees) is to ensure the efficiency, productivity and responsiveness of the registration, renewal and variations processes, and the quality of applications submitted for decision. The fees and exemptions in these provisions were consulted on and are reflected in the cost recovery implementation statement (CRIS) for activities of the Commissioner under this Act. Charging models and fees levels will be reviewed annually before the new financial year begins and changes reflected in the CRIS before they can commence. Any change will also be reflected in these rules. Further information is available at the Aged Care Quality and Safety Commission website: <https://www.agedcarequality.gov.au/cost-recovery-consultation>.

Audits will only be undertaken for the registration categories personal and care support in the home or community, nursing and transition care, and residential care, therefore audit fees only apply for applications to register, renew, or vary (add) one or more of these categories. The fees recognise the different effort required to complete the activity by registration category and audit type (registration, renewal or variation as outlined in 110-40(2)). Renewal audits are akin to reaccreditation site audits (residential services) and quality reviews (home services) in the current legislation, however fees have only been charged for reaccreditation site audits, and reaccreditation fees have been set at approximately 60% of the full recoverable amount. In recognition of this, and the exemptions for registration, renewal and variation applications which support entities enter and operate in this market and to remain in the market by supporting providers to continue to operate in thin markets and to address potential viability risks, there are reduced fees that represent 50% or 100% of the full fee for audits for providers who meet certain eligibility criteria. These criteria is aligned with the exemptions in the rules for section 597 of the Act. Please see 597-5 for more information.

Section 110-45 – Audit fee – audit in connection with registration

Section 110-45 provides for audit fees in connection with registration.

Subsection (1) provides that this section applies to an audit, for one or more of the following provider registration categories, in connection with an entity applying to be registered as a registered provider under subsection 104(1) of the Act in the provider registration category or categories:

- personal and care support in the home or community;
- nursing and transition care;
- residential care.

Subsection (2) provides that the fee payable by the entity for an audit for one or more of the provider registration categories is:

- unless subsection (3) applies to the entity—\$14,870.00; or
- if subsection (3) applies to the entity—\$0.

Subsection (3) provides that this subsection applies to an entity if, at the time of the application:

- 1) the entity intends to deliver funded aged care services under the MPSP or the TCP; or
- 2) the entity intends that 85% of the individuals that the entity is to deliver services to will be located in an area with a 2023 MM category known as MM 6 or MM7; or
- 3) the entity is known as an Aboriginal Community Controlled Organisation.

Section 110-47 – Audit fee—audit in connection with registration renewal

Section 110-47 provides for audit fees in relation to an audit in connection with a renewal of registration.

Subsection (1) provides that this section applies to an audit, for one or more of the following provider registration categories, in connection with the renewal of the registration of a registered provider under subsection 107(1) of the Act in the provider registration category or categories:

- personal and care support in the home or community;
- nursing and transition care;
- residential care.

Subsection (2) provides that the fee payable by the registered provider for an audit for one or more of the provider registration categories is the sum of:

- in any case:
 - unless subsection (3) applies to the registered provider—\$7,890.00; or
 - if subsection (3) applies to the registered provider—\$0; and
- for either or both of the provider registration categories personal and care support in the home or community and nursing and transition care:
 - unless subsection (3) applies to the registered provider—the amount that applies to the registered provider under subsection (5); or
 - if subsection (3) applies to the registered provider—\$0; and
- for the provider registration category residential care:

- unless subsection (4) applies to the registered provider—the sum of the amounts applicable under subsection (6) or (7) (as the case may be) for each of the approved residential care homes included in the registered provider’s registration at the time of the application and for which home assessments must be conducted under subsection 110-26(2); or
- if subsection (4) applies to the registered provider—\$0.

The effect of paragraph (2)(a) is that the following base fee will apply: \$7,890.00.

However, the base fee does not apply in the circumstances listed under subsection (3).

The effect of paragraph (2)(b) is that in addition to the base fee, for those providers renewing in the following registration categories, further fees also apply (see subsection (5) for the additional amounts):

- personal and care support in the home or community; or
- nursing and transition care

However, these fees also do not apply in the circumstances listed under subsection (3).

The effect of paragraph (2)(c) is that in addition to the base fee, for those providers renewing their registration in the provider registration category residential care, the further fees that will apply to them are listed in subsection (6).

However, a reduced fee (see subsection (7) for the reduced fee amounts) applies in the circumstances listed under subsection (8), or no fee will apply in the circumstances listed under subsection (4).

Circumstances in which a nil fee component is applicable

Subsection (3) provides that for the purposes of paragraphs (2)(a) and (b), this subsection applies to a registered provider if, on the day the Commissioner invites the provider under section 106 of the Act to renew the registration:

- the entity is a registered provider delivering funded aged care services only under the MPSP or the TCP; or
- the entity intends that all of the individuals that the entity is to deliver services to will be located in an area with a 2023 MM category known as MM 5, MM6 or MM7; or
- the Commissioner considers, based on the information held by the Commissioner as at that day, that the provider is in the smallest 10% of all registered providers based on the number of individuals to whom funded aged care services are delivered by the provider.

Subsection (4) provides that for the purposes of paragraph (2)(c), this subsection applies to a registered provider if, on the day the Commissioner invites the provider under section 106 of the Act to renew the registration:

- the registered provider is delivering funded aged care services only under the MPSP or the TCP; or
- both of the following apply:

- an approved residential care home included in the provider's registration is located in an area in the 2023 MM category known as MM 4, MM 5, MM 6 or MM 7;
- the average number of occupied beds per day over the quarter immediately preceding the day the invitation was given was fewer than 25; or
- both of the following apply:
 - an approved residential care home included in the provider's registration has specialised Aboriginal or Torres Strait Islander status or has specialised homeless status;
 - the average number of occupied beds per day over the quarter immediately preceding the day the invitation was given was fewer than 25.

Personal and care support in the home or community and nursing and transition care

Subsection (5) provides that for the purposes of paragraph (2)(b), the amount that applies to the registered provider is:

- if, on the day the Commissioner invites the provider under section 106 of the Act to renew the registration, the registered provider delivers funded aged care services only to fewer than 30 individuals in a single State or Territory—\$9,800.00; or
- if, on that day, the registered provider delivers funded aged care services only to between 30 and 342 individuals in a single State or Territory—\$15,550.00; or
- if, on that day, the registered provider delivers funded aged care services to:
 - 343 or more individuals in a single State or Territory; or
 - any number of individuals in more than one State or Territory;
- \$17,950.00.

Residential care—standard amounts

Subsection (6) provide that for an approved residential care home to which subsection (8) does not apply, the amount is:

- for an approved residential care home with not more than 150 beds—\$16,340.00; or
- for an approved residential care home with more than 150 beds but not more than 250 beds—\$17,510.00; or
- for an approved residential care home with more than 250 beds—\$18,670.00.

Residential care—reduced amounts

Subsection (7) provides that for an approved residential care home to which subsection (8) applies, the amount is:

- for an approved residential care home with not more than 150 beds—\$8,170.00; or
- for an approved residential care home with more than 150 beds but not more than 250 beds—\$8,760.00; or
- for an approved residential care home with more than 250 beds—\$9,340.00.

Subsection (8) provides that this subsection applies to an approved residential care home included in a registered provider's registration if:

- on the day the Commissioner invites the provider under section 106 of the Act to renew the registration, funded aged care services are delivered in the approved residential care home:
 - in any case—to fewer than 25 individuals; or
 - if the approved residential care home is located in an area in the 2023 MM category known as MM category 4—to at least 25, and fewer than 30, individuals; or
 - if the approved residential care home is located in an area in the 2023 MM category known as MM category 5—to at least 24, and fewer than 39, individuals; or
 - if the approved residential care home is located in an area in the 2023 MM category known as MM category 6 or 7—to at least 25 individuals; or
- on the day the Commissioner invites the provider under section 106 of the Act to renew the registration:
 - the approved residential care home has specialised Aboriginal and Torres Strait Islander status or specialised homeless status; and
 - funded aged care services are delivered in the approved residential care home to at least 25 individuals.

Subsection (9) provides that for the purposes of paragraph (8)(b), the number of individuals is to be worked out by reference to the average number of occupied beds per day over the quarter immediately preceding the day the invitation was given.

Section 110-49 – Audit fee—audit in connection with variation of registration

Section 110-49 provides for audit fees in connection with varying a provider’s registration.

Subsection (1) provides that this section applies to an audit, for one or more of the following provider registration categories, in connection with a registered provider applying to vary the provider’s registration to register the provider in the provider registration category or categories:

- personal and care support in the home or community;
- nursing and transition care;
- residential care.

Subsection (2) provides that the fee payable by the registered provider for an audit for one or more of the provider registration categories is:

- unless subsection (3) applies to the registered provider—\$18,530.00; or
- if subsection (3) applies to the registered provider—\$0.
- Subsection (3) provides that this subsection applies to an entity if, at the time of the application:
 - the entity intends to deliver funded aged care services under the MPSP or the TCP; or
 - the entity intends that 85% of the individuals that the entity is to deliver services to will be located in an area with a 2023 MM category known as MM 6 or MM7; or
 - the entity is known as an Aboriginal Community Controlled Organisation.

Section 110-5 – Audit fee—refunds

Subsection (1) This section prescribes circumstances in which any of the following may be refunded to an entity:

- an audit fee prescribed in section 110-45 of this instrument in connection with an application under section 104 of the Act;
- an audit fee prescribed in section 110-47 of this instrument in connection with an application under section 107 of the Act;
- an audit fee prescribed in section 110-49 of this instrument in connection with an application under section 124 of the Act.

Subsection (2) provides that the circumstances are that:

- the entity makes the application; and
- the entity pays, in connection with the application (whether before or after making the application), the audit fee; and
- an audit of the entity is not conducted under section 110 of the Act.

Subdivision H—Audit timeframes

Section 110-53 – Audit timeframes for provider registration categories

Section 110-53 provides the requirements for audit timeframes for provider registration categories.

Subsection (1) provides that subsections (2) and (3) of this section prescribe the timeframes within which an audit must be conducted for the following provider registration categories:

- personal and care support in the home or community;
- nursing and transition care;
- residential care.

Subsection (2) provides that an audit in relation to an initial application for registration must be conducted during the period beginning on the date of the application and ending when the Commissioner makes a decision on the application.

Subsection (3) provides that an audit in relation to a renewal of registration must be conducted during the period beginning on the date of the invitation to renew under subsection 106(1) of the Act and ending when the Commissioner makes a decision on the application. A registration will general last about 3 years. Before the registration period comes to an end, it is expected that the Commissioner will contact the registered provider to invite them to renew their registration up 18 months in advance of their registration end date. The invitation will include an indicative audit timeframe.

Subsection (4) provides that the Commissioner must not make a decision to register an entity, or renew a registration, until the final audit report is completed. This means that all registered providers indicated in subsection (1) that are applying to renew their registration, will be required to undergo an audit which will inform the Commissioner to make a decision on the renewal of registration.

Division 3—Applications for approval of residential care homes

Section 111-5 – Application fee

Section 111-5 provides that for the purposes of paragraph 111(2)(b) of the Act, the application fee for an application by an entity for approval of a residential care home in relation to the entity is \$3,800.00 for each residential care home specified in the application.

The note provides that exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

Cost recovery by the Commissioner aligns with the Government's overarching Cost Recovery Policy that, where appropriate, non-government recipients of specific government activities should be charged some or all of the costs of those activities. The Cost Recovery Policy also notes that if the same cost recovered activity is provided to both government and non-government stakeholders, charges should be set on the same basis for all stakeholders. The objective of regulatory charging activities (fees) is to ensure the efficiency, productivity and responsiveness of the registration, renewal and variations processes, and the quality of applications submitted for decision. The fees and exemptions in these provisions were consulted on and are reflected in the cost recovery implementation statement (CRIS) for activities of the Commissioner under this Act. Charging models and fees levels will be reviewed annually before the new financial year begins and changes reflected in the CRIS before they can commence. Any change will also be reflected in these rules. Further information is available at the Aged Care Quality and Safety Commission website: <https://www.agedcarequality.gov.au/cost-recovery-consultation>.

Section 111-10 – Information for residential care homes

Section 111-10 provides that for the purposes of subparagraph 111(3)(b)(ii) of the Act, the other information for each residential care home specified in an application is as follows:

- the name of the residential care home;
- the street address of the residential care home;
- the name of the responsible person in charge of the residential care home;
- a copy of the certificate of occupancy or equivalent certificate (however described) for the residential care home, or any other document that specifies or relates to the number of beds in the residential care home or the total number of individuals that may occupy or reside in the residential care home;
- documentary evidence demonstrating that the building or buildings that comprise the residential care home are permanent and will not present a risk to the delivery of quality and safe residential care including, but not limited to:
 - floor plans and bed layout; and
 - fixtures, furnishings and design; and
 - an explanation of the design of the residential care home.

Subsection 111-10(d) provides for alternatives that could be used if a copy of the certificate of occupancy may not be able to be included in the application. This means that not providing a copy of the certificate of occupancy will not make the application invalid if the other criteria outlined is satisfied. After reviewing the application, if the Commissioner requires a copy of the certificate of occupancy to make a decision on the application and it was not provided in the application, the Commissioner may use requests for further information under section 588 of the Act.

Documentary evidence referenced in subsection 111-10(e) also supports the Commissioner to determine the total number of beds for each of the residential care homes.

Section 112-5 – Period for making decision

Section 112-5 provides that for the purposes of subsection 112(2) of the Act, the period within which the Commissioner must make a decision on an application for approval of a residential care home in relation to an entity is:

- if the entity has made an application for registration under subsection 104(1) of the Act—the period that applies to that application under section 1055 of this instrument; or
- if the entity is a registered provider—90 days from the day the Commissioner receives the application for approval of the residential care home.

This means providers can have some assurance that a decision will be made within 90 days which is important to manage provider expectations. The expectation is a provider would submit an application when they are ready to deliver residential care services at the home. If a home has been recently constructed, the expectation is that the construction phase is completed, or nearing completion at the time the provider lodges the application. The Commission will be able to issue guidance on when to apply for new buildings, including if an application can be submitted before the buildings or their fit-out or furnishing are complete. The Commission may use requests for further information under section 588 of the Act to ‘pause’ the consideration of an application until finishing touches, that allow the entity or registered provider to commence delivering residential care services at the home, are complete.

Section 113-5 – Approval of residential care homes

Section 113-5 provides that for the purposes of subparagraph 113(b)(ii) of the Act, other requirements of which the Commissioner must be satisfied before approving a residential care home in relation to an entity are as follows:

- that either:
 - the entity owns the premises at which the residential care home is located; or
 - if the entity does not own the premises at which the residential care home is located—the owner of the premises agrees to the entity using the premises as a residential care home;
- that the building or buildings that comprise the residential care home are permanent; and
- that the building or buildings that comprise the residential care home and its total number of beds will not present a risk to the delivery of quality and safe residential care.

With respect to the building or buildings that comprise the home and its total number of beds, scenarios presenting possible risks are outlined below:

- A room that does not have sufficient space to accommodate equipment and aids.
- Approving an additional bed to make a double room that is currently used as a single room.
- Converting an existing room to accommodate a residential bed that was previously used for another function such as an activities room or an office.

If, during the registration period, there is a change in the ownership of the premises at which the residential care home is located or there is a new (or varied) agreement entered into between the owner and the entity, a notice must be given to the Commissioner informing it of this change as required by section 167-70 of this instrument.

Division 4—Notice of decisions and other provisions

Section 114-5 – Other matters for notices of decisions to register or renew

Section 114-5 provides that for the purposes of paragraph 114(3)(f) of the Act, other matters that must be included in a notice of a decision given to an entity are the details of each residential care home (if any) that is approved in relation to the entity. This is to ensure each registration and/or renewal of registration with residential care homes attached to their registration identifies the approved residential care homes that the provider operates.

Section 117-5 – Deemed registration—classes of entity

Section 117-5 provides that for the purposes of subsection 117(1) of the Act, the following classes of entity are prescribed:

- hospitals (whether operated by government entities or non-government entities);
- entities that are not registered providers, but that:
 - deliver services similar to funded aged care services that are delivered in an approved residential care home; or
 - deliver services similar to funded aged care services that are delivered in a home or community setting or in a similar sector;
- registered providers that are not registered in all of the provider registration categories.

This means that the System Governor may determine that any of the above classes of entities are taken to be registered as a registered provider to support the delivery of funded aged care services to individuals during an emergency.

Section 117-10 – Deemed registration—other matters for determinations of deemed registration

Section 117-10 provides that for the purposes of paragraph 117(2)(h) of the Act, other matters that must be specified in a determination that an entity is taken to be a registered provider are as follows:

- the ABN of the entity;
- each responsible person of the entity;
- the business location of the entity.

This information is required to ensure the correct entities are appropriately identified as being taken to be a registered provider to support the delivery of funded aged care services to individuals during an emergency.

Part 3—Variations, suspensions and revocations of registration

Division 1—Variations, suspensions and revocations

These sections are used to ensure procedural fairness is maintained so that if a registered provider is subject to suspensions or revocations, they will be able to seek a review of the

decision. Where a registered provider applies to for a variation, the Commissioner will be required to consider the application and make a decision.

Section 124-5 – Application fee – variation to add provider registration categories

Section 124-5 provides that for the purposes of paragraph 124(2)(b) of the Act, the application fee for an application by a registered provider to vary the provider's registration to register the provider in a new provider registration category is the sum of the amounts specified in column 2 of the following table for each new provider registration category that the provider is applying to be registered in.

The note provides that exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

The table provides the following amounts for each registration category:

- Item 1, Home and community services, the amount is \$1,270.00
- Item 2, Assistive technology and home modifications, the amount is \$1,270.00
- Item 3, Advisory and support services, the amount is \$1,270.00
- Item 4, Personal and care support in the home or community, the amount is \$3,800.00
- Item 5, Nursing and transition care, the amount is \$3,800.00
- Item 6, Residential care, the amount is \$5,070.00.

Section 124-10 – Application fee—variation to remove provider registration categories

Section 124-10 provides that for the purposes of paragraph 124(2)(b) of the Act, this section prescribes the application fee for an application by a registered provider to vary the provider's registration by removing the provider from being registered in a provider registration category.

Subsection (2) provides that for an application to remove the provider from being registered in one or more of the following provider registration categories, the application fee is \$545.00:

- home and community services;
- assistive technology and home modifications;
- advisory and support services.
- any of the following provider registration categories under which the registered provider is not delivering funded aged care services at the time of the application:
 - personal and care support in the home or community;
 - nursing and transition care;
 - residential care.

Subsection (3) provides that for an application to remove the provider from being registered in one or more of the following provider registration categories under which the registered provider is delivering funded aged care services at the time of the application, the application fee is \$4800.00 for each such category:

- personal and care support in the home or community;
- nursing and transition care;
- residential care.

The note provides that exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act.

Cost recovery by the Commissioner aligns with the Government's overarching Cost Recovery Policy that, where appropriate, non-government recipients of specific government activities should be charged some or all of the costs of those activities. The Cost Recovery Policy also notes that if the same cost recovered activity is provided to both government and non-government stakeholders, charges should be set on the same basis for all stakeholders. The objective of regulatory charging activities (fees) is to ensure the efficiency, productivity and responsiveness of the registration, renewal and variations processes, and the quality of applications submitted for decision. The fees and exemptions in these provisions were consulted on and are reflected in the cost recovery implementation statement (CRIS) for activities of the Commissioner under this Act. Charging models and fees levels will be reviewed annually before the new financial year begins and changes reflected in the CRIS before they can commence. Any change will also be reflected in these rules. Further information is available at the Aged Care Quality and Safety Commission website: <https://www.agedcarequality.gov.au/cost-recovery-consultation>.

For variation application fees, the type of variation applied, adding or removing a category, will be the primary point of differentiation. The difference in fees across the registration categories 1-6 is reflective of the different effort (time taken and level of APS staff) required to complete the activity.

Section 133-5 – Classes of persons who must not be appointed as eligible advisers

Section 133-5 provides that for the purposes of paragraph 133(4)(a) of the Act, classes of persons who must not be appointed by a registered provider as an eligible adviser are as follows:

- persons who are not independent of the registered provider;
- persons who are unsuitable having regard to the matters specified in subsection 13(1) of the Act;
- persons who have, or may be perceived to have, a conflict of interest between their duties as an eligible adviser and any other interests or duties.

Examples of persons who are not independent of the registered provider and who may have an actual or perceived conflict of interest are current employees of the registered provider and current responsible persons of the registered provider. Current employees and current responsible persons should not be appointed as eligible advisers. Depending on the person and the circumstances, a former employee or former responsible person may also be excluded for the same reason.

Section 133-10 – Matters to be taken into account in specifying period within which eligible adviser must be appointed

Subsection (1) provides that for the purposes of paragraph 133(4)(b) of the Act, this section prescribes matters that the Commissioner must take into account in specifying a period in a notice given under subsection 133(2) of the Act for the purposes of paragraph 133(3)(a) of the Act (requiring a registered provider to appoint an eligible adviser).

Subsection (2) provides that the matters are as follows:

- the location where funded aged care services are delivered by the registered provider;

- the nature of any contravention, or proposed contravention, of the Act by the registered provider that the Commissioner is satisfied has occurred, is occurring or may occur;
- whether, as a result of any such contravention or proposed contravention of the Act by the registered provider, there is an immediate and severe risk to the safety, health and well-being of individuals to whom the registered provider is delivering funded aged care services;
- the availability of persons who have appropriate qualifications, skills or experience to assist the registered provider to comply with the conditions and obligations that apply to the registered provider under Part 4 of Chapter 3 of the Act in relation to the matters specified in subparagraphs 133(3)(a)(i) and (ii) of the Act (which relate to funded aged care services and governance and business operations);
- any other relevant matters.

This section replicates equivalent provisions set out in the *Aged Care Quality and Safety Commission Rules 2018*, to ensure registered providers appoint independent advisers. It outlines the factors the Commissioner must consider when specifying the period within which a registered provider must appoint an eligible adviser during a period of suspension. This aims to ensure that providers address compliance issues promptly to safeguard the quality and safety of services for individuals, or to support the orderly exit from the aged care sector if non-compliance cannot be addressed and revocation will occur after the period of suspension ends.

Mandating a specific period for appointing an adviser encourages providers to act swiftly in rectifying issues, minimising potential risks to individuals. By setting clear timeframes, the rules hold providers accountable for implementing necessary changes under expert guidance. Defined periods also allow the Commissioner to monitor compliance effectively and take further action if providers fail to meet the requirements within the stipulated timeframes.

Division 2—Variations, suspensions and revocations of approvals of residential care homes

Section 136-5 – Variation of approval on Commissioner’s own initiative—bed availability

Section 136-5 provides that for the purposes of paragraph 136(2)(a) of the Act, the period for which the Commissioner must be satisfied that the number of beds available in a residential care home is likely to be reduced is a period of at least 2 years.

Setting the minimum two-year timeframe ensures that registered providers are only having to vary their total bed numbers if there is a permanent reduction, or when their capacity is reduced for a significant period (i.e. major re-development of a home). This would prompt the Commissioner to assess if the number of beds meets the approval requirements of a residential care home.

If the total number of beds are temporarily unavailable, known as being ‘offline’, then the registered provider must notify the Commissioner outlined in 167-70 if the change to the total number of beds reduced for a period of more than 3 months and less than 2 years.

Section 137-10 – Variation of approval on application by registered provider—bed availability

Section 137-10 provides that for the purposes of paragraph 137(3)(a) of the Act, the period for which the Commissioner must be satisfied that the number of beds available in a residential care home is likely to be reduced is a period of at least 2 years.

The Commissioner will be able to make a variation to the total number of beds if the Commissioner is satisfied that the number of beds will be reduced for a period of 2 or more years.

Division 3—Provider Register

Section 141-10 – Other matters that must be included in the Provider Register—registered providers

Section 141-10 provides that for the purposes of paragraph 141(3)(p) of the Act, other matters that the Provider Register must include in relation to the registration of a registered provider are as follows:

- the name of each parent or holding company forming part of the registered provider's business structure;
- the ACN of the registered provider's business entity (if relevant);
- whether the registered provider is known as an Aboriginal Community Controlled Organisation or Aboriginal Community Controlled Health Organisation;
- the name of each associated provider that delivers funded aged care services on behalf of the registered provider in any of the following provider registration categories:
 - personal and care support in the home or community;
 - nursing and transition care;
 - residential care;
- if the registered provider's registration has been suspended:
 - the date of suspension; and
 - the period of suspension, including the expiry date (if known); and
 - whether the suspension was at the request of the Commissioner or at the request of the registered provider; and
 - any specified condition to which the suspension relates;
- if the registered provider delivers funded aged care services in one or more approved residential care homes:
 - the name of the responsible person of the registered provider who is in charge of each approved residential care home; and
 - the total number of beds at each approved residential care home, updated in accordance with any variations to the registered provider's registration and any notification under subsection 167(1) of the Act;
- if a compliance notice has been given to the registered provider under section 481 or 482 of the Act:
 - the date of the notice; and
 - whether the notice was given by the Commissioner or the System Governor; and
 - the details of the noncompliance or -possible noncompliance- with the Act; and

- whether the notice was given under subparagraph 481(a)(i) or 482(a)(i) of the Act (non-compliance) or subparagraph 481(a)(ii) or 482(a)(ii) of the Act (possible noncompliance-); and
- the action the provider must take or refrain from taking in response to the notice; and
- whether the notice was varied or revoked;
- if a banning order against the registered provider is in force under section 497 of the Act:
 - the date of the banning order; and
 - a linking electronic reference to the detail of the banning order in the banning orders register.

The fields on the Provider Register do not have to be filled if the item is not applicable to the registered provider.

The information on the Provider Register will be accurate insofar as the information is supplied to the Commissioner.

It is expected that these details will be kept up to date through notifications of changes in circumstances to the Commissioner, variations to registration, or as a result of a registration or renewal application. This will be essential to the Commissioner's work as the regulator, the System Governor as system steward, and to the public when parts or the whole of the provider register will be published. Matters that must be included in the Provider Register are not automatically published. See section 141(3) of this instrument for matters to which the Commission must have regard when deciding whether to publish the Provider Register in whole, or in part, or to publish specified information included in the Provider Register.

Section 141-15 – Other matters that may be included in the Provider Register—former registered providers

Section 141-5 provides for the purposes of paragraph 141(4)(e) of the Act, other matters that the Provider Register may include in relation to an entity that was a registered provider are as follows:

- if the entity's registration lapsed—the date the registration lapsed;
- if the entity's registration was revoked:
 - whether the registration was revoked at the request of the provider, or on the Commissioner's initiative; and
 - the date of the revocation.

It is also important for the Commissioner to retain information relevant to a former registered provider. Records in relation to an entity's registration lapsing or whether the registration was revoked at the request of the provider or the Commissioner may be relevant to future decisions on registration.

Section 141-20 – Other matters that must be included in the Provider Register—responsible persons and aged care workers against whom banning orders are in force

Section 141-20 provides that for the purposes of paragraph 141(5)(d) of the Act, other matters that must be included in the Provider Register in relation to a responsible person, or

an aged care worker, of a registered provider against whom a banning order is in force under section 498 are as follows:

- the date of the banning order;
- a linking electronic reference to the detail of the banning order in the banning orders register.

This section provides transparency on those responsible persons and aged care workers that have banning orders in force. As there is a separate banning order register a link between the registers is enough to achieve this intent. Other matters that may be included in the Provider Register are not automatically published. See section 14130 of this instrument for matters to which the Commission must have regard when deciding whether to publish the Provider Register in whole, or in part, or to publish specified information included in the Provider Register

Section 141-22 – Other matters that may be included in the Provider Register—responsible persons and aged care workers against whom banning orders were in force

Section 141-22 provides that for the purposes of paragraph 141(6)(d) of the Act, other matters that may be included in the Provider Register in relation to a responsible person, or an aged care worker, of a registered provider against whom a banning order was in force under section 498 are as follows:

- the date of the banning order;
- a linking electronic reference to the detail of the banning order in the banning orders register.

This section provides transparency on those responsible persons and aged care workers that previous had banning orders in force. As there is a separate banning order register a link between the registers is enough to achieve this intent.

Other matters that may be included in the Provider Register are not automatically published. See section 14130 of this instrument for matters to which the Commission must have regard when deciding whether to publish the Provider Register in whole, or in part, or to publish specified information included in the Provider Register.

Section 141-25 – Corrections of the Provider Register

Section 141-25 provides for requirements of the Provider Register.

Subsection (1) provides that for the purposes of paragraph 141(8)(a) of the Act:

- a person may request orally or in writing that the Commissioner make a correction to information relating to that person that is included in the Provider Register; and
- if the Commissioner considers that information included in the Provider Register is inaccurate, incomplete, out of date, irrelevant or misleading, the Commissioner must correct the information (whether or not a person has made a request under paragraph (a) of this subsection).

This section ensures information is accurately reflected in the Provider Register and remains current. This is different from updates to the Provider Register which will triggered by a regulatory activity, such as a change in circumstance notification, registration, renewal or variation process or the Commissioner taking regulatory action as highlighted in the below.

Subsection (2) provides that despite subsection (1), the Commissioner must not make a correction to the Provider Register under this section if there is another process under the Act through which information included on the Provider Register can be updated or changed.

The note provides that for example, a change that can be made through a variation or change in circumstances notification is not a correction of the Provider Register.

Section 141-30 – Publication of the Provider Register

Section 141-30 provides requirements for the publication of the Provider Register.

Subsection (1) provides that for the purposes of paragraph 141(8)(b) of the Act, this section makes provision for and in relation to the publication of the Provider Register.

Subsection (2) provides that in deciding whether to publish the Provider Register in whole or in part, or to publish specified information entered on the Provider Register on the Commission's website the Commissioner must have regard to:

- whether the Commissioner considers that publication would be contrary to the public interest; and
- whether the Commissioner considers that publication would be contrary to the interests of an individual accessing funded aged care services.

This subsection relates to decisions made by the Commissioner about publishing information from the Provider Register. Paragraph (a) means that the Commissioner must think about whether making some or all of the information public could negatively affect the broader public good. For example, if publishing certain information might undermine public confidence without justification or jeopardise ongoing investigations then the Commissioner may decide not to publish that information. Paragraph (b) requires the Commissioner to consider how publishing the information might negatively affect individuals accessing funded aged care services. For example, if it could risk someone's privacy or safety, or if it could unfairly identify or stigmatise an individual receiving funded aged care services, the Commissioner may decide against publication in whole or in part. The Commissioner must weigh up whether publishing information serves the public and individual interest, or whether it could cause harm. If it could harm either the public or a person accessing services, the Commissioner may choose to limit or withhold publication.

Chapter 4 – Conditions on provider registration

Part 1 – Introduction

Section 142-1 – Simplified outline of this Chapter

Section 142-1 provides that this Chapter deals with matters relating to conditions on provider registration under Part 4 of Chapter 3 of the Act.

Part 3 of this Chapter relates to conditions relating to Rights, Principles and the Aged Care Code of Conduct.

Part 4 of this Chapter relates to the delivery of funded aged care services, and deals with conditions relating to:

- The Aged Care Quality Standards; and

- Continuous improvement; and
- The delivery of funded aged care services; and
- Requirements for starting and ceasing the provision of funded aged care services and continuity of those services.

Part 5 of this Chapter relates to conditions relating to financial matters.

Part 6 of this Chapter relates to aged care workers, and deals with conditions relating to:

- Workforce and aged care worker requirements; and
- Vaccinations.

Part 7 of this Chapter relates to information and access, and deals with conditions relating to:

- Personal information and recordkeeping; and
- Provision of information to individuals; and
- Access by supporters.

Part 8 of this Chapter relates to governance, and deals with conditions relating to membership of governing bodies and advisory requirements.

Part 9 of this Chapter relates to restrictive practices in approved residential care homes, and deals with conditions relating to:

- Requirements relating to the use of restrictive practices; and
- requirements relating to behaviour support; and
- immunity from civil or criminal liability in relation to the use of restrictive practices in certain circumstances.

Part 10 of this Chapter relates to the management of incidents and complaints, and deals with conditions relating to:

- implementing an incident management system and managing and preventing incidents; and
- implementing a complaints and feedback management system and managing complaints and feedback; and
- implementing a whistleblowing system and maintaining a whistleblower policy.

Part 3—Rights and principles

Section 144-1 – Kinds of providers to which the conditions apply

Section 144-1 provides that for the purposes of subsections 144(1) and (2) of the Act, every kind of registered provider is prescribed.

Part 4—Delivery of funded aged care services

Division 1—Aged Care Quality Standards

Section 146-5 – Kinds of providers to which the conditions apply

Section 146-5 provides that, for the purposes of section 146 of the Act (Compliance with Aged Care Quality Standards), a registered provider registered in any of the following provider registration categories is prescribed:

- personal and care support in the home or community;

- nursing and transition care;
- residential care.

Division 2—Continuous improvement

Section 147-5 – Kinds of providers that must demonstrate capability and commitment

Section 147-5 confirms, in line with section 147(1) of the Act, that every kind of registered provider is prescribed, ensuring all registered providers demonstrate the capability for, and commitment to, continuous improvement towards the delivery of high quality care, as a condition of registration.

Section 147-10 – Kinds of providers that must have a continuous improvement plan

Section 147-10 prescribes, in line with section 147(2) of the Act, that the registered providers in any of the following registration categories must have a continuous improvement plan as a condition of registration:

- personal and care support in the home or community;
- nursing and transition care;
- residential care.

Division 3—Delivery of funded aged care services

Subdivision A—Kinds of provider to which the condition applies

Section 148-5 – Kinds of providers to which the condition applies

Section 148-5 provides that section 148 of the Act applies to every kind of registered provider. This means that all registered providers must:

- deliver funded aged care services in accordance with the requirements prescribed in the rules, and
- have a service agreement in place with each individual accessing services, and
- deliver services in accordance with the service agreement, and
- have a care and services plan with each individual accessing services, and
- delivery services in accordance with the service list.

In addition to the above conditions of registration, providers registered in the residential care service group will be required to:

- maintain and manage any approved residential care homes in accordance with any requirements prescribed in the rules, and
- deliver the services in an approved residential care home.

Subdivision B—Requirements for delivering funded aged care services

Section 148-10 Purpose of this Subdivision

Section 148-10 provides that for the purposes of paragraph 148(a) of the Act, this Subdivision prescribes requirements for delivery of funded aged care services. This Subdivision prescribes ongoing obligations on certain registered providers alongside the Aged Care Quality Standards and the service list.

Section 148-15 All registered providers—preventing damage to an individual’s property

Section 148-15 provides that a registered provider must take reasonable steps to prevent damage being caused to an individual’s property by the provider, or an aged care worker of the provider, in delivering funded aged care services to the individual.

This provision covers situations where the actions of a registered provider, or the provider’s aged care worker, damage property. For example, the aged care worker of a provider in the registration category, home and community services, delivering the service type, domestic assistance, in an individual’s home must take reasonable steps to ensure that any property within the home (such as, for example, furniture) is not damaged while the home is cleaned.

Section 148-20 Providers delivering services under provider registration category home and community services or personal and care support in the home and community—requirements for meals, snacks and drinks

Section 148-20 provides requirements for meals, snacks and drinks delivered to an individual’s home and provided during community and cottage respite. The requirements apply to meals, snacks and drinks delivered as part of a funded aged care service under programs such as the Support at Home Program, CHSP, NATSIFACP and MPSP. Meals, snacks and drinks include, but are not limited to, main meals (breakfast, lunch, dinner), multi-course meals (such as those with entree and dessert), drinks, midmeals and snacks, and fresh, frozen, hot or chilled meals.

The requirements for meals, snacks and drinks were developed to align with the new regulatory model for aged care which sets out provider obligations under the Act based on risk and service type. Under the new regulatory model for aged care, residential care providers must meet the food and nutrition requirements under the Aged Care Quality Standards described at section 15-35. The requirements for meals, snacks and drinks under section 148-20 were developed considering the difference between the residential care and home and community care settings including:

- meals, snacks and drinks in the community may not provide 100% of nutrition for older people as individuals commonly supplement funded meals with other food and drinks
- individuals use meal services differently, some have three meals a day, while others occasionally receive delivered meals.

Consultation on the requirements for meals, snacks and drinks occurred in November and December 2024 including key stakeholders such as sector representatives, allied health professionals, nutrition experts and peak bodies. Public consultation on the requirements for meals, snacks and drinks was completed in April to May 2025 as part of consultation on the Rules of the Act (release 4b).

Subsection (1) outlines that this section applies to a registered provider that:

- is registered in any of the following provider registration categories:
 - home and community services (registration category 1)
 - personal and care support in the home and community (registration category 4); and

- delivers any of the following funded aged care services to an individual on a day through the service group home support under one of the registration categories mentioned above:
 - the service meal delivery in the service type meals
 - the service community and centre-based respite in the service type home or community general respite
 - a service in the service type community cottage respite.

The requirements are not intended to apply to:

- providers delivering group or individual social support services as the primary purpose of these activities is to participate in community life and feel socially included
- community respite day outings where meals, snacks and drinks are provided by an external location
- meal preparation in an individual's home, which typically occurs when an aged care worker assists an individual to prepare meals, snacks and drinks using ingredients and foods sourced by the individual themselves

Registered providers outlined under subsection (1) are responsible for meeting the requirements for meals, snacks and drinks even when a subcontracted company or associated provider may be used to deliver services.

Subsection (2) provides that the provider must ensure any meals, snacks and drinks delivered to an individual through the funded aged care services mentioned in paragraph (1)(b) are nutritious and appetising, having regard to the individual's needs and preferences.

The note under subsection (2) points to the fact that providers have other statutory obligations in relation to food safety under the Australian New Zealand Food Standards Code (Code). It is acknowledged that older people have higher risk of foodborne illness. Providers should have systems and processes in place to ensure meals, snacks and drinks are prepared and stored safely in line with their legislative responsibilities under the Code.

The intent of subsection (2) is that meals, snacks and drinks are nutritious meaning they provide essential nutrients, such as vitamins, minerals, proteins, fats, fibre, and carbohydrates, which are crucial for maintaining health and supporting bodily functions. These nutrients help sustain energy, support growth and repair, and protect against diseases. Meals, snacks and drinks should be appropriate for individuals meaning people aged 65 years and older (or 50 years and older for Aboriginal and Torres Strait Islander individuals). This means for meals, snacks and drinks designed for individuals without specialised dietary needs, this should consider that individuals generally have higher needs for protein, calcium and other nutrients than individuals under 65 years of age.

Subsection (2) sets out that meals, snacks and drinks are appetising referring to having an appealing taste, texture, appearance and aroma. It is important for meals, snacks and drinks to be appetising because meals, snacks and drinks cannot be nutritious to individuals if they are not consumed. While subsection (2) requires meals, snacks and drinks to be appetising, it is not an expectation that providers meet every unique individual preference when delivering meals, snacks and drinks (such as each individual's personal dislike of a certain ingredient). Providers should ensure they clearly communicate the types of meals, snacks and drinks they provide, including how they may cater to specific preferences. Providers are encouraged to

continuously improve their meals, snacks and drinks offerings by taking into account individuals' feedback as part of Quality Assurance Framework requirements under subsection (4).

Subsection (2) also sets out the expectation for providers to have regard to individuals' needs and preferences when delivering meals, snacks and drinks. This means considering the nutrition needs of older people as a cohort such as higher requirements for protein. It also means taking into account any specialised dietary needs of older people. It is expected that through aged care assessment processes, and any other assessments the provider may undertake, any specialised dietary needs and preferences are identified.

These specialised dietary needs and preferences include medical needs, or religious or cultural preferences. These result in a need to modify or remove certain foods, ingredients, nutrients and other subcomponents or prepare foods in certain ways. Examples include vegetarian, kosher, gluten free and low lactose diets. The intent is for providers to consider any of the identified specialised dietary needs and preferences when delivering meals, snacks and drinks. For example, if an individual is identified as needing vegetarian meals, snacks and drinks, the provider should take this into account by providing access to vegetarian meals, snacks and drinks.

To support dignity of risk and choice for older people the requirements for meals, snacks and drinks will not monitor or seek to influence individual's decisions regarding the meals, snacks and drinks they select. However, providers should ensure individuals are aware of relevant risks and have processes to support dignity of risk.

Subsection (3) provides that the provider must, at least annually, have a dietitian assess the meals, snacks and drinks delivered by the provider through the funded aged care services mentioned in paragraph (1)(b) to ensure that meals, snacks and drinks:

- are appetising; and
- are appropriate for the nutrition needs of individuals accessing funded aged care services, including individuals with specialised dietary needs; and
- reflect evidence-based guidelines and practices.

The role of a dietitian includes assessing the meals, snacks and drinks in relation to nutritional, sensory, medical, cultural and religious considerations. In-person dietitian review of meals, snacks and drinks is recommended to enable assessment including texture, taste and aroma. Where access to dietitians is limited such as in rural and remote areas, assessment can be conducted remotely. Where this occurs, remote assessment should include consideration of photos and videos, interviews with staff and comprehensive desktop review. Dietitian assessment should consider if the meals, snacks and drinks are nutritionally adequate, accurate to menu offerings, are appetising, use appropriate cooking, storage and transport methods and are aligned to food safety standards.

The note under subsection (3) provides examples of specialised dietary needs which includes medical needs, or religious or cultural preferences. The intent of subsection (3)(b) is for dietitians to use their expertise to assess the meals, snacks and drinks designed for individuals including those with specialised dietary needs. To meet subsection (3)(c), it is expected that the dietitian determines the most suitable contemporary and evidence-based practice to refer to when assessing meals, snacks and drinks. This should refer to established government

approved guidelines and standards where available and other types of established guidance by reputable sources.

Subsection (4) provides that the provider must implement a Quality Assurance Framework to continuously improve the meals, snacks and drinks delivered to individuals through the funded aged care services mentioned in subsection (1) by taking into account:

- the satisfaction of individuals with the meals, snacks and drinks they are provided; and
- the assessments and any recommendations made by the dietitian in accordance with subsection (3)

The intention is for providers to develop a Quality Assurance Framework in a format that suits their unique needs and organisation. This may include incorporating the Quality Assurance Framework into existing systems and processes for quality assurance. This also applies to collecting information on satisfaction of individuals with meals, snacks and drinks. This could be sought through a variety of methods such as phone interviews, surveys or workshops. This feedback should include individual's satisfaction with aspects of the meals, snacks and drinks such as taste, size and variety. Feedback from individuals outlined at subsection (4)(a) and the findings of the dietitian assessment (if improvements are identified) outlined at subsection (4)(b) should be used to inform improvements to the meals, snacks and drinks delivered by registered providers.

Section 148-25 – Providers delivering services under provider registration category home and community services, assistive technology and home modifications or advisory and support services—requirements for service delivery equipment

Section 148-25 provides for requirements for services delivery equipment for providers delivering services under provider registration categories home and community services, assistive technology and home modifications or advisory and support services.

Subsection 148-25(1) provides that this Section applies to a registered provider that:

- is registered in any of the following provider registration categories:
 - home and community services;
 - assistive technology and home modifications;
 - advisory and support services; and
- is delivering funded aged care services to an individual on a day under any of the registration categories listed in paragraph (a); and
- uses equipment in delivering the service; or
- delivery of the service involves the sourcing, supply and provision of equipment to the individual.

Subsection 148-25(2) provides that the provider must ensure that the equipment is safe and meets the needs of the individual at the time the service is delivered to the individual.

This Section imposes a requirement, which is comparable to the requirement in the Aged Care Quality Standards, on registration categories to which the Aged Care Quality Standards do not apply.

Section 148-30 – Providers delivering services under provider registration category home and community services, assistive technology and home modifications or advisory and support services—requirements for personal protective equipment, infection prevention and control

Section 148-30 provides for requirements for personal protective equipment and infection prevention and control for providers delivering services under provider registration categories home and community services, assistive technology, and home modifications or advisory and support services. The requirements apply only to these categories so as not to duplicate comparable requirements in the Aged Care Quality Standards for the registration categories, personal and care support in the home or community, nursing and transition care and residential care (being the categories to which the Standards apply).

Subsection 148-30(1) provides that this Section applies to a registered provider that is registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community; and
- nursing and transition care.

Subsection 148-30(2) provides that when delivering funded aged care services to an individual on a day under any of the registration categories listed in subsection 148(1), the provider must ensure that:

- personal protective equipment is available to the individual, the aged care workers of the provider delivering the services and any other persons who need it; and
- the persons mentioned above are supported to correctly use the equipment.

Subsection 148-30(3) requires the provider to:

- have an appropriate infection prevention and control system for delivery of funded aged care services; and
- ensure that aged care workers of the provider use hygienic practices and take appropriate infection prevention and control precautions when delivering funded aged care services.

Section 148-33 – Providers delivering services under provider registration category residential care—services that must be delivered

Section 148-33 provides requirements for services that must be delivered by providers registered in registration category residential care.

Subsection (1) provides that this Section applies to a registered provider that:

- is registered in the provider registration category residential care; and
- is delivering funded aged care services to an individual through the service group residential care.

Subsection (2) provides that services delivered to the individual by the provider must include the services listed and described in Division 8 (residential care service types) of Part 3 of Chapter 1.

Section 148-35 – Providers delivering services under the TCP—services that must be delivered

Section 148-35 provides requirements for services that must be delivered by providers delivering services under the TCP.

Subsection 148-35(1) provides that this Section applies to a registered provider that is delivering funded aged care services to an individual under the TCP.

Subsection 148-35(2) provides that the services delivered to the individual by the provider must include the service transition care management in the service type assistance with transition care.

Section 148-40 – Providers delivering short-term funded aged care services through the service group home support—services that must be delivered

Section 148-40 prescribes requirements that providers delivering short-term funded aged care services through the service group home support must deliver.

Subsection (1) provides that this section applies to a registered provider that is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for a classification level restorative care pathway through the service group home support.

Subsection (2) provides that the services delivered to the individual by the provider must comprise a multidisciplinary package of early intervention care that is designed to optimise the functioning and independence of the individual, and reverse or slow the individual's functional decline, to help delay the individual's need to access ongoing funded aged care services.

Subsection (3) provides that without limiting subsection (2), the services delivered to the individual must include the following:

- the service home support restorative care management in the service type restorative care management;
- a variety of services (where appropriate) from the service type allied health and therapy; and
- services from the service type nursing care (where appropriate).

Subsection (4) provides that the provider must ensure an aged care worker of the provider who is an allied health professional or a registered nurse (a *restorative care partner*) delivers the service mentioned in paragraph (3)(a) to the individual.

These requirements reflect a best practice approach to restorative care and support improved outcomes for participants through coordinated, multidisciplinary care.

Section 148-45 – Providers delivering certain funded aged care services through the service group home support—requirements for the service home support care management

Section 148-45 prescribes requirements for the service home support care management for providers delivering certain funded aged care services through the service group home support.

Subsection (1) provides that this section applies to a registered provider that:

- is delivering ongoing funded aged care services to an individual (other than under a specialist aged care program) through the service group home support; or
- is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for the classification level end-of-life through the service group home support.

Subsection (2) provides that the provider must deliver the service home support care management in the service type care management to the individual at least once in each month where the provider also delivers other services to the individual. This is to ensure the overall safety and wellbeing of the individual and the care management delivered should be direct, that is, speaking, communicating or meeting with the individual.

Subdivision C—Requirements for service agreements

Subdivision C places a condition on a provider's registration that registered providers must enter into written service agreements with the individual on or before the start day.

This agreement must be made with the informed consent of the individual receiving services (or their supporter). The requirement supports consumer protection. Individuals must receive clear, written information about the type and extent of services to be delivered, the fees or charges that may apply, and any rights and responsibilities under the arrangement. The agreement must be explained in a way that the individual understands, and consent must be obtained prior to services commencing, protecting individuals from being unknowingly charged or receiving services they did not agree to. By documenting the scope of the services and associated obligations, the agreement provides the basis for accountability if services are not delivered as agreed, strengthening the consumer's ability to seek redress. Requiring a service agreement from the outset respects the individual's right to be actively involved in decisions about their care arrangements and to have those decisions honoured in a formal, reliable way. This subdivision forms part of the broader safeguarding framework under the new aged care legislation, aimed at shifting the system to one that places the person accessing funded aged care services at the centre of decision-making and service delivery. For registered providers registered in the residential care service group, these legally binding agreements will formalise the offer of a place in an approved residential care home in conjunction with the accommodation agreement. Service agreements give individuals entering care a sense of security, confidence and assurance about the decision they are making. Service agreements outline a number of different things, including the care and services being offered, the costs what will be charged, complaints processes and other key policies (e.g. visitors, smoking, health and safety).

Section 148-60 – Purpose of this Subdivision

Section 148-60 provides that for the purposes of paragraph 148(c) of the Act, this Subdivision prescribes requirements for service agreements.

Section 148-65 – Requirements for service agreements—general

Section 148-65 provides general requirements for service agreements.

Entry into service agreement

Subsection (1) provides that a registered provider must enter into a service agreement with an individual:

- before the individual's start day; or
- if the individual is accessing funded aged care services in any of the circumstances specified in subsection 71(4) of the Act, or the registered provider is delivering funded aged care services to the individual under the MPSP or the NATSIFACP - within 28 days after the day the registered provider commences delivery of the services to the individual.

Subsection (2) provides that a registered provider must ensure the following:

- the individual is involved in the development and negotiation of the service agreement;
- if requested by the individual, a supporter, family member, carer or advocate of the individual, or any other person significant to the individual, is present during the development and negotiation of the service agreement;
- the service agreement is expressed in plain language and is readily understandable by the individual;
- the individual is helped to understand the terms of the service agreement.

Cooling off period

Subsection (3) provides that a service agreement must provide that, if the individual notifies (whether verbally or in writing) the registered provider that they wish to withdraw from the service agreement:

- within 14 days after the date of entry into the service agreement; and
- before the individual's start day; then
- the service agreement has no effect; and
- the registered provider must refund any amount paid by the individual under the service agreement.

It is important that the individual be supported to verbally withdraw from a service agreement. It is expected that providers have procedures in place to receive and document any verbal instructions from individuals in relation to the service agreement. It would be best for the individual to receive confirmation of this withdrawal in writing from the provider.

Subsection (4) requires that a service agreement for an individual to whom the registered provider is to deliver funded aged care services under the classification type ongoing through the service group residential care, must provide that, if the individual notifies (whether verbally or in writing) the registered provider that the individual wishes to withdraw from the

service agreement within 28 days after the date of entry into the service agreement, the registered provider must refund any amount paid by the individual under the service agreement in relation to services that had not been delivered by the termination date.

Variation of service agreement

Subsection (5) requires that the service agreement must provide that the agreement may be varied:

- by the registered provider if:
 - the variation is necessary to implement the *A New Tax System (Goods and Services Tax) Act 1999*; and
 - the provider has given reasonable notice in writing about the variation to the individual; and
 - the variation is not inconsistent with the *A New Tax System (Goods and Services Tax) Act 1999* or the Act; or
- by mutual consent of the individual and the registered provider if:
 - there has been adequate consultation about the variation between the individual and the provider; and
 - the provider has obtained written consent from the individual to make the variation; and
 - the variation is not inconsistent with the *A New Tax System (Goods and Services Tax) Act 1999* or the Act.

Review of service agreement

Subsection (6) provides that a service agreement between a registered provider and an individual accessing ongoing funded aged care services must provide that the provider will review the service agreement:

- at least once every 12 months; and
- upon request from the individual.

Subsection (7) provides that without limiting the nature of the review, the provider must:

- give the individual an opportunity to participate in the review; and
- consider whether any updates need to be made to the service agreement; and
- if necessary, vary the service agreement in accordance with subsection (5).

A review of the service agreement should be triggered whenever an individual experiences a change in their care needs or receives a new needs assessment. If changes need to be made to the service agreement, these can be made under the variation section. It will be important for registered providers to document the discussions that take place between the provider and the individual and ensure that the outcomes are documented. This could be done for example, via email to the individual. Consent to any changes to the service agreement can also be sought and received via email.

Section 148-70 – Requirements for service agreements—contents

Section 148-70 provides requirements for the contents of service agreements. All registered providers must include these sections in their service agreements with individuals.

All registered providers

Subsection (1) provides that a service agreement must not contain any provision that would have the effect of the individual being treated less favourably in relation to any matter than the individual would otherwise be treated, under any law of the Commonwealth, in relation to that matter. This section replicates the provision from the previous aged care legislation. It ensures that service agreements between registered providers and individuals must not include any terms that reduce or limit the individual's rights under Commonwealth law. In effect, it prohibits any section that would result in the individual being treated less favourably in any respect than they would otherwise be entitled under Commonwealth legislation. This includes, for example, rights under the Aged Care Act, privacy laws, anti-discrimination laws, and consumer protection legislation.

Key consumer protection aims of this section include:

- preserving legal rights such that individuals cannot be asked to sign away their legal entitlements – such as the right to fair treatment, access to complaints processes, or privacy protections – as a condition of receiving services.
- Preventing unfair contract terms by acting as a safeguard against agreements that might otherwise seek to reduce a provider's obligations or limit an individual's rights to remedies under law.
- Reinforcing trust and fairness such that it ensures all terms comply with broader legal standards, this rule strengthens the fairness and legitimacy of service agreements and enhances trust in the aged care system.

This section is a key part of ensuring that individuals are not disadvantaged by the fine print of contracts and that their legal protections remain intact, even when entering into private arrangements with registered providers.

Subsection (2) provides that a service agreement entered into between a registered provider and an individual must contain the following:

- a statement setting out the parties to the agreement, including the following:
 - the name of the individual;
 - the contact details of the individual;
 - the name of the provider;
 - the contact details of the provider;
- the contact details of the supporters of the individual (if any);
- a copy of the individual's access approval;
- the approved residential care home (if any) in or from which the provider will deliver funded aged care services to the individual;
- the service delivery branch (if any) through which the provider will deliver funded aged care services to the individual;
- the date when the service agreement commences;
- the start day for the individual;
- if the individual is accessing short-term or hospital transition funded aged care services:
 - when the provider will cease delivering short-term or hospital transition funded aged care services to the individual; and
 - the date when the service agreement ends;

- if the individual is accessing ongoing funded aged care services, the date the service agreement is to be reviewed in accordance with subsection 148-65(6);
- how the individual will be involved in decisions relating to how, when and by whom funded aged care services are delivered to the individual.

Subsection (3) provides that despite subsection (2), a service agreement entered into between a registered provider and an individual does not have to contain the matters specified in paragraph (2)(i) if the provider is delivering funded aged care services to the individual under the TCP.

Certain registered providers delivering services through the service groups home support, assistive technology or home modifications (other than under a specialist aged care program)

Subsection (4) provides that a service agreement entered into between a registered provider (to whom subsection (7) applies) and an individual must also contain the following:

- the funded aged care services the provider will deliver to the individual, including the following:
 - the name of each service as provided in the service list under section 8-5 of this Rules;
 - if the provider intends for an associated provider to deliver any services to the individual, which services will be delivered by the associated provider;

This paragraph (paragraph (a)) allows for the participant to receive in their service agreement a list of services with names that are consistent with the services in their access approval and the new aged care service list in order to ensure the services are easily understandable.

- the prices the provider will charge the individual for each of the funded aged care services the provider will deliver to the individual;

This paragraph (paragraph (b)) allows for the participant to receive in their service agreement a list of prices that is clear, understandable and relevant to the services they will receive. The list of prices does not need to be the same as the pricing schedule published on the provider's website or on My Aged Care. For example, the provider may publish on their website their modal prices for the entire country. However, these prices may not be relevant to a participant living in a remote area where the cost of service delivery is higher. The participant can therefore be provided in their service agreement with a list of prices that will correlate with what they will be charged.

- if the individual is to be charged a price for delivery of a funded aged care service that is higher than the price published on the provider's website or the department's website—the reason for the higher price;

This paragraph (paragraph (c)) allows for the participant to receive in their list of prices in their service agreement a clear indication of where a price is higher than the published price and why.

A statement that the prices mentioned in paragraphs (b) and (c) may be subject to regular price increases to account for indexation and the details of such increases, including:

- the date the prices will increase; and
- the method for working out the increase; and
- the reason for the matters specified at subparagraphs (i) and (ii);

This paragraph (paragraph (e)) allows for regular price increases to occur without a variation of the service agreement. For example, if prices are regularly increased in line with an official rate, such as the Consumer Price Increase, this can be included in the agreement noting the date, rate and method for the increase. This subsection only applies to the prices included in the price list under subsection (b) and (c).

- a statement that the provider may only cease delivery of funded aged care services to the individual in the circumstances specified in subsection 149-35(2);
- if either of the circumstances in paragraphs 149-35(2)(e) or (f) arise, any other requirements for notifying the provider;
- how and when the service agreement may be terminated;
- a statement that the registered provider will not charge an individual contribution to the individual if the individual has made an application for a fee reduction supplement determination under subsection 197-20(1) and the System Governor has not decided on that application;
- a statement that where, in relation to an application mentioned in paragraph (h), the System Governor makes a determination that the fee reduction supplement should not apply to the individual, the registered provider can collect the unpaid individual contributions for the period beginning on the day the application was made.

Subsection (5) provides that this subsection applies to a registered provider that is delivering funded aged care services to an individual through the service groups home support, assistive technology or home modifications (other than under a specialist aged care program).

Registered providers delivering services under the CHSP, MPSP or NATSIFACP

Subsections (6) and (9) together provide that a service agreement entered into between an individual and a registered provider delivering funded aged care services under the CHSP must also contain the following:

- the matters mentioned in paragraphs (4)(a), (e), (f) and (g); and
- the fees and contribution that the registered provider will charge the individual for each of the funded aged care services the provider will deliver to the individual.

Under the CHSP, registered providers need to clearly articulate how the services are delivered and funded (i.e. grant funding to providers) and how the client contribution fees are set (i.e. the provider's client contribution policy).

Subsections (7), (8) and (10) together provide that a service agreement entered into between an individual and a registered provider delivering services under the MPSP or the NATSIFACP must also contain:

- the matters mentioned in paragraphs (4)(a), (e), (f) and (g), and
- a statement that the individual agrees to pay any applicable fees referred to in Division 3 of Part 3 of Chapter 4 of the Act.

The applicable fees referred to above are the specialist aged care program fees outlined in section 286-10. These may be charged by MPSP or NATSIFACP providers where they choose to do so, and the amount is agreed between the provider and the individual in a written agreement. This agreement may be the service agreement.

Registered providers delivering services through the service group residential care

Subsection (11) provides that a service agreement entered into between a registered provider (to whom subsection (13) or (14) of this Section applies) and an individual must also contain which fees or contributions (if any), referred to in Division 2 or Division 3 of Part 3 of Chapter 4 of the Act, the provider will charge the individual.

Subsection (12) provides that a service agreement entered into between a registered provider (to whom subsection (13) of this Section applies) and an individual must also contain the following:

- the provider may only ask the individual to leave the approved residential care home in the circumstances specified in subsection 149-60(1);
- the assistance the provider will provide to the individual to obtain suitable alternative accommodation with an alternative registered provider if the individual is asked to leave the approved residential care home;
- how and when the service agreement may be terminated.

Subsection (13) provides that this subsection applies to a registered provider that is delivering ongoing funded aged care services to an individual through the service group residential care.

Subsection (14) provides that this subsection applies to a registered provider that:

- is delivering short-term funded aged care services to an individual through the service group residential care; or
- is delivering funded aged care services to an individual through the service group residential care under the TCP.

Subdivision D—Requirements for care and services plans

For residential aged care, home support and transition care, a care and services plan should be in place for individuals accessing ongoing and short-term care. It should outline their individual needs, goals and preferences, with respect to their care and services. They should note any clinical interventions or health services needed, as well as additional supports required for social, emotional or personal care. Additionally, the care and services plan should identify any key risks or issues that need to be taken into account with care planning and note strategies to manage these.

Once a care and services plan is in place, it needs to be reviewed regularly to ensure it continually meets the resident's or participant's needs. Care and services plans should be developed in consultation with the individual, and their family if required, and there should be ongoing communication if there are major changes to what will be delivered.

CHSP providers develop and negotiate service agreements and care and services plans with individuals prior to their receiving services. The care and services plan details the services delivered to clients which are in line with their assessed services and individual goals. This is based on the aged care assessor's support plan.

Section 148-75 – Purpose of this Subdivision

Section 148-75 provides that for the purposes of paragraph 148(e) of the Act, this Subdivision prescribes requirements for care and services plans.

Section 148-80 – Requirements for care and services plans—general

When a care and services plan must be developed

Subsection (1) provides that a registered provider must develop a care and services plan for an individual:

- before or on the individual's start day; or
- if the individual is accessing funded aged care services in any of the circumstances specified in subsection 71(4) of the Act, or the registered provider is delivering funded aged care services to the individual under the MPSP or the NATSIFACP—within 28 days after the day the registered provider commences delivery of the services to the individual.

How a care and services plan is developed

Subsection (2) provides that a registered provider to whom subsection (5) applies must actively engage with:

- the individual;
- supporters of the individual (if any); and
- any other persons involved in the care of the individual;

in developing and reviewing the individual's care and services plan through ongoing communication.

Care and services plan to be in line with the individual's needs

Subsection (3) provides that a registered provider to whom subsection (5) applies must ensure an individual's care and services plan:

- describes the current care needs, goals and preferences of the individual; and
- includes strategies for risk management and preventative care; and
- where an individual is accessing ongoing funded aged care services, is reviewed at least once every 12 months.

Care and services plan to be accessible to individual

Subsection (4) provides that a registered provider must provide a copy of an individual's care and services plan to the individual at the following times:

- once the plan is developed;
- any time the plan is updated;
- upon request from the individual.

Subsection (5) provides that this subsection applies to a registered provider that is delivering funded aged care services to an individual under any of the following registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services.

Some of the requirements in this section are applicable only to the above registration categories to avoid duplicating the requirements in the Aged Care Quality Standards for providers in the registration categories to which the Aged Care Quality Standards apply.

A provider registered in multiple registration categories including where the Standards apply are not expected to need to have two separate care and services plans for an individual to meet this requirement and the requirements under the Aged Care Quality Standards. The intention is that a care and services plan that is meeting the outcomes of the Standards will be suitable for the requirements in this Section.

Note 1 provides that subsections 15-20(1) to (3) of these rules for the Aged Care Quality Standards relating to care and services plans apply to providers registered in provider registration categories personal and care support in the home and community, nursing and transition care, and residential care.

Note 2 provides that for funded aged care services relating to care and services plans, see item 1 of the table in section 8-20 of these rules and items 1 and 4 in the table in section 8-155 of these rules.

Section 148-81 – Requirements for care and services plans—restorative care partner to be responsible for care and services plans in certain circumstances

A restorative care partner develops what is referred to as a ‘goal plan’ under the Restorative Care Pathway, which is described in this section. A goal plan ensures services delivered are in line with the participant’s needs, goals and preferences and existing supports. Goals should align with helping improve function and promoting independence to support healthy ageing. A restorative care partner is responsible for engaging with the participant and their supporters to develop the goal plan and should also consider exit planning, given the short-term nature of support.

Section 148-81 provides requirements for care and service plans for restorative care partners to be responsible for care and services plans in certain circumstances.

Subsection (1) provides that this section applies to a registered provider that is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for a classification level SAH restorative care pathway through the service group home support.

Subsection (2) provides that the provider must ensure the restorative care partner who will deliver the service mentioned in paragraph 148-40(3)(a) to the individual develops a care and services plan for the individual in accordance with any applicable requirements set out in this Subdivision.

Subsection (3) provides that the provider must consider exit planning as part of the care and services plan and must ensure the plan complements any ongoing services the individual is also accessing.

Section 148-85 – Requirements for care and services plans—contents for all individuals (other than individuals accessing services through the service group residential care)

Section 148-85 provides requirements for care and services plans relating to the contents for all individuals other than individuals accessing services through the service group residential care.

Application of this section

Subsection (1) provides that this section applies to a registered provider that is delivering funded aged care services to an individual under any of the following registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Contents

Subsection (2) provides that a care and services plan for an individual must include the following:

- funded aged care services that the provider will deliver to the individual, including:
 - the frequency of the services; and
 - the volume or duration of the services;
- when the care and services plan will be reviewed;
- if the individual is accessing ongoing funded aged care services, the date the individual's service agreement is to be reviewed in accordance with subsection 148-65(6).

Providers registered into registration category residential care do not have additional requirements for care and services plan as there are requirements on the care and services plan content in the residential care service list and the Quality Standards.

Division 4 – Starting and ceasing the provision of funded aged care services and continuity of those services

This Division provides that the following items relate to starting and ceasing the provision of funded aged care services and continuity of those services.

Subdivision A – Preliminary

Section 149-5 – Requirements relating to starting and ceasing the provision of funded aged care services and continuity of those services

Section 149-5 of the Rules prescribes the requirements relating to starting and ceasing the provision of funded aged care services and continuity of those services. It provides that for the purposes of section 149 of the Act, this Division prescribes requirements for the following:

- providing a start notification to the System Governor and the Commissioner;
- ceasing the delivery of funded aged care services to an individual;
- providing a cessation notification to the System Governor and the Commissioner;
- ceasing to deliver any funded aged care services;
- if the provider delivers funded aged care services in an approved residential care home—security of tenure for individuals accessing those services;
- continuity of funded aged care services for individuals.

The note points readers to section 148-70 of the rules for requirements relating to a service agreement between an individual and a registered provider.

Subdivision B – Start notifications

This subdivision indicates the following items relate to start notifications.

Section 149-10 – Requirements for start notifications - general

Section 149-10 provides for requirements for start notifications that apply generally.

Subsection 149-10(1) prescribes that a registered provider must prepare a start notification for delivering funded aged care services to an individual in accordance with this Section.

Subsection 149-10(2) prescribes that despite subsection (1), a registered provider does not have to prepare a start notification for an individual accessing services under a specialist aged care program other than the TCP.

Subsection 149-10(3) prescribes that a start notification must be in an approved form.

Start notification for an individual accessing funded aged care services through the service groups home support, assistive technology or home modifications

This heading indicates that the subsequent provisions relate to the start notification for an individual accessing funded aged care services through the service groups home support, assistive technology or home modifications.

Subsection 149-10(4) prescribes that a start notification for an individual accessing funded aged care services through the service groups home support, assistive technology or home modifications must specify the following:

- the name of the individual, to identify the correct person for which the registered provider will claim subsidy.
- the start day for the individual, meaning the day that services commenced
- the service delivery branch through which funded aged care services will be delivered to the individual.

Start notification for an individual accessing funded aged care services through the classification type ongoing for the service group residential care

This heading indicates that the subsequent provisions relate to the start notification for an individual accessing funded aged care services through the classification type ongoing for the service group residential care.

Subsection 149-10(5) prescribes that a start notification for an individual accessing funded aged care services through the classification type ongoing for the service group residential care must specify the following:

- The name of the individual, to identify the correct person for which the registered provider will claim subsidy.
- The start day for the individual, meaning the day that services commenced
- the approved residential care home at which funded aged care services will be delivered to the individual.

Start notification for an individual accessing funded aged care services through the classification type short-term for the service group residential care

This heading indicates that the subsequent provisions relate to the start notification for an individual accessing funded aged care services through the classification type short-term for the service group residential care.

Subsection 149-10(6) prescribes that a start notification for an individual accessing funded aged care services through the classification type short-term or hospital transition for the service group residential care must specify the following:

- the name of the individual, to identify the correct person for which the registered provider will claim subsidy.
- the start day for the individual, meaning the day that services commenced
- the approved residential care home at which funded aged care services will be delivered to the individual.

Section 149-15 – Requirements for start notifications – provision to System Governor and Commissioner

Section 149-15 prescribes that a registered provider must give a start notification for an individual to the System Governor and the Commissioner:

- for an individual mentioned in subsections 149-10(4) and (5), within 28 days after the individual's start day. This is to allow the registered provider sufficient time to notify the System Governor and the Commissioner of the start days.
- for an individual mentioned in subsection 149-10(6), within 14 days after the individual's start day. The earlier period here is to recognise the short-term nature of the residential care being provided.

Subdivision C—Cessation notifications

Section 149-20 – Requirements for cessation notifications—general

Section 149-20 provides general requirements for cessation notifications.

Subsection (1) provides that a registered provider must prepare a cessation notification for ceasing the delivery of funded aged care services to an individual in accordance with this section.

Subsection (2) provides that despite subsection (1), a registered provider does not have to prepare a cessation notification for an individual where the individual is accessing funded aged care services under a specialist aged care program other than the TCP.

Subsection (3) provides that a cessation notification must be in an approved form.

Subsection (4) provides that a cessation notification for an individual must specify the following:

- the name of the individual;
- the day the provider ceased to deliver funded aged care services to the individual;
- the reason for ceasing the delivery of funded aged care services to the individual.

Section 149-25 – Requirements for cessation notifications—provision to System Governor and Commissioner

Section 149-25 provides that a registered provider must give a cessation notification for an individual to the System Governor and the Commissioner:

- for an individual accessing funded aged care services through the classification type short-term for the service group residential care—within 14 days after the cessation of delivery of services through the approved residential care home of the provider; or
- for all other individuals—within 28 days after the cessation of delivery of services through the approved residential care home or service delivery branch of the provider.

Subdivision D—Ceasing delivery of funded aged care services (other than services delivered in an approved residential care home)

Section 149-30 – Application of this Subdivision

Section 149-30 provides that this Subdivision applies to a registered provider who is delivering funded aged care services to an individual for a classification type for the service groups home support, assistive technology or home modifications.

Section 149-35 – Requirements for ceasing delivery of funded aged care services general

Section 149-35 provides general requirements for ceasing the delivery of funded aged care services.

Subsection (1) provides that a registered provider must not cease to deliver funded aged care services to an individual unless:

- one of the circumstances in subsection (2) apply; and
- the provider has given notice to the individual in accordance with section 149-40.

Circumstances where registered provider may cease delivery of funded aged care services to an individual

Subsection (2) provides that the circumstances in which a registered provider may cease to deliver funded aged care services to an individual are:

- the individual cannot be cared for in the home or community with the resources available to the provider; or
- the individual's condition changes to the extent that:
 - the individual no longer needs the funded aged care services delivered by the provider; or
 - the individual's needs, as assessed by an approved needs assessor, can be more appropriately met by other types of funded aged care services; or
- the individual has:
 - intentionally caused serious injury to an aged care worker of the provider; or
 - intentionally infringed the right of an aged care worker of the provider to work in a safe environment; or
- the individual:

- has not paid to the provider, for a reason within the individual's control, any fee or contribution specified in the service agreement between the individual and the provider; and
- has not negotiated an alternative arrangement with the provider for payment of the fee or contribution; and
- if the individual is accessing the services other than under a specialist aged care program— has no application for the fee reduction supplement in place; or
- the individual notifies the provider, in writing, that the individual wishes to move to a location where funded aged care services are not delivered by the provider; or
- the individual notifies the provider, in writing, that the individual no longer wishes to receive funded aged care services from the provider.

The note indicates that the circumstances in which a registered provider may cease delivering funded aged care services to an individual must be specified in a service agreement between the individual and the registered provider made under section 148-70 of this Rules.

Section 149-40 – Requirements for ceasing delivery of funded aged care services—notice to individual about cessation of services

Section 149-40 provides requirements for ceasing the delivery of funded aged care services and the notice to be given to individuals about cessation of services.

Notice to be given if registered provider intends to cease delivery of funded aged care services

Subsection (1) provides that if a registered provider intends to cease delivery of funded aged care services to an individual, the provider must give the individual a written notice which includes the following:

- the decision;
- the reasons for the decision;
- the date the provider intends to cease delivery of funded aged care services to the individual;
- the individual's rights in relation to cessation of the delivery of funded aged care services, including the right to access:
 - the provider's complaints and feedback management system; and
 - any other mechanisms available to address complaints; and
 - independent aged care advocates.

The note provides that for complaints and feedback management systems, the reader is pointed to section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this Rules.

Subsection (2) provides that the registered provider must give the notice to the individual at least 14 days before the date the provider ceases delivery of funded aged care services to the individual.

Notice to be given if registered provider no longer intends to cease delivery of funded aged care services

Subsection (3) provides that if:

- the decision to cease the delivery of funded aged care services was based on the individual's behaviour; and
- the registered provider has given the individual a notice under subsection (1); and
- after giving the notice, the provider has agreed with the individual that, because of a change in the behaviour, the delivery of funded aged care services will not cease;

then the provider must give the individual a written notice stating that the provider no longer intends to cease delivery of funded aged care services to the individual.

Section 149-45 – Requirements for ceasing delivery of funded aged care services—notice to individual about unspent portions

Section 149-45 provides requirements for ceasing the delivery of funded aged care services and the notice to individuals about unspent portions.

Subsection (1) provides that this section applies if:

- a registered provider holds an unspent Commonwealth portion or unspent individual portion for an individual to whom the provider is delivering funded aged care services; and
- section 226C or 226D of the Act apply.

Subsection (2) provides that the registered provider must give a notice relating to the individual's unspent Commonwealth portion or unspent individual portion in accordance with this section.

The note points readers to paragraphs 226C(2)(a) and 226D(2)(a) of the Act for requirements to give written notice to the System Governor about the unspent Commonwealth portion.

Subsection (3) provides that the notice must:

- specify the following:
 - the day the provider ceased to deliver funded aged care services to the individual;
 - the available balance (including a nil amount) of the unspent Commonwealth portion for the individual;
 - the balance (including a nil amount) of the unspent individual portion for the individual;
 - if the amount of the unspent individual portion for the individual was reduced by the individual contributions charged to the individual by the provider under paragraph 273A20(a) of this Rules—the amount of those individual contributions; and
- explain:
 - the effect of paragraphs 226C(2)(b) and 226D(2)(b) of the Act; and
 - the effect of subsections 226A(7) to (9) and 226E(5) and (6) of the Act; and
 - the effect of paragraph 273A20(b) of this Rules.

When notice must be given

Subsection (4) provides that the notice must be given within 28 days after the cessation of delivery of services.

Who notice is given to

Subsection (5) provides that the notice must be given to:

- the individual; or
- if the individual has died:
 - the individual's legal representative; or
 - the individual's estate.

The note provides that a copy of the notice may also need to be given to another registered provider under section 149-80 or a supporter of the individual under section 29 of the Act.

Section 149-46 – Requirements for ceasing delivery of funded aged care services—notice to new registered provider about account balances

Section 149-46 provides the requirements for ceasing the delivery of funded aged care services and the notice to new registered providers about account balances.

Subsection (1) provides that this Section applies if:

- a registered provider has ceased the delivery of funded aged care services to an individual through a service delivery branch of the provider; and
- within 60 days after the day the registered provider ceased to deliver funded aged care services to the individual, the provider is notified that the individual has entered into a service agreement with a new registered provider; and
- the new registered provider will deliver funded aged care services to the individual for a classification type for the service groups home support, assistive technology or home modifications through a service delivery branch of the new registered provider. has ceased the delivery of funded aged care services to an individual through a service delivery branch of the provider; and

Subsection (2) provides that the registered provider must give a notice to the individual's new registered provider specifying what the provider estimates will be the available balance of the individual's:

- notional ongoing home support account (if any); and
- notional short-term home support account (if any); and
- notional assistive technology account (if any); and
- notional home modifications account (if any); and
- notional home care account (if any);

after the provider gives a claim in accordance with section 251 of the Act for payment of subsidy for the delivery of funded aged care services to the individual for the relevant period where the provider ceased delivering services to the individual.

This section allows the commencing registered provider to know how much funding remains in the participant's budget for their provision of ongoing and/or short term services while the ceasing registered provider can still submit claims for ongoing and/or short term services they

have delivered prior to the exit date. This will also allow the commencing provider to determine if the participant has any Commonwealth Home Care Package unspent funds.

Subsection (3) provides that the notice must be given within 28 days after the registered provider is notified that the individual has entered into a service agreement with the new registered provider.

Subdivision E—Security of tenure for individuals accessing funded aged care services in an approved residential care home

Subdivision E provides for the security of tenure for individuals accessing funded aged care services in an approved residential care home. Security of tenure is critically important for individuals living in approved residential care homes. It secures the resident's place at the home, which ensures stability, safety and dignity at a vulnerable stage of life. Its key importance lies in maintaining stable living arrangements which fosters a sense of home and belonging. Security of tenure also supports consistent relationships with workers which is essential for personalised care, especially for residents with dementia or complex health needs.

The security of tenure framework set out in this subdivision provides protections against arbitrary relocation or discharge from an approved residential care home without appropriate justification and procedural fairness. Knowing they cannot be easily forced to move gives individuals a greater sense of control over their lives, reinforcing their autonomy and dignity.

Section 149-50 – Application of this subdivision

Section 149-50 provides that this subdivision applies to a registered provider who is delivering funded aged care services to an individual for a classification type ongoing for the service group residential care in an approved residential care home of the registered provider.

Section 149-55 – Security of tenure—general

Section 149-55 provides that a registered provider must not take action to make an individual accessing funded aged care services in an approved residential care home of the approved provider leave the home, or imply that the individual must leave the home, unless:

- one of the circumstances in subsection 149-60(1) apply; and
- suitable alternative accommodation is available for the individual that meets the requirements in subsection 149-60(2); and
- the provider has given notice to the individual in accordance with section 149-65.

Section 149-60 – Security of tenure—circumstances where registered provider may ask an individual to leave an approved residential care home

Subsection (1) provides that a registered provider may only ask an individual accessing funded aged care services in an approved residential care home of the approved provider to leave the residential care home if:

- the approved residential care home is closing; or
- the provider can no longer provide accommodation and funded aged care services through the approved residential care home which are suitable for the individual, having regard to the individual's needs as assessed in accordance with subsection (4) and the provider has not agreed to deliver funded aged care services of the kind that the individual presently needs; or

- the individual no longer needs the funded aged care services delivered through the approved residential care home, as assessed by an approved needs assessor in accordance with subsection 64(2) of the Act; or
- individual has been accessing funded aged care services under a specialist dementia care agreement and a clinical advisory committee constituted in accordance with the agreement has determined that the individual is not suitable to continue accessing those services; or
- the individual has not paid any agreed fee or contribution to the provider within 42 days after the day when it is payable, for a reason within the individual's control; or
- the individual has intentionally caused:
 - serious damage to the approved residential care home; or
 - serious injury to an aged care worker of the provider, or to another individual accessing funded aged care services at the approved residential care home; or
- the individual is away from the approved residential care home for a continuous period of at least 7 days for a reason other than:
 - emergency leave; or
 - hospital leave; or
 - hospital transition leave; or
 - extended hospital leave; or
 - social leave.

Note 1 explains that section 244 of the Act explains when an individual is on leave.

Suitable accommodation to be available before individual can be required to leave approved residential care home

Subsection (2) provides that if a registered provider intends to ask an individual to leave the approved residential care home, the provider must ensure suitable alternative accommodation is available:

- with an alternative registered provider that meets the individual's needs and is affordable by the individual; or
- in a place more suited to the individual's long terms needs.

Subsection (3) provides that without limiting subsection (2), suitable alternative accommodation with an alternative registered provider will be available if the alternative registered provider has offered to enter into a service agreement with the individual under section 148-70 of this Rules for delivery of funded aged care services to the individual.

The note provides that a registered provider is required to detail the steps taken to ensure any alternative accommodation meets the needs of the individual in a continuity of care plan for the individual prepared under section 149-75.

Assessing the individual's needs

Subsection (4) provides that for the purposes of paragraph (1)(b), the needs of the individual must be assessed by:

- an approved needs assessor; or
- at least 2 medical or other health practitioners who meet the following criteria:

- one must be independent of the registered provider and the approved residential care home, and must be chosen by the individual;
- both must be competent to assess the aged care needs of the individual.

Section 149-65 – Security of tenure—notice requirements

Notice to be given if individual asked to leave residential care service

Subsection (1) provides that if a registered provider of an approved residential care home decides to ask an individual to leave the approved residential care home, the provider must give the individual a written notice which includes the following:

- the decision;
- the reasons for the decision;
- the date the individual is to leave;
- the individual's rights in relation to being asked to leave the approved residential care home, including the right to access:
 - the provider's complaints and feedback management system; and
 - any other mechanisms available to address complaints; and
 - independent aged care advocates;
- a copy of the continuity of care plan for the individual.

The note explains that complaints and feedback management systems are outlined at section 165 of the Act and Division 2 of Part 10 of Chapter 4 of this Rules.

Subsection (2) provides that the registered provider must give the notice to the individual at least 14 days before the individual is to leave.

Notice to be given if individual no longer required to leave approved residential care home

Subsection (3) provides that if:

- the decision to require the individual to leave the approved residential care home was based on the individual's behaviour; and
- the registered provider has given the individual a notice under subsection (1); and
- after giving the notice, the provider has agreed with the individual that, because of a change in the behaviour, the individual should not be required to leave the residential care home;

then the provider must give the individual a written notice stating that the individual is no longer required to leave the residential care home.

Section 149-70 – Security of tenure—movement of individuals

Subsection (1) provides that a registered provider must not move an individual from a room, or part of a room, in the approved residential care home to another room, or part of a room, in the home unless:

- the move is at the individual's request; or
- the individual agrees to the move after being fully consulted and without being subjected to any pressure; or
- the move is necessary on genuine medical grounds as assessed by one of the following:
 - an approved needs assessor;

- at least 2 medical or other health practitioners who meet the criteria in subparagraphs 149-60(4)(b)(i) and (ii); or
- the individual has been accessing funded aged care services under a specialist dementia care agreement and a clinical advisory committee constituted in accordance with the agreement has determined that the individual is not suitable to continue accessing those services in the individual's current room, or part of a room; or
- the move is necessary to carry out repairs or improvements to the home and the individual has the right to return to the room, or the part of the room, if it continues to exist as a room, or part of a room, for individuals when the repairs or improvements are finished; or
- the move is necessary due to an emergency that includes but are not limited to the following:
 - during serious medical situations such as disease outbreak, viral pandemic and epidemic;
 - in circumstances in which the safety of the individual is compromised such as during a fire, natural disaster or flood;
 - the individual has been repeatedly violent towards another person in the same room or in close proximity to the individual.

Subdivision F—Continuity of funded aged care services

Section 149-75 – Continuity of care plan

Section 149-74 provides requirements for the continuity of care plan. It provides requirements for registered providers to ensure continuity of care to individuals when ceasing to provide funded aged care services to them. Continuity of care is essential for older people transitioning between registered providers because it directly affects their health, safety and overall wellbeing.

Subsection (1) provides that a registered provider must prepare a plan for ensuring the continuity of funded aged care services for an individual (a continuity of care plan) in accordance with this section if the provider intends to ask an individual to leave an approved residential care home of the provider in any of the circumstances prescribed in subsection 149-60(1).

Disruptions in services can lead to missed medications, inconsistent treatment of chronic conditions, or a lack of understanding of a person's health history which could potentially result in serious health complications.

Individuals accessing residential care often have complex needs and can be disoriented or distressed by change. A smooth transition between registered providers helps to maintain routine, familiarity, and comfort, which are critical to emotional and mental stability. Continuity of care helps safeguard individuals from neglect, abuse, or medical errors during transitions.

Continuity of care plan for individuals accessing funded aged care services in an approved residential care home

Subsection (2) provides that a continuity of care plan for an individual accessing funded aged care services through the classification type ongoing for the service group residential care in an approved residential care home of a registered provider must specify the following:

- details of any suitable alternative accommodation that is available that meet the requirements in subsection 149-60(2);
- the steps the registered provider has taken to ensure that any alternative accommodation meets the individual's needs;
- how any records relating to ensuring the continuity of funded aged care services for the individual will be transferred to a suitable alternative registered provider if required under section 149-80;
- the intended start date (if any) for the individual with a suitable alternative registered provider;
- where an individual will not continue accessing funded aged care services with an alternative registered provider, the reason for this;
- the way in which the registered provider proposes to help the individual move (with their personal possessions);
- the measures that the registered provider proposes to take to refund any fees or contributions to the individual as required by Part 3 of Chapter 4 of the Act;
- the measures that the registered provider proposes to take to deal with any refundable deposit balance paid by the individual as required by Division 7 of Part 4 of Chapter 4 of the Act.

Section 149-80 – Transfer of records between registered providers

Section 149-80 provides requirements for registered providers to transfer records relating to individuals ceasing to be provided with funded aged care services. The requirements relate to the transfer of records from the outgoing provider to the incoming provider. A seamless handover of care and services plans, preferences, and history allows the incoming provider to tailor services immediately, avoiding a one-size-fits-all approach that may not meet the individual's needs.

Subsection (1) provides that this section applies if:

- a registered provider (the ***outgoing provider***) ceases to deliver funded aged care services to an individual; and
- another registered provider (the ***incoming provider***) starts the delivery of funded aged care services to the individual.

Records to be given to incoming provider on request

- The incoming provider may request the outgoing provider give records relating to the individual which are necessary to ensure the continuity of funded aged care services for the individual.
- If a request for records is made under subsection (2), the outgoing provider must give the incoming provider the records, or copies of such records, within 28 days after the request is made.
- Without limiting subsections (2) and (3), the outgoing provider must give the following records:
 - any records relating to the individual the provider is required to keep under section 7 of the *Records Principles 2014*;
 - any records relating to the individual the provider is required to keep under Section 154-1000 of this Rules.

Part 5 – Conditions relating to financial matters

Section 150A-1 – Requirements for refundable deposit register

Section 150A-1, provides that for the purposes of section 150A of the Act, a registered provider's refundable deposit register must be able to be produced in a single itemised document. This enables the information to be set out clearly and in a manner that is understandable for those reviewing the information.

The refundable deposit register must be provided to the Commissioner where required or requested.

Section 150A-3 – Kinds of providers to which the condition applies

Section 150A-3 clarifies the kinds of providers to which the condition applies. A registered provider delivering residential care that has received payment of a refundable deposit, accommodation bond or entry contribution, wholly or partly as a lump sum, must comply with the below recordkeeping obligations.

Section 150A-5 – Refundable deposit register to include information about refundable deposit paid and refundable deposit balances held

Section 150A-5 sets out what information must be included in the refundable deposit register in relation to the refundable deposits paid by, and balances held on behalf of, individuals residing within the approved residential care home.

The following information must be included in the refundable deposit register, for each relevant individual:

- the individual's name;
- the individual's Aged Care Management Payment System number;
- the date the individual entered the approved residential care home;
- the date each lump sum refundable deposit payment was made to the registered provider and the amount of each payment, the amount of each deduction made from an individual's refundable deposit (authorised under section 307 or section 308 of the Act), the date each deduction was made, the specific provision that authorised the deduction and the reason for the deduction;
- the individual's refundable deposit balance at the end of each calendar month while the provider held the deposit;
- any amount refunded to the individual under subsection 304-5(1) of the Rules and the date of the refund;
- the Independent Health and Aged Care Pricing Authority approval number (applicable only if the accommodation payment charged to the individual was higher than the maximum amount set by the rules for the purposes of section 289 of the Act)
- details of any transfer of the individual's refundable deposit made under section 312 of the Act, including the amount transferred, the date of transfer, and the remaining retention period on the refundable deposit.

Section 150A-15 – Refundable deposit register to include information about refundable deposit balances refunded

Section 150A-15 sets out what information must be included in the refundable deposit register in relation to refundable deposit balances that are refunded.

The following information must be included in the refundable deposit register for each relevant individual:

- per paragraph (a), if a refund is made because an individual dies, the register must include the date the individual died and, if applicable, the date the provider was shown evidence (such as probate, a will, letters of administration or other evidence) to confirm who the individual's refund should be paid to.
- per paragraph (b), if a refund is made because an individual ceased receiving residential aged care services, the register must include the date on which the individual stopped receiving those services.
 - per paragraph (c), if paragraph (b) applies and the individual notified the provider of their intention to enter another approved residential care home before the date they ceased receiving residential aged care services, the register must include the date of notification by the individual.
- per paragraph (d), if a refund is made because the nature of the care received by the individual changes, and those changes resulted in an excess deposit amount being held by the provider, then the register must include a description of the changes to the individual's care.
- per paragraph (e), if a refund is made because the individual's amount of refundable accommodation contribution reduces due to changes in the daily means tested amount, or accommodation supplement, and that reduction resulted in an excess deposit amount, then the register must include:
 - The date the new daily means tested amount or new accommodation supplement applied to the individual; and
 - The date the provider refunded the excess refundable deposit amount to the individual.
- per paragraph (f), the register must include the date on which, or by which, a refund was made to the individual in accordance with section 311 of the Act.
- per paragraphs (g) and (h), the register must include the date the individual's refund was made to the individual or another person, and the amount of the deposit refunded.
- per paragraphs (i) and (j), the register must include:
 - The amount (if any) of base interest paid as per section 313-10 of this instrument, and the date on which the base interest was paid; and
 - The amount (if any) of the maximum permissible interest paid as per section 313-10 of this instrument, and the date on which the maximum permissible interest was paid.

Section 150A-20 – Refundable deposit register to include information about accommodation bond balances held by the registered provider

Section 150A-20 sets out what information must be included in the refundable deposit register in relation to individuals who paid an accommodation bond on or after 1 July 2006, or for whom the provider holds an accommodation bond balance on or after that date.

The following information must be included in the refundable deposit register for each relevant individual:

- the individual's name;
- the individual's Residential Identification Number allocated by the Department;
- the date the individual entered the approved residential care home on or after 1 July 2006;
 - if the individual had previously entered another approved residential care home (the original home) and paid an accommodation bond for that entry, the register should include the date they entered the original home;
- the date on which the whole or each part of an accommodation bond paid by lump sum was paid for entry to the individual's current registered provider, as well as the amount;
- the amount of each deduction made from the accommodation bond on or after 1 July 2006, as well as the date and reason of each deduction;
- the accommodation bond balance as at 1 July 2006 (if applicable);
- the accommodation bond balance at the end of each calendar month starting on or after 1 July 2006 while the provider held the individual's bond balance

Section 150A-25 – Refundable deposit register to include information about accommodation bond balances refunded

Section 150A-25 sets out what information must be included in the refundable deposit register when an accommodation bond balance is refunded on or after 1 July 2006.

The following information must be included in the refundable deposit register for each relevant individual:

- Per paragraph (a), if the refund was because the individual dies the register must include:
 - the date the individual died; and
 - the date the provider was shown probate, a will, letters of administration, or other evidence confirming that the accommodation bond is to be refunded to a person.
- Per paragraph (b), if the refund was because the individual ceased to be provided with services at the approved residential care home, the register must include the date on which the individual ceased to be provided with that care.
- Per paragraph (c), and where paragraph (b) applies, if the individual intended to enter another approved residential care home to receive residential care, the register must include the date notification.
- Per paragraph (d), the register must include the date by which the provider was required to refund the accommodation bond under section 287-102 of the Rules;
- Per paragraphs (e) and (f), the register must include the date the accommodation bond payment balance was actually refunded and the amount;
- Per paragraphs (g) and (h), the register must include:
 - the amount (if any) of base interest paid under subsection 287-103A(2) of the rules and the date it was paid; and
 - the amount (if any) of maximum permissible interest paid under subsection 287-103A(3) of the rules and the date it was paid.

Section 150A-30 – Refundable deposit register to include information about entry contributions paid and entry contribution balances held

Section 150A-30 sets out what information must be included in the refundable deposit register for individuals who hold an entry contribution balance on or after 1 July 2006.

The following information must be included in the refundable deposit register for each relevant individual:

- the individual's name;
- the individual's Residential Identification Number allocated by the Department;
- the date the individual's entry contribution was originally paid, as well as the amount;
- the individual's entry contribution balance at the end of each calendar month starting on or after 1 July 2006 while the provider held the entry contribution balance.

Section 150A-35 – Refundable deposit register to include information about entry contributions balances refunded

Section 150A-35 sets out what information must be included in the refundable deposit register for individuals when an entry contribution is refunded on or after 1 July 2006.

The following information must be included in the refundable deposit register for each relevant individual:

- the date on which the individual ceased receiving care (which may be due to the individual dying or choosing to relocate to another approved aged care service);
- the date by which the provider was required to refund the individual's entry contribution balance, as determined by the formal agreement applying in respect of the individual's entry contribution balance;
- the date the individual's entry contribution was refunded, as well as the amount refunded;
- the amount (if any) of interest paid on the individual's refunded amount, including the date of payment.

Part 6 – Aged care workers

Division 1 – Workforce and aged care worker requirements

Subdivision A – Kinds of provider to which the condition applies

Section 152-5 – Kinds of provider to which the condition applies

This section confirms that every kind of registered provider is prescribed under this provision, per section 152 of the Act, as a condition of registration.

Subdivision B—Worker screening requirements

Section 152-10 – Purpose of this Subdivision

This section confirms that this Subdivision prescribes worker screening requirements for the purposes of subsection 152(1)(a) and 152(1)(b) of the Act.

Section 152-15 – Responsible persons of registered providers delivering services other than under CHSP or NATSIFACP

Section 152-15 sets out the worker screening, notification, and continuation requirements for responsible persons of registered providers who deliver funded aged care services, excluding those providers operating under CHSP or NATSIFACP. ‘Responsible persons’ are defined in section 12 of the Act.

Subsection 152-15(1) confirms that registered providers, other than those to whom subsection (5) or (6) applies, must ensure that each responsible person:

- has a police certificate (see section 152-25(1) for the applicable requirements); or
- is covered by subsection (2) relating to where an NDIS screening application or a police certificate is pending; or
- has an NDIS clearance decision in force.

Subsection 152-15(2) provides that a responsible person will also satisfy the clearance requirements where the person’s NDIS screening application or police certificate is pending, and they are subject to appropriate supervision during this period. A person whose application or certificate is pending must also provide a statutory declaration stating they have never been convicted of murder or sexual assault, and have never been convicted of, and sentenced to imprisonment for, any other form of assault.

Subsection 152-15(3) sets out the obligation for registered providers to take reasonable measures to ensure that responsible persons notify the provider of any changes relevant to their clearance requirements. These requirements ensure registered providers take reasonable measures to require each responsible person to notify the provider of changes to their NDIS clearance status or criminal record.

Paragraph 152-15(3)(a) confirms that the responsible person must notify the provider if an NDIS exclusion decision is in force in respect of the person.

Paragraph 152-15(3)(b) confirms that the responsible person must notify the provider if their NDIS clearance decision is suspended.

Paragraph 152-15(3)(c) confirms that the responsible person must notify the provider if they have been convicted of murder or sexual assault, or convicted of, and sentenced to imprisonment for, any other form of assault.

Subsection 152-15(4) sets out the circumstances under which a registered provider must ensure that a responsible person is no longer permitted to continue as a responsible person due to a change in their criminal record.

Paragraph 152-15(4)(a) specifies that a responsible person cannot continue as a responsible person if the registered provider is satisfied on reasonable grounds that the responsible person has been convicted of murder or sexual assault. Paragraph 152-15(4)(b) specifies that a responsible person cannot continue as a responsible person if the registered provider is satisfied on reasonable grounds that the responsible person has been convicted of, and sentenced to imprisonment for, any other form of assault.

Subsection 152-15(5) clarifies the section 152-15 requirements do not apply to a registered provider that delivers funded aged care services under CHSP, and is registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Subsection 152-15(6) confirms the section 152-15 requirements do not apply to registered providers that deliver funded aged care services under NATSIFACP.

Section 152-16 – Responsible persons of registered providers delivering services only under CHSP, NATSIFACP, or CHSP and NATSIFACP

Section 152-16 sets out the worker screening, notification, and continuation requirements for responsible persons of registered providers who deliver funded aged care services only under CHSP, NATSIFACP or both.

Subsection 152-16(1) confirms that registered providers to whom subsection 152-16(6), (7), or (8) applies must ensure that each responsible person:

- has a police certificate (see subsection 152-25(2), (3) or (5) for the applicable requirements); or
- is covered by subsection (2) of this section relating to an NDIS screening application or a police certificate is pending; or
- has an NDIS clearance decision in force.

Subsection 152-16(2) provides that a responsible person will also satisfy the clearance requirements, where the person's NDIS screening application or police certificate is pending, and they are subject to appropriate supervision during this period. A person whose application or certificate is pending must also provide a statutory declaration stating that they have never been convicted of an offence involving the death of a person and have never been convicted of, and sentenced to imprisonment for, offences specified in subsection 152-16(3).

Subsection 152-16(3) specifies offences for the purposes of subparagraph 152-16(2)(c)(ii). Subsection 152-16(3) confirms these offences are a sex related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child (as per paragraph 152-16(3)(a)), and an offence involving dishonesty (as per paragraph 152-16(3)(b)).

Subsection 152-16(4) sets out the obligation for registered providers that deliver funded aged care services only under CHSP, NATSIFACP, or both, to take reasonable measures to ensure that responsible persons notify the provider of any changes relevant to their clearance requirements. These requirements ensure registered providers take reasonable measures to require each responsible person to notify the provider of their NDIS clearance status or criminal record.

Paragraph 152-16(4)(a) confirms that the responsible person must notify the provider if an NDIS exclusion decision is in force in respect of the person.

Paragraph 152-16(4)(b) confirms that the responsible person must notify the provider if their NDIS clearance decision is suspended.

Paragraph 152-16(4)(c) confirms that the responsible person must notify the provider if after the commencement of this section (after 1 November 2025) they are convicted of an offence involving the death of a person or convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection 152-16(3).

Subsection 152-16(5) sets out the circumstances under which registered providers that deliver funded aged care services only under CHSP, NATISFACP or both, must ensure that a responsible person is no longer permitted to continue in their role as a responsible person due to a change in their criminal record.

Paragraph 152-16(5)(a) specifies that a responsible person cannot continue as a responsible person if after the commencement of this section, the registered provider is satisfied on reasonable grounds that the responsible person has been convicted of an offence involving the death of a person. Paragraph 152-16(5)(b) specifies that a responsible person cannot continue as a responsible person if after the commencement of this section, the registered provider is satisfied on reasonable grounds that the responsible person has been convicted of, and sentenced to imprisonment for at least one year for an offence referred to in subsection 152-16(3).

Subsection 152-16(6) provides that this subsection applies to a registered provider that delivers funded aged care services only under CHSP, and is registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Subsection 152-16(7) provides that this subsection applies to a registered provider that delivers services only under NATSIFACP.

Subsection 152-16(8) provides that this subsection applies to a registered provider that delivers funded aged care services only under CHSP or NATISFACP.

Section 152-17 – Responsible persons of other registered providers

Subsection 152-17(1) confirms that a registered provider that delivers services under either or both CHSP or NATSIFACP, and also other types of services, must comply with each of the worker screening requirements for responsible persons set out in section 152-16. This means that registered providers who provide both funded aged care services under CHSP and NATSIFACP and also other services must meet the requirements applicable to CHSP and NATSIFACP.

Subsection 152-17(2) applies to a responsible person of a registered provider that delivers funded aged care services under CHSP and is registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;

- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Subsection 152-17(3) applies to a responsible person of a registered provider that delivers funded aged care services under NATSIFACP.

Subsection 152-17(4) applies to a responsible person of a registered provider that delivers funded aged care services other than under CHSP or NATSIFACP.

Section 152-20 – Aged care workers delivering services other than under CHSP or NATSIFACP

Section 152-20 sets out the worker screening, notification, and continuation requirements for aged care workers of registered providers, where the workers are delivering funded aged care services other than under CHSP or NATSIFACP.

Subsection 152-20(1) confirms that registered providers must ensure that each aged care worker, other than workers to whom subsection 152-20(5) or (6) applies:

- has a police certificate (see subsection 152-25(1) for the applicable requirements); or
- is covered by subsection (2) of this section relating to an NDIS screening application or a police certificate is pending; or
- has an NDIS clearance decision in force; or
- is a secondary school student on a formal work experience placement with the provider, provided the student is directly supervised by a person who meets the requirements of paragraph 152-20(1)(a) or (c).

Subsection 152-20(2) provides that the person will also satisfy the clearance requirements, where the person's NDIS screening application or police certificate is pending, and they are subject to appropriate supervision during this period. The person whose application or certificate is pending must also provide a statutory declaration stating they have never been convicted of murder or sexual assault and have never been convicted of, and sentenced to imprisonment for, any other form of assault.

Subsection 152-20(3) sets out the obligation for registered providers to take reasonable measures to ensure that aged care workers notify the provider of any changes relevant to their clearance requirements. These requirements ensure registered providers take reasonable measures to require aged care workers to notify the provider of changes to their NDIS clearance status or criminal record. This applies to workers who are not covered by subsection 152-20(5) or (6), meaning those delivering services outside CHSP or NATSIFACP.

Paragraph 152-20(3)(a) confirms that each aged care worker must notify the provider if an NDIS exclusion decision is in force in respect of the worker.

Paragraph 152-20(3)(b) confirms that each aged care worker must notify the provider if their NDIS clearance decision is suspended.

Paragraph 152-20(3)(c) confirms that each aged care worker must notify the provider if they have been convicted of murder or sexual assault or convicted of, and sentenced to imprisonment for, any other form of assault.

Subsection 152-20(4) sets out the circumstances under which a registered provider must ensure that an aged care worker of the provider is no longer permitted to continue in their role due to a change in their criminal record. This applies to workers not covered by subsection 152-20(5) or (6).

Paragraph 152-20(4)(a) specifies that an aged care worker cannot continue if the registered provider is satisfied on reasonable grounds that the worker has been convicted of murder or sexual assault. Paragraph 152-20(4)(b) specifies that an aged care worker cannot continue if the registered provider is satisfied on reasonable grounds that worker has been convicted of, and sentenced to imprisonment for, any other form of assault.

Subsection 152-20(5) confirms that this subsection applies to aged care workers of a registered provider if the worker delivers funded aged care services under CHSP.

Subsection 152-20(6) confirms that this subsection applies to aged care workers of a registered provider if the worker delivers funded aged care services under NATSIFACP.

Section 152-21 – Aged care workers delivering services only under CHSP, NATSIFACP, or CHSP and NATSIFACP

Section 152-21 sets out the worker screening, notification, and continuation requirements for aged care workers employed by registered providers where the workers are delivering funded aged care services only under CHSP, NATSIFACP, or both.

Subsection 152-21(1) confirms that registered providers must ensure that each aged care worker, other than workers to whom subsection 152-21(5), (6) or (7) applies:

- has a police certificate (see subsection 152-25(2), (3) or (5) for the applicable requirements); or
- is covered by subsection (2) of this section relating to an NDIS screening application or a police certificate is pending; or
- has an NDIS clearance decision in force; or
- is a secondary school student on a formal work experience placement with the provider, provided the student is directly supervised by a person who meets the requirements of paragraph 152-21(1)(a) or (c).

Subsection 152-21(2) provides that the person will also satisfy the clearance requirements, where the person's NDIS screening application or police certificate is pending, and they are subject to appropriate supervision during this period. The person whose application or certificate is pending must also provide a statutory declaration stating they have never been convicted an offence involving the death of a person, and have never been convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection 152-16(3).

Subsection 152-21(3) sets out the obligation for registered providers to take reasonable measures to ensure that aged care workers to whom subsections 152-21(5), (6) or (7) apply notify the provider of changes to their NDIS clearance status or criminal record.

Paragraph 152-21(3)(a) confirms that the aged care worker must notify the provider if an NDIS exclusion decision is in force in respect of the worker.

Paragraph 152-21(3)(b) confirms that the aged care worker must notify the provider if their NDIS clearance decision is suspended.

Paragraph 152-21(3)(c) confirms that the aged care worker must notify the provider if after the commencement of this section, they have been convicted of an offence involving the death of a person or convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection 152-16(3).

Subsection 152-21(4) sets out the circumstances under which a registered provider must ensure that an aged care worker of the provider to whom subsections 152-21(5), (6) or (7) apply is not allowed to continue in their role due to a change in their criminal record.

Paragraph 152-21(4)(a) specifies that an aged care worker cannot continue if the registered provider is satisfied on reasonable grounds, after the commencement of this section, that the worker has been convicted of an offence involving the death of a person. Paragraph 152-21(4)(b) specifies that an aged care worker cannot continue if the registered provider is satisfied on reasonable grounds, after the commencement of this section, that the worker has been convicted of, and sentenced to imprisonment for at least one year for, an offence referred to in subsection 152-16(3).

Subsection 152-21(5) confirms that this section applies to aged care workers of a registered provider if the worker delivers funded aged care services only under CHSP.

Subsection 152-21(6) confirms that this section applies to aged care workers of a registered provider if the worker delivers funded aged care services only under NATSIFACP.

Subsection 152-21(7) confirms that this section applies to aged care workers of a registered provider if the worker delivers funded aged care services only under both CHSP and NATSIFACP.

Section 152-22 – Other aged care workers

Subsection 152-22(1) confirms that a registered provider that delivers services under either or both CHSP or NATSIFACP, and also other types of services, must comply with each of the worker screening requirements in relation to their aged care workers set out in section 152-21. This means that registered providers who provide funded aged care services under CHSP and NATSIFACP and also other services must meet the requirements applicable to CHSP and NATSIFACP providers in relation to their aged care workers.

Subsection 152-22(2) applies to an aged care worker of a registered provider if the worker delivers funded aged care services under CHSP.

Subsection 152-22(3) applies to an aged care worker of a registered provider if the worker delivers funded aged care services under NATSIFACP.

Subsection 152-22(4) applies to an aged care worker of a registered provider if the worker delivers funded aged care services other than under CHSP or NATSIFACP.

Section 152-25 – Police certificates

Section 152-25 sets out the requirements for when a person is considered to meet the police certificate conditions for the purposes of responsible person and aged care worker screening under the Act. The section distinguishes between general requirements and modified requirements that apply to responsible persons or aged care workers of certain registered providers delivering services under CHSP or NATSIFACP.

Subsection 152-25(1) applies to responsible persons and aged care workers of registered providers, other than providers who deliver services under CHSP or NATSIFACP.

Paragraph 152-25(1)(a) provides that the police certificate for the person must not be more than 3 years old.

Paragraph 152-25(1)(b) provides that the certificate does not record that the person has been convicted of murder or sexual assault, or convicted of, and sentenced to imprisonment for, any other form of assault.

Paragraph 152-25(1)(c) provides that a person who has been a citizen or permanent resident of a country other than Australia at any time after turning 16, must have made a statutory declaration stating that they have never been convicted of murder or sexual assault, or convicted of, and sentenced to imprisonment for, any other form of assault.

Subsection 152-25(2) applies to a person who is a responsible person or aged care worker of a registered provider to which subsection 152-25(4) applies (CHSP providers). A responsible person or aged care worker satisfies the conditions for holding a police certificate where all conditions are met.

Paragraph 152-25(2)(a) provides that there is for the person a police certificate that is not more than 3 years old.

Paragraph 152-25(2)(b) provides that the person either was engaged as a responsible person or aged care worker of the registered provider on or after the commencement of this section, or the police certificate was issued after the commencement of this section.

Paragraph 152-25(2)(c) provides that the police certificate for the person does not record a conviction for an offence involving the death of a person.

Paragraph 152-25(2)(d) provides that the certificate for the person does not record that, in the last 5 years before the date of the certificate, the person was convicted of, and sentenced to imprisonment for at least one year for a sex related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child, or an offence involving dishonesty.

Paragraph 152-25(2)(e) provides that for a person who has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that they have never been:

- convicted of an offence involving the death of a person; or
- convicted of, and sentenced to imprisonment for at least one year for, a sex related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child; or

- convicted of, and sentenced to imprisonment for at least one year for, an offence involving dishonesty.

Subsection 152-25(3) applies to a person who is a responsible person or aged care worker of a registered provider to which subsection (4) applies (CHSP providers). A responsible person or aged care worker satisfies the conditions for holding a police certificate where all conditions are met.

Paragraph 152-25(3)(a) provides that the person either was engaged as a responsible person or aged care worker of the registered provider before the commencement of this section.

Paragraph 152-25(3)(b) provides that there must be a police certificate for the person that was issued before the commencement of this section and is not more than 3 years old.

Subsection 152-25(4) provides that this subsection applies to a registered provider that delivers funded aged care services under CHSP, and is registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Subsection 152-25(5) applies to a person who is a responsible person or aged care worker of a registered provider to which subsection 152-25(6) applies (NATSIFACP providers). A responsible person or aged care worker satisfies the conditions for holding a police certificate where all conditions are met.

Paragraph 152-25(5)(a) provides that the police certificate for the person must not be more than 3 years old.

Paragraph 152-25(5)(b) provides that the police certificate for the person does not record a conviction for an offence involving the death of a person.

Paragraph 152-25(5)(c) provides that the police certificate for the person does not record that, in the last 5 years before the date of the certificate, the person was convicted of, and sentenced to imprisonment for at least one year for a sex related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child, or an offence involving dishonesty.

Paragraph 152-25(5)(d) provides that for a person who has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been:

- convicted of an offence involving the death of a person; or
- convicted of, and sentenced to imprisonment for at least one year for, a sex related offence, including sexual assault (whether against an adult or child), child abuse material offences, or an indecent act involving a child; or
- convicted of, and sentenced to imprisonment for at least one year for, an offence involving dishonesty.

Subsection 152-25(6) confirms that the modified requirements in subsection (5) apply to a registered provider that delivers funded aged care services under NATSIFACP and is registered in one or more of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care;
- residential care.

Subdivision C – Qualifications and training requirements

Section 152-35 – Qualifications and training requirements

Section 152-35 confirms qualifications and training requirements for the purposes of paragraph 152(c) of the Act. This section requires that aged care workers of registered providers must have appropriate qualifications, skills or experience to provide funded aged care services that the provider delivers to individuals.

Division 2 – Vaccination

Section 153-5 – Kinds of provider to which the condition applies

Section 153-5 prescribes that a registered provider registered in the registration category residential care is the type of provider to which the vaccination requirements apply.

Section 153-10 – Requirements for providing access to vaccinations

Section 153-10 prescribes the requirement that registered providers delivering residential care must follow when providing access to vaccinations mentioned in subsection 153(2) of the Act. This access should be in accordance with the National Immunisation Program (NIP) Schedule, as published by the Department of Health, Disability and Ageing and updated from time to time.

The note under this section provides that as of 2025, the National Immunisation Program (NIP) Schedule is available on the Department's website at <https://www.health.gov.au>.

Further clinical information is available in the Australian Immunisation Handbook. Vaccines specified under the Rules and Section 153 of the Act are subsidised under the National Immunisation Program (NIP) Schedule. The NIP includes best practice regarding frequency of vaccinations, rather than prescribing static requirements, that are not responsive to future changes.

Section 153-15 – Other vaccinations

Section 153-15 provides the other vaccinations that a registered provider must provide access to, under section 153(2)(c) of the Act. The prescribed vaccinations are a pneumococcal vaccination and a shingles vaccination.

Part 7 – Information and access

Division 1 – Personal information and record keeping

Subdivision A – Purpose of this division

Section 154-1 – Purpose of this Division

This Part prescribes the kinds of records that registered providers must keep and retain, and the requirements for keeping and retaining those records.

Subdivision B – Information provided to an individual

Section 154-2 – Requirement to keep and retain information provided to an individual

Subsection 154-2(1) prescribes that a registered provider must keep records demonstrating their compliance with their obligations and conditions of registration under Chapter 3.

Subsection 154-2(2) prescribes it is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

Section 154-3 – Requirement to correct personal information

Subsection 154-3(1) confirms this section applies to a registered provider that is not any of the following:

- an APP entity within the meaning of the Privacy Act;
- a State or Territory; or
- a body established for a public purpose by or under a law of the State or Territory (other than a local government authority).

Subsection 154-3(2) prescribes it is a requirement that when a registered provider keeps and retains records, the registered provider must comply with Australian Privacy Principle 13 as set out in Schedule 1 of the Privacy Act, as if it were an organisation for the purposes of that Act.

The note following subsection 154-3(2) provides that a registered provider that is an APP entity remains subject to the Privacy Act, including APP 13.

Subdivision C – Vaccination

Section 154-5 – Application of this Subdivision to certain registered providers

Section 154-5 confirms that this Subdivision applies to a registered provider registered in the category residential care.

Section 154-10 – Records about service staff – influenza vaccinations

Subsection 154-10(1) provides that a registered provider must keep records for each calendar year of:

- the total number of service staff in relation to the approved residential care home
- the number of those service staff who have informed the registered provider, whether voluntarily or as required under a law of a State or Territory, that they have received the annual seasonal influenza vaccination for that year (whether or not under the registered provider's influenza vaccination scheme (if any)).

Subsection 154-10(2) provides that it is a requirement that a registered provider keep the above records in written or electronic form for 7 years starting on the day the record is made or received.

Section 154-15 – Records about service staff – COVID-19 vaccinations

Subsection 154-15 provides that a registered provider must keep records for each calendar year of:

- the total number of service staff in relation to the approved residential care home
- the number of those service staff who have voluntarily informed the registered provider that they have received a COVID 19 vaccination in that year.

Subsection 154-15(2) provides that it is a requirement that a registered provider keep the above records in written or electronic form for 7 years starting on the day the record is made or received.

Section 154-20 – Records about individuals receiving residential care – influenza vaccinations

Subsection 154-20(1) provides that a registered provider must keep records for each calendar year of:

- the total number of individuals accessing funded aged care services in the approved residential care home
- the number of those individuals who have voluntarily informed the registered provider that they have received the annual seasonal influenza vaccination for that year.

Subsection 154-20(2) provides that it is a requirement for a provider to keep the above records in written or electronic form for 7 years starting on the day the record is made or received.

Section 154-25 – Records about individuals receiving residential care – COVID-19 vaccinations

Subsection 154-25(1) provides that a registered provider must keep records for each calendar year of:

- per subparagraph (1)(a), the total number of individuals accessing funded aged care services in the approved residential care home
- per subparagraph (1)(b), the number of individuals covered by subparagraph (1)(a), who have voluntarily informed the registered provider that they had received one or more COVID 19 vaccinations in that year.
- per subparagraph (1)(c), the number of individuals covered by subparagraph (1)(b) who have informed the registered provider that they had received only one COVID 19 vaccination
- per subparagraph (1)(d), the number of individuals covered by paragraph (1)(b) who have informed the registered provider that they had received two COVID 19 vaccinations.

Subsection 154-25(2) provides that it is a requirement that a registered provider keep a record prescribed under this section in written or electronic form for 7 years starting on the day the record is made or received.

Subdivision D – Quality indicators

Section 154-105 – Application of Subdivision to certain registered providers

Section 154-105 confirms Subdivision D of this Part applies to a registered provider that is required to give a quality indicator report under section 166-110 of the Rules. Section 166-110 confirms such registered providers are registered in the category of residential care.

Section 154-110 – Requirements for records on quality indicators

Subsection 154-110(1) confirms the types of records which are prescribed under this section which a registered provider must keep and retain. A registered provider who is a registered provider prescribed under section 154-105 must keep a quality indicators report and records relating to the collection and measurements of quality indicators.

Subsection 154-110(2) confirms a registered provider must keep a record prescribed under this section in written or electronic form for 7 years starting in the day the record is made or received. The note under this subsection highlights that a registered provider may be required to comply with other laws, including Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision E – Incidents

Section 154-150 – Records about details of incidents

Section 154-150 provides that registered providers must keep and retain the details recorded in relation to an incident under subsection 164-25(1) in written or electronic form for seven years starting on the day the record is made or received. This Section ensures that providers keep records in relation to incidents for a sufficient period to allow those records to inform future actions, and to allow access by the regulator during audit and assessment processes.

A period of seven years aligns with comparable incident management arrangements under the National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018.

Subdivision F – Complaints and feedback

Section 154-200 – Application of Subdivision to feedback received

Section 154-200 provides that Subdivision D applies to feedback received by a registered provider that is managed in accordance with section 165-30 of the Rules, and raises an issue as referred to in subsection 165-30(2) of the Rules.

It is the policy intent that feedback that raises an issue refers to where the feedback raises concerns that require a response from the provider. It does not include feedback that is positive or neutral in character and does not seek a response from the provider.

Section 154-205 – Requirements for records of complaints and feedback

Section 154-205 prescribes the types of records that registered providers must keep and retain in relation to complaints and feedback.

Subsection 154-205(1) sets out that the registered provider must keep and retain the following records in relation to the complaints and feedback received:

- complaints and feedback received each year;
- the nature of complaints and feedback;
- the action taken to resolve complaints and feedback;
- responses provided to individuals about their complaints and feedback;
- any improvements made by a registered provider in relation to complaints and feedback;
- an evaluation of the effectiveness of the actions taken by the registered provider and their related outcome in relation to each complaint and feedback;
- a record of the number of days taken to resolve each complaint and feedback;
- the education and training that has been delivered to the aged care workers and responsible persons of the registered provider in relation to each complaint and feedback.

It is the policy intent that providers keeping records of the above information, will ensure the information is readily available, including for the purposes of provider reporting requirements, and in turn encourage providers to strengthen their performance.

Subsection 154-205(2) provides that the records must be kept in either written or electronic form for 7 years or more starting from the date the record is received. This ensures that registered providers have the choice between written or electronic records. The note highlights that providers may also be subject to other Commonwealth, State, or Territory laws regarding record retention.

Subdivision G – Prudential and financial

Section 154-300 – Requirement to keep and retain financial and prudential reports

Subsection 154-300(1) sets out requirements for the kinds of records that the registered provider must keep and retain in relation to their financial and prudential matters, these being:

- an aged care financial report;
- a quarterly financial report;
- a general purpose financial report;
- an annual prudential compliance statement.

The note under subsection 154-300(1) refers to Subdivision E of Division 3 of Part 2 of Chapter 5 of the rules for requirements relating to each record.

Subsection 154-300(2) provides that records prescribed in subsection (1) must be kept in either written or electronic form for 7 years starting from the date the record is made or received.

The note under subsection 154-300(2) clarifies that a registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision H – CHSP

Section 154-400 – Application of Subdivision

Section 154-400 provides that this subdivision applies to registered providers who deliver funded aged care services under CHSP and are registered in the following registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Section 154-405 – Requirements for records

Subsection 154-405(1) specifies that the kinds of records that CHSP providers must keep and retain are records of the following:

- the amount of financial assistance the System Governor has granted the registered provider within a particular financial year;
- any individual fees and contributions collected over the financial year;
- expenditure for the delivery of funded aged care services by the provider under the funding agreement;
- any surplus and uncommitted funds from the previous financial year;
- service types and duration of services provided;
- activity and performance data;

Subsection 154-405(2) provides that these records must be kept and retained by the registered provider for 7 years in written or electronic form starting on the day the record is made or received.

The note under subsection 154-405(2) clarifies that a registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision J – NATSIFACP

Section 154-500 – Application of Subdivision

Section 154-500 provides that this subdivision applies to registered providers who deliver funded aged care services under NATSIFACP and are registered in one or more the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care;
- residential care.

Section 154- 505 – Requirements for records

Subsection 154-505(1) specifies that the kinds of records that NATSIFACP providers must keep and retain are the following:

- the amount of financial assistance the System Governor has granted the registered provider under subsection 264(2) of the Act within a particular financial year;
- any individual fees and contributions collected over the financial year;
- expenditure for the delivery of funded aged care services by the provider under the funding agreement;
- any surplus and uncommitted funds from the previous financial year;
- service types, and duration of services;
- individual care and service plans;
- progress in embedding a wellness and reablement approach to service delivery;
- individual services agreements;
- a summary of the activities undertaken to prevent disease outbreaks;
- the number of individuals who are waiting to access funded aged care services for the financial year and the reason for the waitlist.

Subsection 154-505(2) provides that these records must be kept and retained by the NATSIFACP provider for 7 years in written or electronic form starting on the day the record is made or received.

The note under subsection 154-505(2) clarifies that a registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

It is important these records are retained as they are critical tools for compliance, transparency and accountability, program improvements, resource allocation, and clear and accurate communication between NATSIFACP stakeholders.

Subdivision K – Multi-Purpose Service Program

Section 154-605 – Application of subdivision to certain registered providers

Subdivision K applies to registered providers delivering funded aged care services under MPSP.

Section 154-610 – Requirement for records

Subsection 154-610(1) provides that, each of the following kinds of records are prescribed kinds of records that MPSP providers must keep and retain:

- records of the amount of subsidy received under Division 5 of Part 2 of Chapter 4 of the Act to deliver funded aged care services at each approved residential care home
- records of any individual fees or contributions paid to the provider under Part 3 of Chapter 4 of the Act by individuals accessing funded aged care services, in or from, each approved residential care home;
- records of expenditure by the registered provider for the delivery of funded aged care services at each approved residential care home for the financial year;
- records of the service types delivered for the financial year;

- records of the number of individuals who have accessed funded aged care services, or are waiting to access services, for the financial year, including:
 - whether the individual had an access approval when they commenced accessing services; and
 - the services the individuals accessed, including the services where specified in the individual's access approval; and
 - the individual's classification type; and
 - when the individual commenced and ceased services; and
 - the reason the individual ceased services;
- records of the demographic information about each individual who has accessed funded aged care services, or are waiting to access services for the financial year, including:
 - the name of the individual; and
 - the gender of the individual; and
 - the date of birth of the individual; and
 - whether the individual is Aboriginal or Torres Strait Islander; and
 - whether the individual has dementia or dementia symptoms;
- records of a summary of the activities undertaken to prevent disease outbreaks.

Subsection 154-610(2) provides that, a registered provider must keep the records prescribed in subsection 154-610(1) for 7 years in written or electronic form, starting on the day the record is made or received.

The note under subsection 154-610(2) clarifies that a registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision L – Transition Care Program

Section 154-650 – Application of subdivision to certain registered providers

Subdivision L applies to registered providers delivering funded aged care services under TCP.

Section 154-665 – Requirements for records

Subsection 154-665(1) provides that each of the following kinds of records are prescribed kinds of records that a TCP provider must keep and retain:

- records of claims for payment of subsidy made by the provider under section 260 of the Act;
- records of the amount of subsidy the Commonwealth has paid to the registered provider for the financial year;
- records of any individual fees and contributions under Part 3 of Chapter 4 of the Act that have been paid by individuals to the registered provider for the financial year;
- records of expenditure by the registered provider for the financial year;

- records of any System Governor approved unspent funds from previous financial years.

Subsection 154-665(2) provides that a registered provider must keep a record prescribed in subsection 154-665(1) for 7 years in written or electronic form, starting on the day the record is made or received.

The Note under subsection 154-665(2) clarifies that a registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

Subdivision M – Governing bodies

Section 154-700 – Records about independent nonexecutive members of a governing body

Section 154-700 prescribes the record-keeping requirements for registered providers that are required to ensure a majority of their governing body members are independent non-executive members.

Subsection 154-700(1) confirms that if a registered provider is required to ensure a majority of its governing body members are independent non-executive members, under paragraph 157(2)(a) of the Act and section 157-5 of the Rules, the provider must keep and retain records of the names of all members of its governing body and which of those members are independent non-executive members.

Subsection 154-700(2) provides that a registered provider must keep the records for 7 years starting on the day the record is made.

Subsection 154-700(3) provides that where a record relates to a specific member of the governing body, the registered provider must keep the record for a period of 7 years following the end of that member's engagement with the governing body.

Section 154-705 – Records about members of a governing body with clinical care provision experience

Section 154-705 prescribes the record-keeping requirements for registered providers that are required to have at least one member of their governing body with experience in the provision of clinical care.

Subsection 154-705(1) confirms that if a registered provider is required, under paragraph 157(2)(b) of the Act and section 157-10 of the rules, to ensure that at least one member of its governing body has experience in the provision of clinical care, the provider must keep and retain records of the names of governing body members who have experience in the provision of clinical care and the details of each member's clinical care experience.

The clinical experience recorded is to be any experience which the provider considers supports the governing body member's decision making, in view of the types of care and services that are provided by the provider.

Subsection 154-705(2) confirms that a registered provider must keep the records for 7 years starting on the day the record is made.

Subsection 154-705(3) provides that where a record made relates to a specific member of the governing body, the registered provider must keep the record for a period of 7 years following the end of that member's engagement with the governing body.

Subdivision N – Advisory bodies

Section 154-800 – Records about the quality care advisory body

Section 154-800 prescribes the record-keeping requirements for registered providers that are required to establish and maintain a quality care advisory body.

Subsection 154-800(1) confirms that if a registered provider is required, under paragraph 158(2)(a) of the Act and section 158-5 of the rules, to establish and maintain a quality care advisory body, the provider must keep and retain the following records:

- records of the names of the members of the quality care advisory body and details of the date each member was appointed to the quality care advisory body and the date (if any) a member resigned from the quality care advisory body;
- records of how the quality care advisory body satisfies the requirements of section 158-15 of the Rules (requirements for reports of quality care advisory bodies);
- a copy of the minutes of any meeting held by the quality care advisory body and the date on which the meeting was held;
- a copy of each written report given to the governing body of the provider by the quality care advisory body under subparagraph 158(2)(a)(ii) of the Act;
- records of any feedback given to the governing body of the provider by the quality care advisory body under subparagraph 158(2)(a)(iii) of the Act;
- a copy of any written advice given to the quality care advisory body by the governing body of the provider under subparagraph 158(2)(b)(ii) of the Act advising how the governing body has considered the report and feedback mentioned in paragraphs 154-800(2)(d) and (e).

Subsection 154-800(2) a registered provider must keep the records for 7 years starting on the day the record is made.

Subsection 154-800(3) confirms where a record relates to a specific member of the quality care advisory body, the registered provider must keep the record for a period of 7 years following the end of that member's engagement with the quality care advisory body.

Section 154-805 – Records about the consumer advisory body

Section 154-805 prescribes the record-keeping requirements for registered providers that are required to offer individuals the opportunity to establish one or more consumer advisory bodies.

Subsection 154-805(1) confirms that if a registered provider is required, under paragraph 158(4)(a) of the Act and section 158-20 of the rules, to offer the opportunity to establish one or more consumer advisory bodies, the provider must keep and retain the following records:

- a copy of each written offer made to individuals receiving funded aged care services and their supporters, inviting them to establish a consumer advisory body

- records of the date on which each offer was given to those individuals and supporters.

Subsection 154-805(2) confirms that if one or more consumer advisory bodies are established, the provider must also keep and retain the following records in relation to each body:

- a copy of the minutes of each meeting held by the consumer advisory body
- records of any feedback provided by the consumer advisory body to the provider's governing body
- a copy of any written advice provided by the governing body to the consumer advisory body under subparagraph 158(4)(b)(ii) of the Act, advising how the governing body has considered the feedback.

Per subsection (3) a registered provider must keep the records for 7 years starting on the day the record is made.

Subdivision P – Worker screening

Section 154-900 – Records of responsible persons

Section 154-900 sets out the recordkeeping obligations of registered providers in relation to individuals who are considered responsible persons under the Act. These requirements are designed to ensure that providers maintain accurate, up-to-date documentation that supports regulatory oversight, workforce screening, and compliance with clearance requirements. The collection, use and potential disclosure of personal information as required under this subdivision is reasonable, necessary and proportionate to achieving these aims, and is consistent with the Privacy Act and the Australian Privacy Principles.

Subsection 154-900(1) confirms that registered providers must keep and maintain an up-to-date record for each responsible person of the registered provider.

Paragraph 154-900(1)(a) confirms that the record must include the responsible person's full name, date of birth, and address.

Paragraph 154-900(1)(b) confirms that if paragraph 152-15(1)(a) or 152-16(1)(a) applies to the person, the record must include a copy of the person's police certificate.

Paragraph 154-900(1)(c) confirms that if paragraph 152-15(1)(b) or 152-16(1)(b) applies to the person, the record must include a copy of the person's statutory declaration. This declaration is used to confirm that the individual has not been convicted of certain offences overseas that cannot be recorded on a police certificate issued in Australia.

Paragraph 154-900(1)(d) confirms that if paragraph 152-15(1)(c) or 152-16(1)(c) applies to the person, the record must include a record of the person's NDIS clearance decision (for example, a clearance identification number).

Subsection 154-900(2) confirms a registered provider must also keep certain records should subsection 154-900(3) apply.

Paragraph 154-900(2)(a) confirms that the registered provider must record the name of the person who ensured that the responsible person obtained the required police certificate, statutory declaration, or NDIS clearance decision.

Paragraph 154-900(2)(b) confirms that the registered provider must record the date on which the person ensured the documentation was obtained. This supports audit trails and accountability in workforce screening processes.

Subsection 154-900(3) confirms that the requirements in subsection 154-900(2) apply only if the responsible person's police certificate, statutory declaration, or NDIS clearance decision is received by the registered provider on or after the commencement of this section. This provision ensures that retrospective compliance is not required under this section for documentation received prior to the commencement date.

Section 154-905 – Records of aged care workers

Section 154-905 sets out the recordkeeping obligations of registered providers in relation to aged care workers. These requirements are designed to ensure that providers keep and maintain accurate, up-to-date documentation that supports workforce capability, regulatory compliance, and screening. The collection, use and potential disclosure of personal information as required under this subdivision is reasonable, necessary and proportionate to achieving these aims, and is consistent with the Privacy Act and the Australian Privacy Principles.

Subsection 154-905(1) confirms that registered providers must keep and maintain a record for each aged care worker.

Paragraph 154-905(1)(a) confirms that the record must include the aged care worker's full name, date of birth, and address.

Paragraph 154-905(1)(b) confirms that the record must include information on how the provider has ensured the worker possesses appropriate qualifications, skills, or experience to provide the funded aged care services delivered by the registered provider, as required under section 152-35 of the Rules, and is given opportunities to develop their capability to provide those services, consistent with paragraph 152(d) of the Act.

Paragraph 154-905(1)(c) confirms that if paragraph 152-20(1)(a) or 152-21(1)(a) applies to the worker, the record must include a copy of the worker's police certificate. This certificate is required to assess whether the individual poses a risk to individuals accessing funded aged care services.

Paragraph 154-905(1)(d) confirms that if paragraph 152-20(1)(b) or 152-21(1)(b) applies to the worker, the record must include a copy of the worker's statutory declaration. This declaration is used to confirm that the individual has not been convicted of certain offences overseas that cannot be recorded on a police certificate issued in Australia.

Paragraph 154-905(1)(e) confirms that if paragraph 152-20(1)(c) or 152-21(1)(c) applies to the worker, the record must include a record of the worker's NDIS clearance decision (for example, a clearance identification number).

Subsection 154-905(2) sets out additional recordkeeping requirements for aged care workers.

Paragraph 154-905(2)(a) confirms that the registered provider must record the name of the person who ensured that the aged care worker obtained the required police certificate, statutory declaration, or NDIS clearance decision.

Paragraph 154-905(2)(b) confirms that the registered provider must record the date on which the person ensured the documentation was obtained. This supports audit trails and accountability in workforce screening processes.

Subsection 154-905(3) clarifies that the requirements in subsection 154-905(2) apply only if the aged care worker's police certificate, statutory declaration, or NDIS clearance decision is received by the registered provider on or after the commencement of this section. This provision ensures that retrospective compliance is not required for documentation received prior to the commencement date.

Section 154- 910 – How long records required by sections 154-900 and 154-905 to be kept

Section 154-910 sets out the minimum retention period for records relating to responsible persons and aged care workers, as required under sections 154-900 and 154-905. It confirms that a registered provider must retain each record required under section 154-900 and section 154-905 for a period of 7 years, starting on the later of the following:

- the day the record is first made
- the day the latest update to the record is made.

Section 154-915 – Copies of records relating to allegations of misconduct

Section 154-915 sets out the recordkeeping obligations of registered providers in relation to allegations of misconduct against responsible persons or aged care workers of the provider.

Per subsections 154-915(1) and (2), a registered provider must retain for 7 years, starting from the first day the provider has the record, a copy of a record relating to:

- an allegation of misconduct against a responsible person or aged care worker of the provider
- any action taken, including any investigation, in response to such an allegation.

This retention period ensures that documentation is available for future reference and regulatory compliance, and aligns with standard practices for incident and complaint management in aged care settings.

Subdivision Q – Delivery and continuity of funded aged care services

Section 154-1000 – Requirement to keep and retain records relating to continuity of funded aged care services

Section 154-1000 sets out the requirements for registered providers to keep and retain records in relation to the continuity of funded aged care services.

Subsection 154-1000(1) lists the types of records a registered provider must keep for an individual whom the provider is delivering funded aged care services. The records a registered provider must keep and retain include:

- any assessment and classification records of the individual that are not provided to the System Governor in electronic form;
- the service agreement between the provider and the individual;
- the care and services plan for the individual;
- the medical records, progress notes and other clinical records of the individual;

- where the provider is delivering funded aged care services to the individual through the service group residential care, the accounts of the individual, including:
 - the entry (if any) in the refundable deposit register of the provider that relates to the individual; and
 - amounts (if any) of daily accommodation payments, daily accommodation contributions or accommodation charge paid by the individual; and
 - entry and leave arrangements for the individual; and
 - the accommodation agreement between the provider and the individual; and
- where the provider is delivering funded aged care services to the individual through the service groups home support, assistive technology or home modifications, the accounts of the individual, including any notices provided to the individual in accordance with section 149-45 of the Rules;
- applicability of any fee reduction supplements to the individual under sections 197-5, 231-15 or 231-20 of the Rules;
- the name and contact details of any supporter registered in relation to the individual;
- measurements, assessments and information about the individual obtained in accordance with sections 154-110, 166-110 and 166-112 of the Rules;
- monthly statements prepared in accordance with section 155-40 of the Rules.

Subsection 154-1000(2) ensures that a registered provider is to keep and retain records under this section for a period of 7 years starting on the day the record is made.

Subdivision R – Status of service delivery branches

Section 154-1100 – Requirement to keep and retain records about service delivery branches

Subsection 154-1100(1) prescribes that a registered provider must keep records of their compliance with the reporting requirements under Subdivision M of Division 3 of Part 2 of Chapter 5, including records of the following:

- any reports given under section 166-910;
- any reports given under section 166-915;
- any reports given under section 166-920;
- any reports given under section 166-925;
- any reports given under section 166-930.

Subsection 154-1100(2) confirms it is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made

Subdivision S – Claims for subsidy

Section 154-1200 – Application of this Subdivision

Subsection (1) provides that this subdivision applies to a registered provider in any registration category.

Subsection (2) provides that despite subsection (1), this subdivision does not apply to a registered provider only delivering funded aged care services under one of the following specialist aged care programs:

- CHSP
- MPSP
- NATSIFACP.

Section 154-1205 – Requirement to keep and retain records which enable claims for payment of subsidy to be verified

Subsection (1) provides that a kind of record that a registered provider must keep and retain under paragraph 154(a) of the Act is any record that enables claims for payments of subsidy to be properly verified.

Subsection (2) provides that, without limiting subsection (1), a kind of record that enables claims for payments of subsidy to be properly verified includes the following:

- The service agreement between the registered provider and the individual to whom the provider is delivering funded aged care services;
- The medical records, progress notes and other clinical records of the individual to whom the provider is delivering funded aged care services;
- Invoices for the delivery of funded aged care services to an individual;
- Attendance records for an aged care worker of the provider.

Subsection (3) provides that the records prescribed under subsection (1) must be kept for 7 years starting on the day the record is made.

Subdivision T – Compliance

Section 154-1300 – Requirement to keep and retain records relating to compliance

Subsection 154-1300(1) prescribes a kind of record that a registered provider must keep and retain under section 154 of the Act is any record that enables proper assessments to be made of whether a provider has complied, or is complying, with its obligations under Chapter 3 of the Act.

Subsection 154-1300(2) confirms it is a requirement that a registered provider keep a record prescribed under this section for 7 years starting on the day the record is made.

Division 2—Provision of information to individuals

Section 155-1 – Purpose of this Division

Section 155-1 outlines that, for the purposes of section 155 of the Act, this Division prescribes the requirements for the following:

- the records and information that a registered provider must provide and explain to individuals accessing, or seeking to access funded aged care services;
- the records and information (including personal information) held by the registered provider about the individual to whom the registered provider delivers funded aged care services that a registered provider must allow and facilitate access by an individual.

A number of these requirements are existing in the aged care system but were previously required to be included in a service agreement. As many of the items do not require agreement, it is more appropriate that they are included under section 155 of the Act.

Section 155-5 – Kind of information to be provided and explained

Section 155-5 outlines that, for the purposes of subsection 155(1) of the Act, this Division prescribes requirements for the provision and explanation of the following kinds of information:

- Statement of Rights;
- information to assist individuals to choose funded aged care services that best meet their needs;
- clear and understandable invoices;
- information about a registered provider's management and use of refundable deposits;
- information for prospective individuals;
- monthly statements;
- individualised budget;
- general information for individuals accessing any funded aged care services;
- general information for individuals accessing funded aged care services in a home or community setting;
- general information for individuals accessing funded aged care services in an approved residential care home;
- information about the financial position of a registered provider in a provider registration category other than residential care; and
- pricing information.

Section 155-15 – Information to be provided and explained—Statement of Rights

Section 155-15 provides, for the purposes of subsection 155(1) of the Act, requirements for registered providers registered in any provider registration categories to provide and explain the Statement of Rights to individuals accessing or seeking to access funded aged care services.

This section is based on sections 11, 20 and 23AE of the *User Rights Principles 2014*. While retaining the requirement for a registered provider to provide an individual accessing or seeking to access funded aged care services with a copy of the Statement of Rights, the specific requirements relating to how the copy must be provided to the individual (such as being signed by a staff member, setting out the full name of the individual and giving the individual an opportunity to sign the copy) have been removed to reduce administrative burden and allow for flexibility in how the registered provider may comply. The registered provider is still required to demonstrate compliance with the requirement by retaining records relating to its provision of the copy.

Subsection (1) provides that a registered provider must provide an individual accessing or seeking to access funded aged care services the following:

- information about the individual's rights under the Statement of Rights set out in section 23 of the Act, in relation to the funded aged care services the individual accesses;
- a copy of the Statement of Rights set out in section 23 of the Act.

The note under subsection (1) outlines that the registered provider must retain records relating to the Statement of Rights given under paragraph (1)(b) (see section 154 of these rules).

Subsection (2) provides that a registered provider must assist the individual to understand the information and the Statement of Rights given under subsection (1).

Subsection (3) provides that a registered provider must comply with subsections (1) and (2) before, or when, the registered provider commences delivery of funded aged care services to that individual.

Section 155-20 – Information to be provided—information to assist individuals to choose funded aged care services that best meet their needs

Section 155-20 provides requirements for registered providers registered in a provider registration category other than residential care to assist individuals to choose funded aged care services that best meet their needs.

Subsection (1) provides that this section applies to a registered provider registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Subsection (2) provides that a registered provider must provide such information as is reasonably necessary to assist an individual to choose the funded aged care services that best meet the individual's goals and assessed needs and preferences within the limits of the resources available.

Section 155-25 – Information to be provided—clear and understandable invoices

Section 155-25 provides that a registered provider must provide an individual with invoices that are clear and in a format that is understandable.

This section applies to a registered provider registered in any provider registration category.

This section is not intended to provide any requirements as to if or when a registered provider is to provide an individual with an invoice. Its scope is limited to ensuring that, where an invoice is provided, it must be clear and in a format that is understandable.

Section 155-30 – Information to be provided—information about a registered provider's management and use of refundable deposits

Section 155-30 provides that certain registered providers registered in the provider registration category residential care are required to provide information about their management and use of refundable deposits. This information provides greater transparency

about the operations of the provider for individuals who are accessing funded aged care services.

Subsection (1) provides that this section applies to a registered provider if the registered provider is prescribed under section 150A of these rules.

Notification by registered provider

Subsection (2) provides that, within 7 days after an accommodation agreement is entered into between a registered provider and an individual, the registered provider must notify the individual, in writing, that the registered provider will give the individual, within 7 days of a request by the individual, the following information and documents:

- a summary of the permitted uses for which refundable deposits and accommodation bonds have been used by the registered provider during the previous financial year;
- if, during the 2 years prior to the request, the registered provider has given the System Governor an aged care financial report for the registered provider that included a permitted uses reconciliation—a copy of that permitted uses reconciliation included in the most recent such report;
- information about whether the registered provider has, during the previous financial year, complied with section 310 of the Act and the Financial and Prudential Standards;
- information about the number (if any) of refundable deposit balances or accommodation bond balances that, in the previous financial year, were not refunded in accordance with section 311 of the Act or section 287-102 of these rules, and the number (if any) of entry contribution balances that, in the previous financial year, were not refunded in accordance with a formal agreement;
- if the registered provider is required to implement and maintain a written investment management strategy under the Financial and Prudential Standards—the registered provider's investment objectives as recorded in the registered provider's investment management strategy;
- a copy of the audit opinion referred to in paragraph 166-380(g) of these rules for the previous financial year;
- a copy of either the most recent statement of the audited accounts in relation to the registered provider, or—if the registered provider is operated as part of a broader organisation—the most recent statement of the audited accounts of the organisation's aged care component;
- a copy of the refundable deposit record that relates to the individual, as at the time of the request.

Subsection (3) provides that a registered provider that is not required to prepare annual financial reports under Part 2M.3 of Chapter 2M of the *Corporations Act 2001* is not required to comply with paragraph (2)(g) of this section.

Disclosure of refundable deposit register entry relating to an individual

Subsection (4) provides that, a copy of the refundable deposit register entry that relates to the individual, must be provided to the individual or another person in the following circumstances:

- when the individual ceases to access funded aged care services through the registered provider's approved residential care home, the record must be provided to the individual, or if the individual has died, the individual's legal representative or estate;
- when the individual moves to another approved residential care home of another approved provider, the record must be provided to the individual.

Disclosure on request

Subsection (5) provides that if an individual requests the registered provider of an approved residential care home in which the individual is accessing funded aged care services to give the individual the information and documents referred to in subsections (2) and (4), the registered provider must give the individual the information and documents requested within 7 days after receiving the request.

Subsection (6) provides that subsection (5) applies in relation to an individual who is accessing funded aged care services through an approved residential care home:

- whether or not the individual entered into an accommodation agreement with the registered provider of the approved residential care home; and
- whether or not the individual has paid a refundable deposit; an accommodation bond or an entry contribution to that registered provider.

Subsection (7) provides that, if, as a result of a request by an individual, a registered provider is required under subsection (5) to give the individual the summary referred to in paragraph (2)(a), and the registered provider has given the System Governor an aged care financial report for the registered provider for the previous financial year, and that report included a permitted uses reconciliation, then the registered provider may satisfy the requirement to give the individual the summary by giving the individual a copy of that permitted uses reconciliation.

Disclosure after end of financial year for registered provider

Subsection (8) provides that, within 4 months after the end of each financial year for a registered provider, the registered provider must give each individual who has paid a refundable deposit, an accommodation bond or an entry contribution to the registered provider for entry to the approved residential care home operated by the registered provider:

- a copy of the refundable deposit record that relates to the individual as at the end of the financial year; and
- a written statement that the registered provider will provide, within 7 days of a request by the individual, the information and documents referred to in subsection (2).

Section 155-35 – Information to be provided—to prospective individuals

Section 155-35 provides that certain registered providers registered in the provider registration category residential care are required to provide information to prospective individuals about their management and use of refundable deposits.

Residential care providers with refundable deposits and accommodation bonds carry responsibility and bear the associated risk of residents' money (through refundable deposits and accommodation bonds). It is pertinent that individuals can access information about how their money is being used and how it relates to their care.

Subsection (1) provides that this section applies to a registered provider if the registered provider is prescribed under section 150A-3 of these rules.

Prospective residents have the right to know they can have timely access to information about the financial prudence of a provider.

Subsection (2) provides that, within 7 days of a request from a prospective individual, a registered provider must give the prospective individual the information and documents referred to in paragraphs 155-30(2)(a) to (g).

Section 155-36 – Information to be provided—statement of audited accounts

Section 155-36 provides requirements for certain registered providers registered in the provider registration category residential care to provide a statement of audited accounts to provide more transparency over their operations.

The purpose of this section is to ensure that residential care providers that do not hold refundable deposits or accommodation bonds are still required to produce audited evidence of financial prudence, providing a level of transparency to an individual.

Some providers may not prepare annual financial reports or general purpose financial reports, and remain exempt from the requirements of this section.

Subsection (1) provides that, if section 155-30 of these rules does not apply to the registered provider that is registered in the provider registration category residential care, the provider must, if asked by an individual to whom the provider is delivering funded aged care services, give the individual, within 7 days of the request, a copy of either:

- the most recent statement of the audited accounts in relation to the registered provider; or
- if the registered provider is operated as part of a broader organisation—the most recent statement of the audited accounts of the organisation’s aged care component; or
- the most recent audited general purpose financial report prepared under Subdivision E of Division 3 of Part 2 of Chapter 5 of these rules.

Subsection (2) provides that, despite subsection (1) of this section, a registered provider is not required to comply with this requirement if the registered provider:

- is not required to prepare annual financial reports under Part 2M.3 of the Chapter 2M of the *Corporations Act 2001*; and
- is not required to prepare a general purpose financial report under section 166-345 of these rules.

Section 155-40 – Monthly statement

Section 155-40 provides requirements for certain registered providers registered in a provider registration category other than residential care to provide monthly statements. This information provides greater transparency to individuals on what services they have received and how their budget is being spent.

Subsection (1) provides that this section applies to a registered provider registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Subsection (2) provides that the requirements do not apply to the delivery of funded aged care services provided under any specialist aged care program. This means that this requirement is for registered providers delivering care to an individual under Support at Home.

Subsection (3) provides that a registered provider that has delivered funded aged care services to an individual through a service delivery branch in a calendar month must give the individual a written statement of the services delivered in that calendar month no later than the last day of the following month.

Monthly statement for an individual accessing care through the service group home support

Subsection (4) provides that, for an individual accessing support at home services, the monthly statement must contain:

- the budget for the individual for the quarter in their support at home support account, less the amount credited as provider-based subsidy;
- the budget available in the individual's support at home account at the beginning of the month;
- the remaining budget amount available in the individual's support at home account at the end of the month;
- the name and amount of the primary person-centred supplements (if any) in the individual's support at home account for the quarter;
- rollover amount of unspent funds received in respect of the quarter (if any);
- an itemised list of each service or item delivered to the individual during the month and any adjustments, variations or refunds from previous calendar months, including the service name and delivery date if relating to a service;
- rollover credits received in respect of the quarter;
- an itemised list of:
 - o each episode of services or items delivered to the individual during the calendar month; and
 - o any adjustments, variations or refunds from previous calendar months, including the service name and delivery date if relating to a service;
 - o any adjustments, variations or refunds from previous calendar months, including the service name and delivery date if relating to individual contribution amounts.
- for each service or item delivered under the classification type ongoing or the classification type short-term:
 - o the name of the service or item as described in the service list under section 8-5 of these rules; and
 - o the price or cost that the registered provider charged the individual in respect of the calendar month; and

- o the date on which the service or item was delivered in respect of the calendar month; and
 - o the contribution amount for the individual in respect of each service or item delivered in the calendar month; and
 - o the total amount of contribution paid by the individual for the calendar month; and
 - o the amount of subsidy claimed by the registered provider in respect of each service or item delivered in the calendar month; and
 - o the number of units or hours delivered in respect of the calendar month; and
 - o if the service or item was delivered by an associated provider of the registered provider, that fact;
- for each service delivered under the classification type ongoing:
 - o identify the individual contribution rate, which must be provided each time there is a change to the contribution rate arising from a new determination made under section 314 of the Act; and
 - o the corresponding amount for which the individual is responsible to contribute for delivery of that service.
- for individuals with the classification type ongoing, information relating to the total number of units or hours delivered for the service type care management delivered in the relevant calendar month;
- for individuals with the classification level SAH end of life pathway for the classification type short-term, information relating to:
 - o the total number of units or hours delivered for the service type care management; and
 - o the price and cost of the service and amount of subsidy claimed by the provider in respect of that service;
- for individuals with the classification level SAH restorative care pathway for the classification type short-term, information relating to:
 - o the total number of units or hours delivered for the service type restorative care management; and
 - o the price and cost of the service and amount of subsidy claim by the provider in respect of that service;
- for each service taken to be delivered in accordance with subsection 11A(2) of the Act:
 - o the name of the service as provided in the list referred to in subsection 8(1) of the Act; and
 - o the amount that the registered provider charged the individual for the service; and
 - o the date on which the service was taken to be delivered; and
 - o if the registered provider charged an individual contribution for the service, the individual contribution rate used to work out the individual contribution; and
 - o the amount of subsidy claimed by the registered provider for the service.

Monthly statement for an individual accessing care through the service groups assistive technology or home modifications

Subsection (5) provides that, for an individual accessing care in the service groups assistive technology and/or home modifications, the monthly statement must contain the following:

- the amount of person-centred subsidy for the individual for the account period;
- the available balance of the individual's notional assistive technology or home modifications account (if any) at the beginning of the calendar month;
- the available balance of the individual's notional assistive technology account or home modifications account at the end of the calendar month;
- the available balance of the individual's notional assistive technology account or notional home modifications account after taking into account any committed funds;
- any amount of the available balance that is no longer available to the individual due to the ceasing of the individual's notional assistive technology account or notional home modifications account in respect of the calendar month;
- the end date of the account period for the individual's notional assistive technology account or notional home modifications account in the following calendar month;
- the name and amount of primary person-centred supplements (if any) for the individual for the account period;
- any additional approved amounts as specified in the determination made under subsection 211-20(5) of these rules;
- an itemised list of:
 - assistive technology or home modification items and services (if any), including administration or coordination, delivered to the individual during the calendar month; and
 - any adjustments, variations or refunds from previous calendar months;
- for each item or service delivered:
 - the name of the item or service; and
 - the price that the registered provider charged the individual for the item or service in respect of the calendar month; and
 - the date on which the item or service was delivered in respect of the calendar month; and
 - the amount of contribution (if any) paid by the individual in respect of each item or service delivered in the calendar month; and
 - the total amount of contribution paid by the individual for the calendar month; and
 - the amount of subsidy claimed by the registered provider in respect of each service or item delivered in the calendar month; and
 - the rate and number of item units or service hours delivered in respect of the calendar month; and
 - the name of the supplier for any third-party services or items;
- any commitments to assistive technology or home modifications made during the calendar month, including those items, modifications or related services which are agreed to with the individual, but which have not yet been delivered within the calendar month;
- for each item or service committed to but not yet delivered:
 - the name and price for each item or service agreed to; and

- o the amount of contribution in respect of each item or service that remains to be paid; and
 - o the total amount of committed funds, including a breakdown of the total amount of subsidy to be claimed and the total amount of contribution to be paid;
- any assistive technology or home modification items charged through the assistive technology or home modifications account or through unspent Commonwealth portion;
- for each service taken to be delivered in accordance with subsection 11A(2) of the Act:
 - o the name of the service as provided in the service list under section 85 of these rules; and
 - o the amount that the registered provider charged the individual for the service; and
 - o the date on which service was taken to be delivered; and
 - o if the registered provider charged an individual contribution for the service, the individual contribution rate used to work out the individual contribution; and
 - o the amount of subsidy claimed by the registered provider for the service.

Unspent portions and notional home care accounts

Subsection (6) provides that, if an individual has a home care account, or the registered provider holds an unspent Commonwealth portion or an unspent individual portion for the individual, the monthly statement must contain the following:

- the available balance of the individual's notional home care account at the beginning and end of the calendar month;
- the available balance of the individual's unspent Commonwealth portion at the beginning and end of the calendar month;
- the amount of the individual's unspent individual portion at the beginning and end of the calendar month.

Monthly statement for established account types

Subsection (7) provides that, the monthly statement must only contain information regarding the notional accounts established for the individual.

Monthly statement for a period in which no services are delivered

Subsection (8) provides that if no service or item was delivered by registered provider to the individual during the calendar month, a statement must still be provided no later than the end of the following calendar month.

When statement must be given

Subsection (9) provides that a registered provider must give the statement to the individual no later than the last day of the following calendar month.

Informing the individual of, and helping the individual to understand, statement

Subsection (10) provides that a registered provider must inform the individual of and help the individual to understand the monthly statement.

Section 155-45 – Information to be given—final monthly statement

Section 155-40 provides requirements for certain registered providers registered in a provider registration category other than residential care to provide a final monthly statement. This information provides greater transparency to individuals on what services they have received and how their budget is being spent.

Subsection (1) provides that this section applies to a registered provider registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Subsection (2) provides that the requirements do not apply for the delivery of funded aged care services provided under any specialist aged care program.

Subsection (3) provides that, if a registered provider ceases to deliver funded aged care services to the individual, the registered provider must give the individual or their supporter, a final monthly statement after the final claim has been submitted for the individual.

Subsection (4) provides that the final monthly statement must be prepared in accordance with the requirements in subsection 155-40(4) or (5).

Subsection (6) provides that a registered provider must give the final monthly statement to the individual or their supporter no later than the last day of the calendar month after the last claim is made.

Section 155-50 – Information to be provided—individualised budget

Section 155-50 provides requirements for certain registered providers registered in a provider registration category other than residential care to provide an individualised budget. The individualised budget sets out the funding available to an individual and how registered providers will spend the funding to provide services for assessed needs. Registered providers are required to prepare the individualised budget in partnership with the participant. This provides older people transparency about what the individual's budget is for and how the budget works.

Subsection (1) provides that this section applies to a registered provider registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;

- nursing and transition care.

Subsection (2) provides that the requirements of this section do not apply in respect of the delivery of funded aged care services provided under any specialist aged care program.

Subsection (3) provides that a registered provider that delivers funded aged care services to an individual for a classification type for the service groups home support, assistive technology or home modifications through a service delivery branch of the registered provider must give an individual a written individualised budget.

Subsection (4) provides that the individualised budget for an individual must:

- be prepared in partnership with the individual; and
- cover a period agreed with the individual (the budget period); and
- be prepared having regard to the individual's goals and assessed needs, preferences, the resources available and the services selected by the individual; and
- set out an itemised budget for the funded aged care services to be provided to the individual, as set out in the individual's care plan; and
- if an individual contribution rate determination for the individual is in effect (that is, if means testing has been completed and Services Australia has advised a contribution rate for the individual)—the individual contribution rate for the service for the individual; and
- if an individual contribution rate determination for the individual is not in effect (that is, if means testing has not been completed and Services Australia has not advised a contribution rate for the individual)—the maximum individual contribution rate that could apply to the service for the individual (when determined for each means testing category for the individual under section 314 of the Act); and
- if known- the cost for the delivery of the service;
- if known- the amount that will be the individual contribution for the delivery of the service to the individual on the day; and
- if known- the amount of subsidy for which the provider will be eligible for the delivery of the service to the individual on the day; and
- for the service group assistive technology, specify the description and cost for products and equipment, the description and cost for product and equipment repair or maintenance, the prescription cost (if applicable), the description and cost of wraparound services, and administrative costs charged by the registered provider; and
- for the service group home modifications, specify the description and cost of supplies and services, the prescription cost (if applicable), the description and cost of wraparound services, and coordination costs charged by the registered provider; and
- if known - set out the amount of subsidy payable to the registered provider to the individual in respect of the period agreed between the individual and the registered provider.

Subsection (5) provides that a registered provider must give the individualised budget to the individual as soon as practicable after the registered provider has all the necessary information to complete it.

Subsection (6) provides that a registered provider must review and, if necessary, revise the individualised budget for the individual if:

- a change to the funded aged care services to be provided to the individual through home support, assistive technology and/or home modifications is proposed; or
- the costs of providing the funded aged care services change; or
- the contribution rate for the individual changes; or
- the individual requests the registered provider to do so.

Subsection (7) provides that, if a registered provider reviews and revises the individualised budget for an individual under subsection (6), the registered provider must give the individual a copy of the revised individualised budget:

- as soon as practicable after the registered provider has all the necessary information to complete it; or
- if the individualised budget is reviewed and revised in response to a request from the individual, within 14 days of the request being made.

Subsection (8) provides that the individual must be informed of, and helped to understand, the individualised budget for the individual.

Section 155-55 – Information to be provided—general information for individuals accessing any funded aged care services

Section 155-55 provides general provision of information requirements for registered providers registered in any provider registration category.

Subsection (1) provides that a registered provider must give an individual accessing or seeking to access funded aged care services the following:

- a copy of the document mentioned in paragraph 165-20(1)(f) of these rules, relating to giving complaints and feedback;
- an explanation of the effect of section 168 of the Act (which deals with protection of personal information);
- a copy of the Aged Care Code of Conduct.

Subsection (2) provides that a registered provider must assist the individual to understand the information given under subsection (1) of this section.

Subsection (3) provides that a registered provider must comply with subsections (1) and (2) before, or when, the registered provider commences delivery of funded aged care services to that individual.

Section 155-60 – Information to be provided—general information for individuals accessing funded aged care services in a home or community setting

Section 155-60 provides general provision of information requirements for registered providers registered in a provider registration category other than residential care. The requirements for residential care are included in section 155-65.

Subsection (1) provides that this section applies to a registered provider registered in any of the following provider registration categories:

- home and community services;

- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Subsection (2) provides that a registered provider must give an individual accessing or seeking to access funded aged care services in a home or community setting the following:

- an explanation of the effect of Division 1 of Part 5 of Chapter 4 of the Act and Division 1 of Part 2 of Chapter 10 of these rules (which deals with means testing in a home or community setting);
- information about the circumstances in which the provider may cease delivery of funded aged care services to the individual as specified in subsection 149-35(2) of these rules, including an explanation of the effect of section 149-40 (which deals with notice requirements applicable to the provider);
- an explanation of the effect of subsection 148-80(1) of these rules (which deals with the development of a care and services plan for the individual);
- information that the provider will give the individual a monthly statement in accordance with sections 155-40 and 155-45 of these rules;
- for individuals accessing funded aged care services through the service group home support, other than under a specialist aged care program, a copy of the Support at Home Service List published by the Department, as existing on 30 June 2025, before or on commencement of the delivery of services.

The note provides that the Support at Home Service List could in 2025 be viewed on the Department's website (<https://www.health.gov.au>).

Subsection (3) provides that a registered provider must assist the individual to understand the information given under subsection (2) of this section.

Subsection (4) provides that a registered provider must comply with subsections (2) and (3) before, or when, the registered provider commences delivery of funded aged care services to that individual.

Subsection (5) provides that, despite subsection (2) of this section, the requirements of paragraphs (2)(a) and (2)(d) of this section do not apply in respect of the delivery of funded aged care services provided under any specialist aged care program.

Section 155-65 – Information to be provided—general information for individuals accessing funded aged care services in an approved residential care home

Section 155-65 provides general provision of information requirements for registered providers registered in the provider registration category residential care. The requirements for the home or community setting are in section 155-60.

Subsection (1) provides that this section applies to a registered provider registered in the provider registration category residential care.

Subsection (2) provides that a registered provider must give an individual accessing or seeking to access funded aged care services in an approved residential care home the following:

- information about the circumstances in which the individual may be asked to leave the approved residential care home as specified in subsection 149-60(1) of these rules, including an explanation of the effect of section 149-65 (which deals with notice requirements applicable to the provider);
- information about any policies or protocols of the approved residential care home that are relevant to the individual.

Subsection (3) provides that a registered provider must assist the individual to understand the information given under subsection (2) of this section.

Subsection (4) provides that a registered provider must comply with subsections (2) and (3) before, or when, the registered provider commences delivery of funded aged care services to that individual.

Section 155-70 – Information to be provided—information about the financial position of a registered provider registered in a provider registration category other than residential care

Section 155-70 provides requirements for registered providers registered in a provider registration category other than residential care to provide information about their financial position.

Subsection (1) provides that this section applies to a registered provider registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Subsection (2) provides that this section does not apply to registered providers of services in the registration categories listed above, which are government entities.

Subsection (3) provides that, before or when a registered provider commences delivery of funded aged care services to an individual, the registered provider must notify the individual, in writing, that the registered provider will give the individual, within 7 days of a request by the individual, the following information and documents:

- a clear and simple presentation of the financial position of the registered provider;
- a copy of the most recent statement of the audited accounts of the service delivery branch or, if the service delivery branch is operated as part of a broader organisation, the most recent statement of the audited accounts of the organisation's aged care component (that includes the service delivery branch).

Subsection (4) provides that, if an individual requests the registered provider to give the individual the information and documents referred to in subsection (3), the registered provider must give the individual the information and documents requested within 7 days after receiving the request.

Subsection (5) provides that a registered provider that is not required to prepare annual financial reports under Part 2M.3 of Chapter 2M of the *Corporations Act 2001* is not required to comply with paragraph (3)(b) of this section.

Section 155-80 – Information to be provided—pricing information (by way of publication)

Section 155-80 provides requirements for certain registered providers registered in a provider registration category other than residential care publish pricing information on their website.

Subsection (1) provides that this section applies to a registered provider registered in any of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Service group home support

Subsection (2) provides that a registered provider delivering funded aged care services in the service group home support must publish on the registered provider's website the most common price that the registered provider charges individuals for each service in the following service types:

- allied health and therapy;
- care management;
- domestic assistance;
- home maintenance and repairs;
- home or community general respite;
- meals;
- nursing care;
- personal care;
- restorative care management;
- social support and community engagement;
- therapeutic service for independent living;
- transport.

Subsection (3) provides that the pricing information published for the purposes of subsection (2) of this section must:

- align to the unit type specified in the service list for the applicable service; and
- specify the most common price for delivery of the service during standard business hours; and
- specify the most common price for delivery of the service on weekdays outside standard business hours; and
- specify the most common price for delivery of the service on Saturdays; and
- specify the most common price for delivery of the service on Sundays; and
- specify the most common price for delivery of the service on public holidays.

Subsection (4) defines ***most common price*** as the price for a service that the registered provider has most frequently charged during the previous 2 calendar months, calculated at the end of the following:

- August;
- October;
- December;
- February;
- April;
- June.

Subsection (5) provides that a registered provider must update the pricing information on the registered provider's website for a service where the most common price for the service changes, within 30 days of the end of the calculation period mentioned in subsection (4) of this section.

Subsection (6) provides that a registered provider is not required to publish a price for a service under subsection (2) of this section if:

- the base efficient price for the service is listed as 'not applicable' in the aged care service list; or
- the registered provider is not currently delivering the service and has not delivered the service in the last 12 months.

Subsection (7) provides that the requirements of this section do not apply to a registered provider in respect of the delivery of funded aged care services under a specialist aged care program.

Service group assistive technology

Subsection (8) provides that a registered provider registered in the provider registration category assistive technology and home modifications delivering funded aged care services in the service group assistive technology must publish on the registered provider's website:

- whether the registered provider charges a provider administration fee for the provision of funded aged care services in the service group assistive technology; and
- if the registered provider charges a provider administration fee, the amount of the provider administration fee as a percentage of the price for the provision of services.

Subsection (9) provides that a registered provider must update the pricing information on its website where the information published under subsection (8) of this section changes, within 30 days of the change.

Service group home modifications

Subsection (10) provides that a registered provider registered in the provider registration category assistive technology and home modifications delivering funded aged care services in the service group home modifications must publish on the registered provider's website:

- whether the registered provider charges a provider coordination fee for the provision of funded aged care services in the service group home modifications; and

- if the registered provider charges a provider coordination fee, the amount of the provider coordination fee as a percentage of the price for the provision of services.

Subsection (11) provides that a registered provider must update the pricing information on its website where the information published under subsection (10) of this section changes, within 30 days of the change.

Section 155-85 – Requirements for allowing and facilitating access to information held about an individual

Section 155-85 provides, for the purposes of subsection 155(2) of the Act, requirements for certain registered providers to allow and facilitate access to information held about an individual.

Subsection (1) provides that a registered provider that is not any of the following is prescribed:

- an APP entity within the meaning of the Privacy Act;
- a State or Territory;
- body established for a public purpose by or under a law of the State or Territory (other than a local government authority).

Subsection (2) provides that it is a requirement when a registered provider is allowing and facilitating access, by an individual to whom the registered provider delivers funded aged care services, to records and information (including personal information) held by the registered provider about the individual, that the registered provider must comply with Australian Privacy Principle 12 as set out in Schedule 1 of the Privacy Act, as if it were an organisation for the purposes of the Privacy Act.

The note under subsection (2) outlines that a registered provider that is an APP entity remains subject to the Privacy Act, including APP 12.

Division 3 – Access by supporters etc.

Section 156-5 – Access to individuals

Section 156-5 prescribes the access requirements that apply to all registered providers under subsection 156(1) of the Act. This section affirms the right of individuals receiving funded aged care services to maintain meaningful connections and access to support persons, legal advisors, advocates, and volunteer visitors.

Subsection 156-5(2) provides that it is a requirement that a registered provider must allow and facilitate access by a supporter of an individual receiving funded aged care services, where it is requested to or consented to by the individual. The note provides subsection 156(4) of the Act as guidance for access requirements that only apply in relation to times during which those services are being delivered.

Subsection 156-5(3) outlines that it is a requirement that a registered provider must allow and facilitate access to an individual receiving funded aged care services by a relevantly qualified person providing legal advice or another legal service to the individual at any time requested, or consented to, by the individual. Access must be provided in the manner requested by the individual, whether physically, by visual link, or through other reasonable means.

Subsection 156-5(4) provides that it is a requirement that a registered provider must allow and facilitate access at any time by an independent aged care advocate to an individual who is receiving funded aged care services from the provider. It is the policy intent that this subsection will remove barriers where a registered provider is refusing to facilitate access in both residential and home care settings. An ongoing barrier for independent aged care advocates seeking to engage with individuals in aged care services is registered providers refusing to allow access, particularly for the provision of education. This includes limiting the hours of access to exclude out of hours periods, weekends and disproportionate clinical restrictions. Access at all times negates the ability of a registered provider being able to refuse access citing restrictions.

Individuals may request or consent to the access of the independent aged care advocate at any time. However, where the person is unable to request or consent to the access, the independent aged care advocate may access the individual at any time.

This section is intended to capture individuals with cognitive impairment who are unable to request or consent to engaging with an independent aged care advocate for the purposes of assisting with upholding their rights. Individuals with cognitive impairment are vulnerable and it is critical there are mechanisms in place to safeguard their wellbeing. The importance of this is amplified in situations where there is suspected elder abuse or where a substitute decision maker is not acting in the best interests of the individual and is intentionally blocking access to an independent aged care advocate. The policy intent is to ensure that persons who are unable to request or consent are able to engage with an independent aged care advocate so that they can be made aware of their rights and supported to address the situation. The note clarifies that access in home or community settings is limited to times when services are being delivered.

Subsection (5) outlines that it is a requirement that a registered provider must allow and facilitate access by an aged care volunteer visitor to an individual receiving funded aged care services, where it is at any time requested or consented to by the individual. This access must be provided in the manner requested by the individual and at any time the individual requests or consents to it. This supports the individual's social engagement and wellbeing through volunteer visitation. The note clarifies that access in home or community settings is limited to times when services are being delivered.

Section 156-10 – Access to settings

Section 156-10 sets out the access requirements that apply to registered providers in relation to the settings in which aged care services are delivered.

Paragraph 156-10(1)(a) confirms that every kind of registered provider is prescribed for the purposes of subsection 156(2) of the Act.

Paragraph 156-10(1)(b) establishes that where a registered provider delivers funded aged care services to an individual in a setting, and the individual requests or consents to access by an independent aged care advocate for the purpose of receiving information and education, the provider must allow and facilitate that access.

Subsection 156-10(2) provides clarification on the types of settings to which the access requirements apply. Without limiting the scope of paragraph (1)(b), it confirms that a setting may include a residential care home, as well as a home or community setting.

It is the policy intent that the purpose of enabling access to settings, is to in turn enable, for instance presentations by advocates to groups of persons i.e. in a residential aged care home.

Part 8 – Governance

Division 1 – Membership of governing bodies

Section 157-5 – Kinds of provider to which the independent non-executive members requirement applies

Section 157-5 prescribes the kinds of registered providers to which the requirement for a majority of governing body members to be independent non-executive members applies.

Subsection 157-5(1) confirms that providers delivering nursing and transition care, and residential care must comply with subsection 157(2)(a) of the Act as a condition of registration. Such providers must ensure that a majority of the members of the governing body of the provider are independent non-executive members. An independent non-executive member is a member who is not a part of the executive team and not part of the day-to-day operations of the provider outside of their position on the governing body. As an independent member their only interest in, or relationship with, the provider stems from their role as a member of the governing body.

Subsection 157-5(2) outlines exceptions to the requirement. A registered provider is not subject to the requirement if it is:

- an Aboriginal Community Controlled Organisation
- a body that is registered under the Co-Operatives National Law or the Co-operatives Act 2009 (WA) as a co-operative and has sections in its rules to the effect that:
 - an objective or primary activity of the registered provider is delivering quality funded aged care services in accordance with the Quality Standards; and
 - distribution of assets to members upon winding-up are limited to the nominal value of the member's contribution to the co-operative, provided that such a limitation complies with the legislation under which the co-operative is registered.

Section 157-10 – Kinds of provider to which the clinical care provision experience requirement applies

Section 157-10 prescribes the kinds of registered providers to which the clinical care provision experience requirement under paragraph 157(2)(b) of the Act applies. Such providers must ensure that at least one member of the governing body has experience in the provision of clinical care.

Paragraph 157-10(a) confirms that the requirement applies to providers registered under the following provider registration categories:

- nursing and transition care; and
- residential care

Paragraph 157-10(b) excludes providers that are Aboriginal Community Controlled Organisations from this requirement, recognising the distinct governance structures and cultural frameworks within which these organisations operate.

Section 157-15 – Kinds of providers to which other governing body requirements apply

Section 157-15 prescribes additional governance training requirements for certain registered providers, as referenced in subsection 157(5) of the Act. Such providers must ensure that the members of the provider's governing body undertake training on governance focused on co-operatives or includes course material on co-operatives within 6 months of the member's appointment as a member of the governing body.

This requirement has been included in the rules in response to the general exemption provided to registered co-operatives under section 157-5, allowing them to form governing bodies on which a majority of members are not independent non-executive members. Acknowledging that the nature of co-operatives means that most governing body members are not independent, mandatory training is to be undertaken to ensure that their governance continues to be based on best principles for the governance of a co-operative.

Section 157-20 – Application for determination that certain conditions do not apply—other matters that the Commissioner may take into account

Section 157-20 sets out requirements for the purpose of subsection 159(4)(h) of the Act, which relates to the Commissioner making a determination that certain conditions relating to the governing body of a registered provider do not apply.

Section 157-20 clarifies that in deciding whether to make the determination in relation to the registered provider, the Commissioner may take into account the following matters:

- the registered provider's history of compliance with the governance conditions set out in paragraph 157(2)(a) and 157(2)(b) of the Act
- any circumstances surrounding the registered provider's history of non-compliance with the governance conditions set out in paragraph 157(2)(a) and 157(2)(b) of the Act, including steps (if any) that the provider has taken to become compliant
- any other matter the Commissioner considers relevant.

The note under this section provides examples of circumstances for the purposes of paragraph (b), including where a member has unexpectedly resigned, and recruitment of a new member is ongoing, which renders a provider non-complaint. Similarly, another example provided includes where a person has accepted a role as member, but is yet to commence.

Division 2—Advisory body requirements

Section 158-5 – Kinds of provider to which the quality care advisory body condition applies

Section 158-5 prescribes the kinds of provider which must comply with subsection 158(2) of the Act. Providers delivering nursing and transition care, and residential care must establish and continue a quality care advisory body as a condition of registration.

Section 158-10 Requirements for membership of quality care advisory body

Section 158-10 sets out the prescribed requirements for the composition of a registered provider's quality care advisory body, as referenced in subparagraph 158(2)(a)(i) of the Act. This section ensures that the advisory body includes members with relevant experience and perspectives to support the delivery of high-quality aged care services.

Paragraph 158-10(a) requires that the advisory body must include a responsible person of the registered provider who has appropriate experience in the delivery of funded aged care services. The term ‘appropriate experience’ is intended to refer to hands-on experience in the delivery of funded aged care services involving actual contact with and care for individuals accessing aged care services. It does not include experience consisting solely of administrative roles connected to the delivery of funded aged care services.

Paragraph 158-10(b) applies specifically to providers registered in the residential care category. It requires that the advisory body include a person who is directly involved in the provider’s delivery of funded aged care services.

Paragraph 158-10(c) applies to providers registered in the nursing and transition care category who deliver services classified as nursing care. It requires that the advisory body include a person directly involved in the delivery of those services.

Paragraph 158-10(d) requires that the advisory body include a person who represents the interests of individuals to whom the provider delivers funded aged care services. The note under this paragraph provides examples of such persons, including an individual currently receiving services from the provider, a member of a consumer advisory body (if established), or a member of an organised consumer advisory service.

Section 158-15 – Requirements for reports of quality care advisory body

Section 158-15 sets out the requirements for a written report given by the quality care advisory body to the governing body for the purposes of subsection 158(2)(a)(ii) of the Act. The report must include any concerns that the body has about the quality of funded aged care services delivered in the reporting period, taking into account the following:

- feedback provided about the quality of funded aged care services delivered by the provider in the report period
- complaints received and the action taken to address the complaints in the report period relating to the quality of funded aged care services
- the use of regulatory mechanisms (if any) under Chapter 6 of the Act by the Commissioner in relation to the quality of funded aged care services
- progress made in the report period in relation to the providers continuous improvement plan
- the results of any audits performed by the Commissioner under section 110-38 of the Rules
- staffing arrangements of the provider during the report period, including the availability of allied health professionals, registered nurses and the turnover of aged care workers
- reportable incidents in connection with the delivery of funded aged care services that occurred in the report period and any action taken by the provider in response.

Per paragraph 158-15(h) where the provider delivers funded aged care services in an approved residential aged care home, the report must also take into account the following:

- feedback received in the report period from individuals relating to the quality of food;
- changes in the report period in the quality of food provided and the food preparation model used by the provider;
- menu assessments conducted by an accredited practising dietitian in the report period in relation to food and nutrition provided by the provider;

- information compiled or derived from a measurement or other assessment made by the provider in the report period in relation to the Quality Indicators in Subdivision B of Division 3 of Part 2 of Chapter 5 of the Rules.

Section 158-20 – Kinds of provider to which the consumer advisory bodies condition applies

Section 158-20 confirms that the condition of registration under subsection 158(4) of the Act applies to providers registered in the provider registration categories of nursing and transition care and residential care. For providers registered in the nursing and transition care category, the condition will extend to any care delivered under that category in a home and community setting. Subsection 158(4) of the Act provides that it is a condition of registration that registered providers must offer individuals and their supporters the opportunity to establish consumer advisory bodies.

Part 9 – Restrictive practices—approved residential care homes

Division 1 – Preliminary

Section 162-5 – Kinds of provider to which the condition applies

Section 162-5 prescribes that for the purposes of section 162 of the Act, the kinds of provider which must comply with the condition relating to restrictive practices is a registered provider registered in the provider registration category residential care. It is intended that restrictive practices will not be used by registered providers outside of this registration category, though the use of restrictive practices outside of residential care may be permitted where there is otherwise compliance with section 16-15 of these Rules.

Section 162-10 – Requirements relating to the use of restrictive practices

Section 162-10 outlines that for the purpose of section 162 of the Act, Part 9 of the rules prescribes requirements relating to the use of restrictive practices in relation to an individual to whom a registered provider is delivering funded aged care services in an approved residential care home.

The note following section 162-10 refers back to sections 17 and 18 of the Act, which set out what a restrictive practice is in relation to an individual accessing funded aged care services, and the matters that these rules must require relating to the use of restrictive practices for the purposes of section 162 of the Act, in relation to an individual to whom a registered provider is delivering funded aged care service.

Division 2 – Requirements relating to the use of restrictive practices

Section 162-15 – Requirements for the use of any restrictive practice

Subsection 162-15(1) provides that the following requirements apply to the use of any restrictive practice in relation to an individual:

- the restrictive practice is used only:
 - as a last resort to prevent harm to the individual or other persons; and
 - after consideration of the likely impact of the use of the restrictive practice on the individual;

- to the extent possible, best practice alternative strategies have been used before the restrictive practice is used;
- the alternative strategies that have been considered or used have been documented;
- the restrictive practice is used only to the extent that it is necessary and in proportion to the risk of harm to the individual or other persons;
- the restrictive practice is used in the least restrictive form, and for the shortest time, necessary to prevent harm to the individual or other persons;
- informed consent to the use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), has been given by the individual, or if the individual lacks capacity to give that consent, their restrictive practice substitute decision-maker; the use of the restrictive practice is in accordance with the informed consent mentioned above;
- the use of the restrictive practice complies with any provisions of the behaviour support plan for the individual that relate to the use of the restrictive practice;
- the use of the restrictive practice complies with the Aged Care Quality Standards and the Aged Care Code of Conduct;
- the use of the restrictive practice is not inconsistent with the Statement of Rights;
- the use of the restrictive practice meets the requirements (if any) of the law of the State or Territory in which the restrictive practice is used.

These requirements will ensure that restrictive practices are only used as a necessary and proportionate response to the circumstances of a particular individual, and ensures the rights of individuals are given primary consideration and protection.

Where a restrictive practice is used, the registered provider must ensure it uses the least restrictive form of restraint to address the risk of harm. To use the least restrictive form of restraint, the registered provider must have regard to the total period for which restraint will be used, including periods of release. This should be determined before the restraint is commenced.

The registered provider must also ensure that the identified risk of harm constitutes a real risk to the individual or others, taking into account the specific characteristics of all persons affected or likely to be affected. Restrictive practices should not be used merely to minimise the discomfort of other individuals.

The registered provider must also consider whether the risk of harm can be managed by using any alternatives to the restrictive practice and use those alternatives to the extent possible. It is intended that the registered provider assess and manage any changed behaviour of an individual and identify and implement strategies to address those behaviours before restrictive practices are considered and used. The registered provider should also, wherever possible, proactively examine the triggers of behaviours to address the causes of these behaviours. The use of restraint must always be the last resort and used only as a temporary solution following the application of alternative behaviour supports.

There are limited situations where it may be appropriate to use restrictive practices to ensure the safety of individuals and others, including in emergencies. This is a safety measure of last resort where all other interventions have been employed and excluded. Restrictive practices must only be used in a way that supports good clinical practice and provides safe and improved care for individuals.

Informed consent requirements

Any decision to restrain an individual carries significant ethical and legal responsibilities. Individuals must provide informed consent to the use of a restrictive practice wherever possible. This requires that consent to the use of the restrictive practice be appropriately specific and based on open and honest disclosure from the provider regarding the basis on which the restrictive practice will be used. This is an important safeguard to protect the health and well-being of individuals. If an individual does not have capacity to consent, consent must be obtained from someone with authority to provide it, in this case, the individual's restrictive practices substitute decision-maker (see section 6-20 above).

The individual or their restrictive practice substitute decision-maker may withdraw their consent at any time. Therefore, the registered provider should take steps to regularly communicate with the individual or their substitute decision-maker, and obtain informed consent contemporaneously, whether or not there is any change to the restrictive practice.

The individual should be supported or assisted to make their own decisions wherever possible. This includes communicating with them in a way they can understand, and they should be given the opportunity to discuss their concerns and expectations. The communication is enhanced if restrictive practices substitute decision-makers and the individual's family are given written information that they can keep and review at any time. Consent obtained via any form of coercion or duress is not informed consent.

Informed consent must be obtained before the restrictive practice is used, unless the restrictive practice is necessary in an emergency (see section 162-15(2)). If the use of a restrictive practice was used in an emergency and the individual lacked capacity to consent to the use of the restrictive practice, the restrictive practice substitute decision-maker must be informed as soon as practicable after the restrictive practice starts to be used (see paragraph 162-35(a)). To remove any doubt, it is not intended that an 'emergency' would exist merely due to a lack of informed consent being given to the use of a restrictive practice.

State and territory legislation in some jurisdictions regulates who can give informed consent to the prescribing of medication for the purposes of chemical restraint on behalf of an individual who cannot consent because they lack capacity. State and territory legislation in these jurisdictions also regulates who can give informed consent to the use of restrictive practices other than chemical restraint on behalf of an individual who lacks capacity to provide consent. These provisions do not affect the operation of those state and territory laws, which protect individuals from undue interference with their personal rights and liberties in relation to the use of restrictive practices.

The State and Territory legislation is not incorporated by reference. The relevant legislation, at the time of making the rules, for each state and territory is set out in Table 1. This table also provides details of relevant organisations who may be able to provide additional information.

Table 1 – State and Territory legislation

State	Legislation	Relevant organisations
ACT	<i>Guardianship and Management of Property Act 1991</i> <i>Medical Treatment (Health Directions) Act 2006</i> <i>Public Trustee and Guardian Act 1985</i> <i>Powers of Attorney Act 2006</i>	Public Trustee and Guardian (ACT) ACT Civil and Administrative Tribunal (ACAT) Public Advocate – ACT Human Rights Commission
NSW	<i>Guardianship Act 1987</i> <i>Guardianship Regulation 2016</i> <i>Powers of Attorney Act 2003</i>	Public Guardian (NSW) NSW Civil and Administrative Tribunal NSW Trustee and Guardian
NT	<i>Guardianship of Adults Act 2016</i> <i>Guardianship of Adults Regulations 2016</i> <i>Northern Territory Civil and Administrative Tribunal Act 2014</i> <i>Advance Personal Planning Act 2013</i>	Northern Territory Civil and Administrative Tribunal Office of the Public Guardian (NT)
QLD	<i>Guardianship and Administration Act 2000</i> <i>Public Guardian Act 2014</i> <i>Human Rights Act 2019</i> <i>Powers of Attorney Act 1998</i>	Office of the Public Guardian (QLD) Public Advocate (QLD) Queensland Civil and Administrative Tribunal
SA	<i>Consent to Medical Treatment and Palliative Care Act 1995</i> <i>Consent to Medical Treatment and Palliative Care Regulations 2014</i> <i>Advanced Care Directives Act 2013</i> <i>Guardianship and Administration Act 1993</i> <i>Guardianship and Administration Regulations 2015</i>	Office of the Public Advocate South Australian Civil and Administrative Tribunal

State	Legislation	Relevant organisations
TAS	<i>Guardianship and Administration Act 1995</i> <i>Guardianship and Administration Regulations 2017</i> <i>Guardianship and Administration (Corresponding Law) Notice 2014</i> <i>Guardianship and Administration (Corresponding Laws) Notice 2022</i>	Office of the Public Guardian (TAS) Guardianship and Administration Board
VIC	<i>Guardianship and Administration Act 2019</i> <i>Medical Treatment Planning and Decisions Act 2016</i>	Office of the Public Advocate (VIC) Victorian Civil and Administrative Tribunal
WA	<i>Guardianship and Administration Act 1990</i> <i>Guardianship and Administration Regulations 2005</i>	State Administrative Tribunal Office of the Public Advocate (WA)

Emergency use of restrictive practices

Subsection 162-15(2) sets out that selected requirements do not apply to the use of the restrictive practice if the use of the restrictive practice in relation to an individual is necessary in an emergency. See below for guidance on identifying when a situation may constitute an emergency.

The exemption of these requirements is intended to ensure a registered provider can appropriately and rapidly respond to an emergency to protect an individual or other person from immediate harm. While the restrictive practice is being used, the registered provider must monitor and review the necessity for the continued use of the restrictive practice (see section 162-30 below).

Subsection 162-15(3) specifies that the exemption of these requirements only applies while the emergency exists.

An emergency situation is not expected to last for an extended period of time. An emergency situation will be considered to have ended when there is no immediate risk of harm or injury for the individual or others. If a restrictive practice is required to be continued after the emergency situation has ended, registered providers will be required to comply with all legislative requirements relating to the use of restrictive practices, including obtaining informed consent for ongoing use of a restrictive practice.

It is expected that registered providers will be actively engaged in an individual's behaviour support planning and that this will reduce any occurrence of emergency use of restrictive practices. This should include consideration of any escalation points for any changed behaviours and how best to manage these behaviours to prevent an emergency in the care planning for individuals.

The note following subsection 162-15(3) provides that section 162-35 sets out other responsibilities of registered providers that apply if the use of a restrictive practice in relation to an individual is necessary in an emergency (see below for further detail). The requirements outlined in section 162-35 ensure that registered providers are not absolved from complying with their legislative obligations in relation to the use of restrictive practices, including in an emergency.

Identifying an emergency

The reference to ‘emergency’ in subsection 162-15(2) is not defined and therefore is intended to have its ordinary meaning. An emergency may include an unforeseen occurrence, or sudden or urgent occasion for action. In aged care, the scope of emergency situations can be quite broad and adopting a prescriptive definition is likely to result in unintended consequences and may exclude situations of genuine emergency. Situations where restrictive practices are required in residential aged care in the event of an emergency should be following unanticipated or unforeseen events which requires immediate action and therefore should be rare. It is expected that registered providers will only rely on subsection 162-15(2) to use restrictive practices where it is immediately necessary to take action to prevent harm. As noted above, an emergency will not occur merely because informed consent to the use of a restrictive practice is not provided under paragraph 162-15(1)(f).

Oversight of emergency use of restrictive practices

The arrangements under subsection 162-15(2) are intended to ensure that a registered provider can appropriately and rapidly respond to an emergency to ensure the protection of an individual or other person from immediate harm. Once the emergency is over, the registered provider should revert to the usual policies and procedures regarding the application or use of any restrictive practice for the individual. This includes reduction or removal of the restrictive practice, assessment, consideration and use of alternative strategies, seeking of informed consent to any ongoing use, and subsequent update and review of the individual’s behaviour support plan and broader care and services plan.

It is expected that registered providers will be actively engaged in an individual’s day to day care and support needs, including behaviour support planning, and that this understanding and engagement will reduce the occurrence of emergencies. While the term ‘emergency’ is not specifically intended as a discretionary term, the Commissioner, in monitoring compliance with provider conditions relating to the use of restrictive practices, will be reviewing care and services plans where emergency use of restrictive practices has been applied.

This review will include considering the individual’s care needs in the lead up to the emergency, whether the emergency could have been anticipated given past history of behaviour, and what action was taken to deal with the situation prior to it becoming critical. Registered providers should be conscious of alternative strategies to avoid the need for emergency use of restrictive practices. This includes actively responding to the needs of individuals under their care in order to avoid the deterioration of health or escalation of changed behaviours, to a point where emergency use of restrictive practices may be required.

If the provider considers that emergencies are occurring for extended periods of time or are occurring regularly for one or more individuals in their care, this may also indicate that a

registered provider is not meeting their obligations, and the Commissioner would monitor or investigate these circumstances. Where there is evidence that insufficient action has been taken by a provider to avoid emergency use of restrictive practices for an individual, the Commissioner, or delegate, may take further regulatory actions where it is deemed appropriate and proportionate in order to address any non-compliance.

Section 162-20 – Additional requirements for the use of restrictive practices other than chemical restraint

Section 162-20 relates to additional requirements regarding the use of restrictive practices other than chemical restraint, including environmental restraint, mechanical restraint, physical restraint and seclusion.

Subsection 162-20(1) sets out the requirements that apply to the use of a restrictive practice in relation to an individual that is not chemical restraint. These requirements are that:

- an approved health practitioner (that is, a medical practitioner, nurse practitioner or registered nurse as defined in section 5 of the rules) who has day-to-day knowledge of the individual has assessed the individual as posing a risk of harm to the individual or any other person and has assessed that the use of the restrictive practice is necessary;
- the approved health practitioner's assessment has been documented.

Paragraph 162-20(1)(b) states that an individual's behaviour support plan is to document the assessments, and a description of any engagement with persons other than the approved health practitioner (including external support services) in relation to the assessments.

The intent of subsection 162-20(1) is to ensure that a health practitioner that is familiar with the individual's care needs assesses whether the use of a particular restrictive practice is necessary. Day to day knowledge of the individual is expected to support better understanding of the individual and their behaviour, as well as warning signs or triggers and how these can be addressed through the use of alternative behaviour supports in the first instance. Although only assessment by a health practitioner is mandated by the rules, it is best practice for behaviour support plans to be developed with input from other professionals, and staff engaged by the provider with day to day knowledge of the individual. This may include professionals such as occupational therapists, social workers and psychologists.

Emergency use of restrictive practices

Subsection 162-20(2) sets out that the requirement to document the assessment by the approved health practitioner does not apply to the use of a restrictive practice that is not a chemical restraint in relation to an individual, if the use of the restrictive practice is necessary in an emergency. This exemption is intended to ensure a registered provider can appropriately and rapidly respond to an emergency to ensure the protection of an individual or other person from immediate harm.

As stated in subsection 162-20(3), this exemption only applies while the emergency exists. The registered provider must document the assessment that the use of the restrictive practice was necessary after the emergency situation has passed. This must be completed as soon as practicable after the restrictive practice starts to be used (see section 162-35 below).

The note following subsection 162-20(3) identifies that section 162-35 sets out other responsibilities of registered providers that apply if the use of a restrictive practice in relation

to an individual is necessary in an emergency. The requirements outlined in section 162-35 ensure that registered providers are not absolved from complying with their legislative obligations in relation to the use of restrictive practices, including in an emergency.

Registered providers should be actively engaged in an individual's behaviour support planning to reduce the risk and occurrence of emergencies occurring. Registered providers are to consider escalation points for changed behaviours and how best to manage these behaviours to prevent an emergency in the care planning for individuals.

Section 162-25 – Additional requirements for the use of restrictive practices that are chemical restraint

The additional requirements introduced by section 162-25 only apply to the use of chemical restraint.

Subsection 162-25(1) sets out the requirements that apply to the use of a restrictive practice in relation to an individual that is chemical restraint. These requirements are that:

- the registered provider is satisfied that a medical practitioner or nurse practitioner has:
 - assessed the individual as posing a risk of harm to themselves or other persons; and
 - assessed that the use of the chemical restraint is necessary; and
 - prescribed medication for the purpose of using the chemical restraint; and
 - obtained informed consent to the prescribing of the medication for the purpose of using the chemical restraint.
- matters, including the assessments by the medical practitioner or nurse practitioners; practitioners' decisions to use the chemical restraint; individual behaviours that are relevant to the need for the chemical restraint; the reasons the chemical restraint is necessary, and information (if any) provided by the registered provider to the medical practitioner or nurse practitioner that informed their decision to prescribe the medication for the purposes of using the chemical restraint, have been documented in the behaviour support plan for the individual;
- the registered provider is satisfied that informed consent to the prescribing of the medication has been given by the individual or, if the individual lacks capacity to give that consent, their restrictive practice substitute decision-maker;
- the behaviour support plan documents the details of the prescription for the prescribed medication, including its name, dosage and when it may be used.

Only a medical practitioner or nurse practitioner can assess whether a chemical restraint is necessary. Prescribing medical practitioners or nurse practitioners are required to document the reason they have prescribed medication for the purpose of chemical restraint, and they must have obtained informed consent from the individual or, if the individual lacks capacity, from their restrictive practice substitute decision-maker.

If medication has been prescribed as a chemical restraint, registered providers must engage with the prescribing practitioner and the individual to communicate the impact and effectiveness of the restraint and any conditions around its use (see section 162-30 described below).

The registered provider is required to satisfy themselves that the prescribing practitioner has obtained informed consent for the use of the medication as a chemical restraint.

Regulation of medical practitioners and nurse practitioners in relation to the use of chemical restraint

The note following subsection 162-25(1)(c) refers to the codes of appropriate professional practice which apply to medical practitioners and nurse practitioners. These codes of conduct are included for information but are not incorporated by reference.

Before prescribing medicines, including antipsychotics and benzodiazepines, medical practitioners and nurse practitioners are responsible for obtaining informed consent from their patients (in this case individuals accessing funded aged care services).

Both of these professions are regulated by their respective boards; the Medical Board of Australia (MBA) and the Nursing and Midwifery Board of Australia (NMBA). Their role includes setting of standards and codes to provide guidance to their professions about what is expected of their practice.

In line with the provisions of the Health Practitioner Regulation National Law, the MBA and NMBA have each published a code of conduct to set the professional expectations for their respective professions. The MBA's *Good medical practice: a code of conduct for doctors in Australia* and the NMBA's *Code of conduct for nurses* set the expectations of the MBA and NMBA for a range of topics including: communication with patients and/or their carers; gaining informed consent; and the use of scheduled medicines.

In 2025, the MBA's code could be viewed on their website <https://www.medicalboard.gov.au> and NMBA's code could be viewed on their website: <https://www.nursingmidwiferyboard.gov.au>.

Both codes of conduct require practitioners to comply with relevant legislation administered by states and territories, including medicines and poisons legislation, which governs the prescribing, dispensing and administration of scheduled medicines.

Emergency use of restrictive practices

Subsection 162-25(2) sets out the requirements that do not apply to the use of a restrictive practice that is a chemical restraint in relation to an individual if the use of the restrictive practice is necessary in an emergency. The requirements that do not apply are subsection 162-25(1)(a)(iv) and paragraph (1)(b) which relate to:

- the registered provider being satisfied that informed consent to the prescribing of the medication has been given by the individual, or if the individual lacks capacity to give that consent, their restrictive practice substitute decision-maker; and
- documenting various matters, including the assessments by the medical practitioner or nurse practitioners; practitioners' decisions to use the chemical restraint; individual's behaviour relevant to the need for the chemical restraint; the reasons the chemical restraint is necessary, and information (if any) provided to the medical or nurse practitioner that informed their decision to prescribe the medication, in the behaviour support plan.

These exclusions are intended to allow registered providers to respond in an emergency where an individual or other person may be at risk of immediate harm in that moment.

As stated in subsection 162-25(3), this exemption only applies while the emergency exists. The registered provider must document the assessment that the use of the restrictive practice was necessary after the emergency has passed. This must be completed as soon as practicable after the restrictive practice starts to be used (see section 162-35 below).

The note following subsection 162-25(3), identifies that section 162-35 sets out other responsibilities of registered providers that apply if the use of a restrictive practice in relation to an individual is necessary in an emergency. The requirements outlined in section 162-35 ensure that registered providers are not absolved from complying with their legislative obligations in relation to the use of restrictive practices, including in an emergency.

The registered provider should be actively engaged in an individual's behaviour support planning to reduce the risk and occurrence of emergency use of restrictive practices. Registered providers are to consider escalation points for changed behaviours and how best to manage these behaviours to prevent an emergency in the care planning for individuals.

Section 162-30 – Requirements while restrictive practice being used

Section 162-30 sets out the requirements registered providers must comply with while the restrictive practice is being used in relation to an individual.

If a registered provider uses a restrictive practice in relation to an individual, the registered provider must ensure that, while the restrictive practice is being used:

- the individual is monitored for:
 - signs of distress or harm, side effects and adverse events, changes in mood or behaviour, changes in wellbeing (including the individual's ability to engage in activities that enhance the quality of life and are meaningful and pleasurable), changes in the individual's ability to maintain independent function, and changes in the individual's ability to engage in activities of daily living; and
- the necessity for the use of the restrictive practice is regularly monitored, reviewed and documented; and
- the effectiveness of the use and the effect of the changes in use of the restrictive practice are monitored; and
- to the extent possible that changes are made to the individual's environment to reduce or remove the need for the use of the restrictive practice; and
- if the restraint is a chemical restraint, that information about the effects and use of the chemical restraint is provided to the medical practitioner or nurse practitioner who prescribed the medication for the purpose of using the chemical restraint (see paragraph 162-25(1)(a)).

This section seeks to provide clarity on how individuals should be monitored while a restrictive practice is being used, including what matters should be monitored. This ensures changes and modifications to the application of a restrictive practice are responsive and the restrictive practice is applied in the least restrictive form, used for the shortest period of time possible and that the safety of individuals is maintained while the practice or intervention is in use.

Section 162-35 – Requirements following emergency use of restrictive practice

Section 162-35 sets out the requirements registered providers must comply with following the use of a restrictive practice if that restrictive practice was used in an emergency.

If a registered provider uses a restrictive practice in relation to an individual and the use of the restrictive practice in relation to the individual is necessary in an emergency, the registered provider must, as soon as practicable after the restrictive practice starts to be used:

- if the individual lacked capacity to consent to the use of the restrictive practice, inform the restrictive practices substitute decision-maker for the restrictive practice about the use of the restrictive practice; and ensure that the following matters are documented in the behaviour support plan for the individual:
 - the individual's behaviours that were relevant to the need for the use of the restrictive practice;
 - the alternative strategies that were considered or used (if any) before the use of the restrictive practice;
 - the reasons the use of the restrictive practice was necessary;
 - the care to be provided to the individual in relation to the individual's behaviour;
 - a record of the restrictive practices substitute decision-maker being informed about the use of the restrictive practice (assuming restrictive practices substitute decision-maker for the restrictive practice was informed about the use of the restrictive practice); and
- if the restrictive practice is not a chemical restraint, ensuring the assessments mentioned in paragraph 162-20(1)(a) from an approved health practitioner are documented; and
- if the restrictive practice is a chemical restraint, ensuring that the assessments by the medical practitioner or nurse practitioners; practitioners' decisions to use the chemical restraint; individuals behaviours that are relevant to the need for the chemical restraint; the reasons the chemical restraint is necessary; and information (if any) provided to the medical practitioner or nurse practitioner that informed their decision to prescribe the medication, are documented in the behaviour support plan for the individual (as mentioned in subparagraphs 162-25(1)(b)(i) to (v) and (vii) to (ix)).

If a restrictive practice is used in an emergency, registered providers are expected to review the behaviour that triggered the emergency and document this in the individual's behaviour support plan. It is also expected that as part of this review registered providers consider and implement alternative behaviour support strategies to minimise the risk of an emergency reoccurring.

Section 162-40 – Requirements relating to nominations of restrictive practices nominees

Section 162-40 provides responsibilities for registered providers in relation to the nomination of restrictive practices nominees (see subsection 6-15(1)).

Subsection 162-40(1) provides that registered providers must take reasonable steps to ensure that an individual to whom the registered provider delivers funded aged care services is not subject to coercion or duress in making, varying or revoking a nomination of a restrictive practices nominee under section 6-15 (discussed above). Alternatively in the case of an individual or body nominated, to take reasonable steps to ensure that their agreement or withdrawal of agreement to the nomination is not subject to coercion or duress. For example, if a registered provider becomes aware that someone is coercing an individual to nominate them as a restrictive practices nominee, the registered provider should take reasonable steps to intervene, such as linking the individual with the necessary supports to consider making a nomination prior to any nomination being made.

These supports may include, where relevant, an independent aged care advocate. This responsibility is intended to provide additional safeguards to individuals while the interim measures are in force and is intended to further ensure effective and valid consent is sought to the use of a restrictive practice.

To the extent that a registered provider considers a nomination of a restrictive practices nomination may have been or was obtained under duress or coercion, the registered provider should not rely on that nomination for the purposes of obtaining consent to the use of a restrictive practice. If the registered provider does rely on this consent, they may not have the benefit of the immunity arrangements under section 163 of the Aged Care Act because there is a question regarding whether consent in these circumstances is legally effective.

Assisting care individuals

Subsection 162-40(2) provides that if an individual nominates an individual to be a restrictive practices nominee (whether as an individual or as part of a group) in accordance with section 6-15, then the registered provider must assist the individual to:

- notify the individual of the nomination; and
- give the individual a copy of the nomination (as it must be made in writing under paragraphs 6-15(2)(b) and (3)(b)); and
- seek the individual's agreement, in writing, to act as a restrictive practices nominee for a restrictive practice in relation to the individual (in accordance with paragraphs 6-15(2)(b) or (3)(b)).

When seeking an individual's agreement to be a nominee, it is good practice to provide the individual with the details of the proposed restrictive practice (where applicable) and outline the responsibilities and limitations of the role of restrictive practices nominee.

Keeping records

Subsection 162-40(3) provides that where an individual nominates a restrictive practice nominee (whether as an individual nominee or as a member of a group nominee) under section 6-15, the registered provider must keep a record of the nomination, or whether the nomination has been varied or withdrawn. This will ensure that in the event that use of a restrictive practice is proposed to be used and the individual lacks the capacity to provide informed consent themselves, the registered provider will have a record of the nomination and be able to easily identify the relevant person who is the restrictive practices substitute decision-maker if item 1 of the table in subsection 6-20(2) applies. This will also assist the

Commission in determining whether a registered provider has complied with its obligations and conditions of registration.

In line with the Quality of Care Amendment (Restrictive Practices) Principles 2022, it is intended that the rules will be amended with effect from 1 December 2026 to repeal section 162-40. This will end the interim measures introduced to address unexpected outcomes in relation to the interaction of restrictive practices consent arrangements with State and Territory guardianship and consent laws.

Division 3—Requirements relating to behaviour support

Section 162-45 - Requirement for behaviour support plans

Subsection 162-45(1) provides that, if a registered provider delivers funded aged care services to an individual and behaviour support is needed for the individual, the registered provider must ensure that a behaviour support plan is included in the care and services plan for the individual. These behaviour supports are expected to be individualised to best address the changed behaviour, and the underlying causes and/or triggers for the behaviour.

Given the number of individuals with dementia or cognitive decline is increasing, registered providers need to continue to build their behaviour support capability and ensure they are equipped to manage behaviours of concern that ensures the rights of individuals and promotes quality of life for individuals under their care.

Subsection 162-45(2) provides that the registered provider must ensure that the behaviour support plan is prepared, reviewed and revised in accordance with this Division and sets out matters as required by this Division and Division 2 (outlined above).

In preparing the behaviour support plan, subsection 162-45(3) provides that the registered provider must consider any previous assessments of the individual that are available to the registered provider. These assessments are not limited to behaviour assessments. They can include any assessment of the individual that may provide insight into the causes or triggers of their changed behaviours such as assessments for pain, mobility or illness, injury or trauma.

Section 162-50 – Requirements for behaviour support plans—alternative strategies for addressing behaviours of concern

Section 162-50 sets out the information that is required to be documented in a behaviour support plan in relation to alternative strategies for individuals with behaviours of concern. The behaviour support plan for an individual must set out the following:

- information about the individual to assist with understanding their behaviour, such as information about the individual's past experience and background. Other examples may be information about an individual's habits or routines, likes or dislikes, hobbies, trauma, illness, injury, or loss of close friends or family;
- any assessment of the individual that is relevant to understanding the behaviour – for example, assessments for pain, mobility, injury or illness, post-surgery, dementia, mental health, alcohol or drug misuse;
- information about the behaviours of concern for which the individual may need support – for example, assistance with activities and emotional supports;

- information about each occurrence of behaviours of concern for which the individual has needed support, including the date, time and duration of the occurrence, any adverse consequences for the individual or other persons, any related incidents, and any warning signs for, or triggers or causes of, the occurrence (including trauma, injury, illness or unmet pain needs, boredom or loneliness);
- alternative strategies for addressing the behaviours of concern that are best practice alternatives to the use of restrictive practices in relation to the individual, and take into account the individual's preferences (including preferences in relation to care delivery) and matters that might be meaningful or of interest to the individual, and aim to improve the individual's quality of life and engagement;
- any alternative strategies that have been considered for use, or have been used, in relation to the individual;
- for any alternative strategy that has been used in relation to the individual, the effectiveness of the strategy in addressing the behaviours of concern and records of the monitoring and evaluation of the strategies;
- a description of the consultation that has been undertaken by the registered provider about the use of alternative strategies with the individual or a supporter of the individual (if any).

The intention of this provision is to ensure the registered provider takes a more preventative approach in relation to the use of restrictive practices by considering alternative strategies in the first instance, while examining and seeking to understand the cause of the behaviours. The registered provider should consider any past events or experiences that led to behaviours of concern to help prevent future behaviours of concern occurring that may be related to these causes or triggers.

Registered providers are encouraged to engage with an individual's family, friends, health practitioners, and anyone else that has known the individual to understand the individual's experiences and preferences. This helps to ensure the individual can have the best quality of life possible while in residential care and are supported with person-centred strategies that consider their rights and preferences.

Section 162-55 – Requirements for behaviour support plans—if use of restrictive practice assessed as necessary

Section 162-55 sets out the information required to be documented in a behaviour support plan if the use of a restrictive practice has been assessed as necessary in accordance with sections 162-20 or 162-25. In these circumstances, the behaviour support plan for an individual must set out the following:

- the individual's behaviours of concerns that are relevant to the need for the use of the restrictive practice;
- what the restrictive practice is and how it is to be used, including its duration, frequency and intended outcome;
- the best practice alternative strategies that must be used before using the restrictive practice;
- how the use of the restrictive practice will be monitored, including how the monitoring will be escalated if required, taking into account the nature of the restrictive practice and any care needs that may arise from the use of the restrictive practice;

- how the use of the restrictive practice is to be reviewed, including consideration of the following:
 - the outcome of its use and whether the intended outcome was achieved;
 - whether an alternative strategy could be used to address the individual's behaviours of concern;
 - whether a less restrictive form of the restrictive practice could be used to address the individual's behaviours of concern;
 - whether there is an ongoing need for its use;
 - if the restrictive practice is chemical restraint, whether the medication prescribed for the purpose of using the chemical restraint can or should be reduced or stopped;
- a description of the registered provider's consultation about the use of the restrictive practice with the individual or, if the individual lacks capacity to give informed consent to the use of the restrictive practice, their restrictive practice substitute decision-maker;
- a record of the informed consent from the individual, or if the individual lacks capacity to give that consent, consent from their restrictive practice substitute decision-maker.

This section provides further requirements for registered providers when a restrictive practice is assessed as necessary, noting that sections 162-15, 162-20 and 162-25 outline the requirements that must be met if a restrictive practice is used, including that a restrictive practice be used only as a last resort (see paragraph 162-15(1)(a)). While approved health practitioners (a medical practitioner, nurse practitioner or registered nurse) may assess a restrictive practice as necessary, it is important to note that comprehensive behaviour support planning and management is intended to reduce the use of restrictive practices. Where possible, behaviour support plans should aim to reduce or eliminate restrictive practices.

This section also clarifies that the registered provider must document, in the behaviour support plan, how the restrictive practice is to be monitored and reviewed. This ensures the individual (or restrictive practices substitute decision-maker where applicable), their supporter, aged care staff and relevant health professionals all understand the conditions of the use of the restrictive practice.

If a behaviour support plan includes a restrictive practice that has been assessed as necessary, any use of a restrictive practice must be reviewed regularly or as soon as practicable after any change in the individual's circumstances (see section 162-70). This includes any circumstance where a restrictive practice is used in an emergency. Any changes in behaviour should mean that the use of the restrictive practice should be reconsidered and reduced or stopped as soon as practicably possible.

The note following section 162-55 clarifies that assessments mentioned in sections 162-20 and 162-25 also require other matters to be documented in the behaviour support plan.

Section 162-60 – Requirements for behaviour support plans—if restrictive practice used

Section 162-60 sets out the information that is required to be included in a behaviour support plan if a restrictive practice has been used in relation to an individual. The behaviour support plan for the individual must set out the following:

- the restrictive practice being used and how it was used, including when it began to be used, the duration of each use, the frequency of its use, the outcome of its use, whether the intended outcome was achieved and whether its use was in accordance with the informed consent set out under paragraph 162-55(h);
- if, under the plan, the restrictive practice is to be used only on an as-needed basis in response to particular behaviour, or in particular circumstances: the individual's behaviours of concern that led to the use of the restrictive practice and the actions (if any) taken leading up to the use of the restrictive practice, including any alternative strategies that were used before the restrictive practice was used;
- details of the persons involved in the use of the restrictive practice;
- a description of any engagement with external support services in relation to the use of the restrictive practice;
- details of the monitoring of the use of the restrictive practice as required by the plan;
- the outcome of the review of the use of the restrictive practice as required by the plan.

The first note under section 162-60 directs the reader, in relation to paragraphs 162-60(e) and (f), to paragraphs 162-55(d) and (e) as those provisions set out the requirements for a behaviour support plan for an individual to require monitoring and review of the use of a restrictive practice in relation to the individual.

The second note under section 162-60 provides that if the use of a restrictive practice in relation to an individual is necessary in an emergency, other matters in section 162-35 must also be documented in the behaviour support plan for the individual.

The use of a restrictive practice must be continually monitored, reviewed and documented. If there is a change to an individual's circumstances or behaviour, a review should be completed to understand what has changed and whether the existing strategies remain best practice for the individual. This includes any circumstance where a restrictive practice is used in an emergency.

If these strategies are no longer effective, new strategies need to be considered and trialled, noting that care needs change over time and can be affected by other factors in the residential care setting.

Registered providers must seek to ensure the least restrictive form of a restrictive practice is being applied and that it is used for the shortest time possible. Registered providers must also continually seek to consider whether an alternative strategy can be used and whether the restrictive practice can be reduced or stopped. These requirements are intended to ensure the use of restrictive practices are reduced and the inappropriate use of restrictive practices are eliminated.

Section 162-65 – Requirements for behaviour support plans—if need for ongoing use of restrictive practice indicated

Section 162-65 sets out the information that is required to be included in a behaviour support plan if a review of the use of a restrictive practice in relation to an individual has indicated the need for the ongoing use of the restrictive practice. In these circumstances, the behaviour support plan for the individual must set out the following:

- the restrictive practice and how it was used, including its duration, frequency and intended outcome;

- how the ongoing use of the restrictive practice is to be monitored, including how the monitoring will be escalated if required, taking into account the nature of the restrictive practice and any care needs that arise from the use of the restrictive practice;
- how the ongoing use of the restrictive practice is to be reviewed, including consideration of the following:
 - the outcome of the ongoing use of the restrictive practice and whether the intended outcome is being achieved;
 - whether an alternative strategy could be used to address the individual's behaviours of concern;
 - whether a less restrictive form of the restrictive practice could be used to address the individual's behaviours of concern;
 - whether there continues to be need for the ongoing use of the restrictive practice;
 - if the restrictive practice is chemical restraint, whether the medication prescribed for the purpose of using the chemical restraint can or should be reduced or stopped;
- a description of the consultation about the ongoing use of the restrictive practice with the individual or, if the individual lacks the capacity to give informed consent to the ongoing use of the restrictive practice, the restrictive practices substitute decision-maker;
- a record of informed consent from the individual or, if the individual lacks capacity to give that consent, consent from their restrictive practice substitute decision-maker.

If the ongoing use of a restrictive practice is assessed as necessary, informed consent for the ongoing use of the practice is required. Perpetual or ongoing approval cannot be given to the use of a restrictive practice. The individual or their restrictive practice substitute decision-maker may withdraw their consent at any time. Therefore, the registered provider should take steps to regularly communicate with the individual or their restrictive practices substitute decisionmaker and obtain informed consent contemporaneously.

Registered providers are required to regularly monitor and review the use of a restrictive practice approved on an ongoing basis and should continually explore alternative strategies to manage behaviours of concern, stopping the restrictive practice where possible.

Additionally, any use of a restrictive practice on an ongoing basis must be applied in the least restrictive form possible to prevent harm to the individual or other persons and must consider the impact of the use of the restrictive practice on the individual.

Section 162-70 – Requirement to review and revise behaviour support plans

Section 162-70 sets out that a registered provider must review a behaviour support plan for an individual and make any necessary revisions:

- on a regular basis; and
- as soon as practicable after any change in the individual's circumstances.

The care needs of individuals in residential aged care are dynamic and may change rapidly. Changes in the care needs of individuals require timely and responsive review by medical practitioners, nurse practitioners and registered nurses with day-to-day knowledge of the individual, together with any other professionals relevant to the individual's specific needs.

Any behaviours of concern, including where this occurs in an emergency, must be reviewed. Additionally, if a behaviour support plan includes a restrictive practice that has been assessed as necessary, the behaviour support plan must be regularly reviewed to determine if the restrictive practice can be reduced or stopped. If a chemical restraint is used, a medication review is also recommended to ensure that any medication is regularly reviewed and updated to ensure medication that is no longer required or can be reduced is reduced or stopped.

Arrangements under the National Disability Insurance Scheme require any behaviour support plan that includes a restrictive practice to be reviewed every 12 months or earlier if the participant's circumstances change. However, for registered providers it is expected that an individual will need their behaviour support plan to be reviewed significantly more frequently than every 12 months. This is due to the dynamic nature of care needs of older people. Conversely, the care needs of people with a disability may be more stable, depending on the particular disability.

In the event an individual's behaviour support needs are stable and do not change the registered provider must review the behaviour support plan on a regular basis or as soon as practicable after a change in the individual's circumstances. The term 'regularly' is not defined and is given its ordinary meaning.

Section 162-75 – Requirement to consult on behaviour support plans

Subsection 162-75(1) provides that in preparing, reviewing or revising a behaviour support plan for an individual, a registered provider must consult the following:

- the individual and a supporter of the individual (unless the individual lacks the capacity to be consulted);
- if the individual lacks capacity to be consulted, a person or body able to make decisions about the care of the individual under the law of the State or Territory in which the individual is provided with aged care;
- any health practitioners with expertise relevant to the individual's behaviours of concern.

Subsection 162-72(2) provides that if the use of a restrictive practice in relation to the individual is assessed as necessary as mentioned in sections 162-20 or 162-25, the registered provider must also consult the following in preparing, reviewing or revising the behaviour support plan:

- the approved health practitioner (medical practitioner, nurse practitioner or registered nurse) that made that assessment;
- if the individual lacks capacity to be consulted, their restrictive practice substitute decision-maker for the restrictive practice.

Subsection 162-75(3) provides that, if consulting under this section, the registered provider must provide the behaviour support plan or revised behaviour support plan, and any associated information, to those persons that are being consulted to support and facilitate the consultation process. The behaviour support plan and any associated materials must be provided in an appropriately accessible format to the persons that are being consulted.

This ensures the delivery of person-centred care and the inclusion of the individual in the care planning and decision-making process. During this process, the individual should be supported or assisted to make their own decisions. This includes communicating with them in a way they can understand, and they should be given the opportunity to discuss their concerns and expectations.

Division 4 - Immunity from civil or criminal liability in relation to the use of a restrictive practice in certain circumstances

Section 163-5 – Giving of informed consent by certain persons or bodies

Section 163-5 prescribes that for the purposes of paragraph 163(2)(a) of the Act (which refers to the giving of informed consent to the use of a restrictive practice in relation to an individual), a person or body that is a restrictive practices substitute decision-maker for the restrictive practice in relation to the individual is prescribed.

Part 10 – Management of incidents and complaints

Division 1 – Incident management

Subdivision A – Preliminary

Section 164-1 – Kinds of provider to which the condition applies

Section 164-1 outlines that for the purposes of section 164 of the Act, a registered provider registered in any of the following provider registration categories is prescribed:

- home and community services;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care;
- residential care.

Section 164-5 – Requirements relating to incident management

Section 164-5 outlines that for the purpose of section 164 of the Aged Care Act, this division prescribes requirements for implementing and maintaining an incident management system and requirements for managing, and taking reasonable steps to prevent, incidents.

The note following section 164-5 highlights that additional requirements for reporting reportable incidents to the Commissioner can be found in Subdivision G of Division 1 of Part 2 of Chapter 5 of the rules.

Section 164-10 – Incidents to which this Division applies

Subsection 164-10(1) explains that Division 1 of Part 10 of Chapter 5 of the rules applies to incidents that consist of acts, omissions, events or circumstances that occur, are alleged to have occurred, or are suspected of having occurred, in connection with the delivery of funded aged care services to an individual by a registered provider; and has caused harm to the individual or another person, or could reasonably have been expected to have caused harm to an individual or another person.

The phrase ‘in connection with’ is broad and includes incidents that may have occurred during the course of providing funded aged care services to an individual. This is intended to capture a range of incidents, for example, a fall during an outing facilitated by the approved residential care home, an individual being aggressive towards staff members, or a visitor slipping on a wet floor. Another example may include a staff member being burnt in the kitchen of the residential care service.

However, this phrase is not intended to capture incidents that have no connection to the funded aged care services provided to an individual. Such an example may be an individual tripping during an outing with a family member away from the approved residential care home. Another example may include a staff member being injured in a car accident on a day they are not at work.

The concept of harm in this context is broad and is not limited to serious harm or injury. It encompasses emotional and psychological as well as physical harm.

The phrase ‘could reasonably have been expected to have caused’ is included to account for circumstances where an incident involves conduct that is not acceptable and would ordinarily cause harm, even though the conduct may not have had such an effect in the circumstances of that specific incident. For example, where a staff member takes photos of an individual while they are showering and shares those photos with other staff members, even if that individual was unaware of this action or is unable to communicate the impact of the event.

Another person in the context of this provision may include, but is not limited to, a staff member of the registered provider, or a visitor to the residential care service.

Paragraph 164-10(1)(b) is not intended to limit the meaning of ‘reportable incident’ in section 16 of the Act and is included for clarification of the meaning of ‘incident’ in the Act.

Subsection 164-10(2) adds that Division 1 of Part 10 of Chapter 5 of the rules also applies to incidents that consist of acts, omissions, events or circumstances that a registered provider becomes aware of in connection with the delivery of funded aged care services to an individual in a residential care home of the registered provider and have caused harm to the individual.

For example, this may include circumstances where a family member is stealing money from an individual by using their internet banking password and the registered provider becomes aware of the incident and the individual is emotionally distressed. This may also include circumstances where an individual is taken on an outing by a family member, and upon return the individual seeks medical attention because they were physically abused by a family member and sustained a physical injury.

The scope of incidents for the purposes of incident management and prevention, including the incident management system, are broader than the scope of incidents that are ‘reportable incidents’ under the Serious Incident Response Scheme (SIRS). This is because a registered provider’s incident management system must apply across their services, while acknowledging that the Commissioner’s regulatory and monitoring capabilities have a primary focus on the health, safety, well-being and quality of life of individuals accessing funded aged care services.

Subdivision B—Implementing and maintaining an incident management system

Section 164-15 Requirements for system—objects

Section 164-15 sets out the objects of a registered provider's incident management system. That is, the incident management system must include the following:

- to promote the safety, health, well-being and quality of life of individuals to whom the provider delivers funded aged care services by:
 - detecting, addressing and remediating incidents; and
 - preventing incidents; and
 - ensuring the provider's incident management system facilitates the open disclosure and resolution of incidents between individuals and the provider; and
- to promote continuous improvement of:
 - the provider's management and prevention of incidents; and
 - the provider's delivery of funded aged care services.

Section 164-20 Requirements for system—general

Section 164-20 outlines the procedures and requirements that must be included in a registered provider's incident management system. The registered provider may include additional procedures and requirements if appropriate to the needs of the provider.

Paragraph 164-20(a) prescribes that the incident management system of a registered provider must be able to identify, record, assess, respond to and report on incidents. Ensuring that incidents are identified and record by the provider is a key first step for any incident management system, and providers should establish clear pathways for aged care workers and others to report incidents to the provider.

Paragraph 164-20(b) prescribes that the registered provider's incident management system must specify procedures for identifying, recording, assessing, responding to and reporting on incidents. For example, the incident management system is to prescribe where and how incidents are recorded, which will then support subsequent reporting (where applicable).

Paragraph 164-20(c) requires that the registered provider's incident management system has appropriate support and assistance (including access to advocates and language services) provided to any persons affected by an incident to ensure their safety, health, wellbeing and quality of life. For example, the procedures may include a set of actions or list of questions that the provider may ask a person affected by an incident to ensure their safety, health and well-being. The procedures may also include a list of potential advocates and their contact details that the approved provider may provide to the persons affected.

Paragraphs 164-20(d) – (f) provide that a registered provider's incident management system must specify all of the following:

- how persons affected by an incident will be appropriately involved in the management and resolution of the incident
- the roles and responsibilities of aged care workers and responsible persons of the registered provider in managing and responding to incidents
- the roles and responsibilities of aged care workers and responsible persons of the registered provider in notifying reportable incidents to the Commissioner

Paragraph 162-20(g) outlines that a registered provider's incident management system must require an aged care worker of the provider who becomes aware of a reportable incident to notify either a responsible person of the provider, a supervisor or manager of the aged care worker, or a person specified for the purposes of paragraphs 164-20(e) or (f) (described above). The person to whom an incident must be reported may vary depending on the type and nature of the incident, and the provider should ensure that aged care workers are suitably familiar with the system.

Paragraph 162-20(h) provides that the incident management system must require reportable incidents to be reported to the Commissioner in accordance with Division 2 of Part 2 of Chapter 5 of the Rules.

Paragraph 164-20(i) provides that the incident management system must specify when an investigation by the provider is required to establish the causes of the particular incident, or the harm caused by the incident, or any operational issues that may have contributed to the incident occurring. The nature of that investigation must also be specified (paragraph 164-20(j)).

Paragraph 164-20(k) provides that the system must specify when remedial action is required and the nature of that action. For example, if system failure or the actions of a staff member contributed to an incident, it is expected that the incident management system would set out a process for addressing those issues.

Paragraph 164-20(l) provides that the system must set out procedures for ensuring that requirements in sections 164-40 and 164-45 are complied with. There may be different procedures in place regarding reporting of incidents and how an incident must be recorded where a person affected by the incident requires medical attention.

Section 164-25 Requirements for system—recording details of incidents

Section 164-25 provides that the registered provider must document its incident management system procedures. It is important that the incident management system is documented so that compliance with the system can be monitored and enforced, including by the Commissioner. This section sets out the requirements in relation to record keeping. It is necessary for registered providers to keep accurate records to enable them to identify any systemic issues and to provide those records to the Commissioner if necessary.

At a minimum, a registered provider's incident management system must require the following be recorded in relation to each incident:

- a description of the incident, including the harm caused to, or which could reasonably have been expected to have been caused to, each person affected by the incident and, if known, the consequences of that harm;
- whether the incident is a reportable incident;
- if known, the time, date and place at which the incident occurred or was alleged or suspected to have occurred;
- the time and date the incident was identified;
- the name and contact details of the persons directly involved in the incident;
- the name and contact details of any witnesses to the incident;

- details of the assessments undertaken in accordance with subparagraph 164-40(1)(b)(i) and subsection 164-45(1), which requires the registered provider to assess and respond to an incident;
- the actions taken in response to the incident, including actions taken under sections 164-40 or 164-45 (see below).
- any consultations undertaken with persons affected by the incident;
- whether persons affected by the incident have been provided with any reports or findings regarding the incident;
- if an investigation is undertaken by the provider in relation to the incident, the details and outcomes of the investigation;
- the name and contact details of the person making the record of the incident;
- if the incident has been reported to the police, the details included in that report.

The registered provider may collect other information if appropriate in the circumstances. For example, a registered provider may decide to collect information about demographics or diversity characteristics if they consider this relevant to their incident management procedures and if they consider it may assist in the prevention of incidents.

Subsection 164-25(2) provides a registered provider's incident management system must require details recorded in relation to an incident to be retained for 7 years after the date the record was made or received, in accordance with section 154-150. A period of 7 years aligns with comparable incident management arrangements under the National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018.

Section 164-30 Requirements for system—data collection and analysis

Section 164-30 sets out the requirements in relation to data collection and analysis for a registered provider's incident management system.

Section 164-30 provides that a registered provider's incident management system must:

- require the collection of data relating to incidents that will enable the provider to:
 - identify occurrences, or alleged or suspected occurrences, of similar incidents; and
 - identify and address systemic issues in the quality of funded aged care services delivered by the provider; and
 - provide feedback and training to the provider's aged care workers and responsible persons about managing and preventing incidents; and
 - provide information to the Commissioner, if required or requested to do so by the Commissioner; and
 - provide information to the provider's quality care advisory body (if any) and consumer advisory bodies (if any) to assist the body or bodies to prepare reports or feedback about the quality of the funded aged care services delivered by the provider; and
 - continuously improve the provider's management and prevention of incidents; and
- require the regular analysis and review of data mentioned in paragraph (a) to assess:
 - the effectiveness of the provider's management and prevention of incidents; and
 - what, if any, actions could be taken to improve the provider's management and prevention of incidents.

Collecting data relating to incidents will enable the provider to continuously improve the provider's management and prevention of incidents, including enabling the provider to:

- identify and address systemic issues in the quality of care provided by the provider; and
- provide feedback and training to staff members of the provider about managing and preventing incidents. For example, building staff capability through awareness raising and education activities.

Further, requiring registered providers to regularly analyse and review the data relating to incidents collected will enable the provider to assess:

- the effectiveness of the provider's management and prevention of incidents, and
- what, if any, actions could be taken to improve the provider's management and prevention of incidents

Section 164-35 Requirements for registered providers

Section 164-35 sets out the requirements for registered providers in relation to incident management. It provides that a registered provider must document its incident management system procedures and make this documentation available. It is important that the incident management system is documented so that compliance with the system can be monitored and enforced, including by the Commissioner. It also addresses the roles and responsibilities of staff members of the registered provider in relation to the incident management system.

This section requires registered providers to:

- prepare and keep up to date documents detailing:
 - the provider's incident management system, including the objects mentioned in section 164-15 and the requirements mentioned in sections 164-20 to 164-30; and
 - the roles and responsibilities in the system of the provider's aged care workers and responsible persons in identifying, managing and resolving incidents and in preventing incidents from occurring; and
- give the documents to:
 - the provider's aged care workers and responsible persons; and
 - to the Commissioner, if required or requested to do so by the Commissioner; and
- ensure that the provider's aged care workers and responsible persons are aware of, and understand, their roles and responsibilities in the system; and
- require the provider's aged care workers and responsible persons to comply with the system; and
- provide appropriate training to the provider's aged care workers and responsible persons on how the system works, including:
 - how to recognise, respond to and report incidents; and
 - their roles and responsibilities in the system; and
- make the documents mentioned in paragraph (a) available, in an accessible form, to the following persons:
 - the individuals to whom the provider is delivering funded aged care services;
 - supporters, family members, carers and advocates of the individuals to whom the provider is delivering funded aged care services, and any other person significant to those individuals; and

- assist persons referred to in paragraph (f) to understand how the system works.

Subsection 164-35(2) provides that without limiting paragraph (1)(e) (relating to providing appropriate training), a provider provides appropriate training to a person who is an aged care worker or responsible person of the provider if the training is provided:

- at least annually; and
- at the following times:
 - when the person becomes an aged care worker or responsible person of the provider;
 - when there is a change to how the system works that affects the person's roles and responsibilities in the system;
 - when there is a change to the person's role that affects the person's roles and responsibilities in the system.

The form, method and extent of training is expected to be appropriate to the size of the registered provider and the funded aged care services provided, as well as the roles of the aged care workers and responsible persons of the registered provider.

Subdivision C—Managing and preventing incidents

Section 164-40 – Requirements for managing incidents

General

Subsection 164-40(1) outlines that a registered provider must manage an incident in accordance with their incident management system and must respond by doing the following:

- assessing the support and assistance required to ensure the safety, health and well-being of persons affected by the incident; and
- providing that support and assistance to the persons affected by the incident; and
- assessing how to appropriately involve each person affected by the incident, or a supporter or advocate of the person, in the management and resolution of the incident; and
- involving each person or supporter or advocate in that way; and
- using an open disclosure process.

Open disclosure requires registered providers to openly communicate with individual's when their care does not go to plan. Depending on the circumstances, this may require open and timely communication, acknowledgement, explanation of what went wrong, apology and expression of regret, as well as continuing to support the individual.

Notifying police of an incident where reasonable grounds to do so

Subsection 164-40(2) provides that if there are reasonable grounds to report the incident to police, the registered provider must notify a police officer of the incident within 24 hours of becoming aware of the incident. For example, if the registered provider reasonably suspects that the incident may be an assault they should report the incident to their local police within 24 hours of becoming aware of the incident.

Subsection 164-40(3) provides that if the registered provider later becomes aware of reasonable grounds to report the incident to police (not within the 24 hours of becoming aware of the incident), the provider must notify a police officer of the incident within 24 hours of becoming aware of those grounds. For example, the registered provider might initially become aware of an incident and at that time did not consider there were reasonable grounds to report the incident to police. However, if they later determine that there are grounds to report the incident to police, the 24-hour timeframe commences when the provider becomes aware of the grounds to report the incident to police (e.g. when they become aware of the additional information).

The phrase ‘reasonable grounds’ may be taken to include a scenario where the registered provider is aware of facts or circumstances (alleged or known) that lead them to believe or suspect that it is likely that the incident is of a criminal nature and therefore should be reported to police (e.g. if the provider suspects the incident involves an indecent assault or if there is an ongoing danger of such).

Section 164-45 – Requirements for improving management of incidents and taking reasonable steps to prevent incidents

Subsection 164-45(1) outlines how, after an incident, a registered provider must assess the incident in relation to the following, while taking into account the views of persons affected by the incident:

- whether the incident could have been prevented;
- what, if any, remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their harm;
- how well the incident was managed and resolved;
- what, if any, actions could be taken to improve the provider’s management and resolution of similar incidents;
- whether other persons or bodies should be notified of the incident.

Subsection 164-45(2) provides that the registered provider must notify the persons or bodies assessed as being persons or bodies that should be notified of the incident under 164-45(1)(e), for example and where relevant, the family of the individual affected or the Australian Health Practitioner Regulation Agency.

Subsection 164-45(3) adds that the registered provider must take any remedial action they have identified under paragraph 164-45(1)(b) to prevent further similar incidents from occurring, or to minimise their harm. For example, repairing flooring that is causing falls, or ensuring additional staff are available during a group activity where, on a previous occasion, a person had acquired a burn injury due in part to a lack of sufficient supervision.

Registered providers must also take any actions they have identified under paragraph 164-45(1)(d) (actions that could be taken to improve their management and resolution of similar incidents) or subparagraph 164-30(b)(ii) that are reasonable in the circumstances. For example, if a family member has been taking money from their relative while visiting the approved residential care home, it may be appropriate for the registered provider to put in place reasonable arrangements to prevent reoccurrence. In this example this may include securing the individual’s wallet during future visits by that family member.

Division 2 – Complaints, feedback and whistleblowers

Subdivision A—Preliminary

Section 165-5 – Purpose of this Part

Section 165-5 provides that the purpose of this Part is to prescribe requirements in relation to implementing a complaints and feedback management system and a whistleblower system and whistleblower policy, as well as requirements for providers to manage both complaints and feedback and whistleblower disclosures that qualify for protection under section 547 of the Act.

Subdivision B – Implementing and maintaining a complaints and feedback management system

Section 165-10 – Objects of this Subdivision

Section 165-10 sets out that the objects of this Subdivision are to promote quality care and the safety of individuals receiving funded aged care services through the providers complaints and feedback management system, as well as to ensure that the system is functioning effectively. Effective complaints and feedback management is key to the aged care system. Complaints and feedback can help to improve or maintain the quality of care provided both to the individual and to other people accessing aged care in Australia.

As outlined in paragraph (c), it is policy intent that older people, their supporters, aged care workers, and other persons are encouraged and supported to make complaints. This would similarly include individuals covered under subsection 28(2) of the Act i.e. Power of Attorney, Guardians. Per paragraph (d), the provider must ensure that the complaints and feedback received contribute to the continuous improvement of the provider's delivery of funded aged care services.

Section 165-15 – Requirements for system—general

Section 165-15 sets out the general requirements for a registered provider's complaints and feedback management system.

Paragraph (1)(a) provides that the complaints and feedback management system must be able to receive, record, assess, acknowledge, respond to and report on complaints and feedback, as well as securely store information relating to complaints and feedback.

Paragraph (1)(b) provides that the complaints and feedback management system must enable any person to make or withdraw a complaint or feedback. This may occur orally and in writing, as well as anonymously, if that is the preference of the individual.

Paragraph (1)(e) requires that there are to be no costs charged by the provider for making, withdrawing or managing a complaint. Similarly, no costs are to be charged for giving, withdrawing or managing feedback.

Per paragraph (1)(f) the complaints and feedback management system, and corresponding processes must be accessible to any person, should they raise or provide a complaint or feedback.

Paragraph (1)(g) provides that the complaints and feedback management system must enable appropriate support and assistance i.e. access to advocates and language services. This support and assistance must be provided to any person who wishes to or has raised a complaint or feedback, as well as each older person directly affected by an issue raised in a complaint or feedback.

Similarly, per paragraph (1)(h), the role of independent aged care advocates must be acknowledged and supported within the providers complaints and feedback management system.

Correspondingly, per paragraph (1)(i), the registered provider must enable cooperation with and facilitate arrangements to allow independent aged advocates to support individuals, their supporters, and other persons, in the complaints and feedback process.

Under paragraph (1)(j), the complaints and feedback management system must ensure that where it is their preference relevant individuals are involved in an appropriate way in the resolution of the complaint and kept informed in an appropriate way as to the resolution, progress and outcome of the complaint. In determining the appropriate level of involvement of relevant individuals, providers should consider the individual's wishes, as well as any applicable restrictions around the use and disclosure of personal or protected information. Providers may also consider their available resources in deciding what is appropriate.

Per paragraph (1)(k) there are no reprisals for individuals who make a complaint or give feedback.

Paragraph (1)(l) requires that the registered provider must keep the information provided in a complaint or feedback confidential. The information can only be disclosed if required by law or if the disclosure is otherwise appropriate in the circumstances. Without limiting paragraph (1)(l), a disclosure is appropriate where the person has consented.

paragraph (1)(m) requires the provider to ensure procedural fairness is provided to both the person who made the complaint or gave feedback, as well as the person (if any) against whom the complaint is made or who is the subject of the feedback.

paragraph (1)(n) sets out that the provider must practice open disclosure and prioritise restorative practices within their complaints and feedback management system. This means that providers must be open and honest in their response to complaints and feedback, including providing an explanation for the circumstances that led to the complaint or feedback. Providers are to prioritise responses that aim to repair the harm (if any) caused and to improve both the quality of care provided and the relationship between the parties.

Paragraph (1)(o) provides that the complaints and feedback management system must ensure that any requirements relating to the referral or notification of complaints under Commonwealth, State or Territory laws (as applicable) are met.

Under paragraph (1)(p), providers must provide for the system to be reviewed as required, and at least annually, to ensure it is meeting the above requirements.

Subsection (2) clarifies that without limiting paragraph (1)(l), a disclosure is appropriate if the person about whom the information relates has consented to the disclosure.

Section 165-20 Requirements for registered providers

Section 165-20 sets out the requirements for registered providers as it relates to the providers complaints and feedback management system.

Paragraph (a) provides that the registered provider must prepare and keep up to date documents detailing their complaints and feedback management system, as well as the roles and responsibilities of aged care workers and responsible persons in the system.

This document must be given to the provider's aged care workers and responsible persons, and the provider must ensure that those individuals are aware of and understand their roles and responsibilities in the system, and that they comply with the system.

Per paragraph (e), the provider must provide appropriate training to aged care workers and responsible persons on how the system operates including:

- how to handle personal information and data
- how to recognise and respond to complaints and feedback
- how to manage relationships and clearly communicate with persons making complaints or giving feedback
- when and how to escalate complaints and feedback in the system
- their roles and responsibilities in the system
- the roles and functions of independent aged care advocates in the system

Subject to subsection (2), the rules allow for providers to exercise discretion in how frequently the training under paragraph (1)(e) is provided, in order to allow providers with the flexibility to determine a frequency that is appropriate for their purposes. Annual training may be generally appropriate for many providers, but some providers may determine that training should be provided more frequently depending on their particular circumstances.

Paragraph (f) sets out that the provider must publish an accessible document that:

- describes how a complaint can be made, or feedback can be given, to the provider
- describes what a person who makes a complaint or gives feedback to the provider can expect in relation to the provider's management of the complaint or feedback
- includes information about how a complaint can be made, or feedback can be given, to the Complaints Commissioner
- explains that the provider will not victimise or discriminate against anyone for making a complaint or giving feedback to the provider or the Complaints Commissioner
- includes information about how to contact an independent aged care advocate

Accessibility of the document refers to both ensuring that the document can be understood by older persons who may have unique needs and preferences and ensuring that the document is easily able to be located and accessed by older persons. Where appropriate, the document should be available both online and in a physical form at the provider's premises.

Per paragraph (g) this document must be given to individuals receiving funded aged care services from the provider and any other person who requests the document.

Paragraph (h) provides that the provider must enable individuals receiving funded aged care services to understand the document, if necessary.

If required, the provider must translate the document or present the document in an alternative format for the older person, to ensure they understand the provider's complaint and feedback management system.

Per paragraph (i) providers are similarly required to help any other person who requests the document to understand how the provider's complaints and feedback management system works.

paragraph (j) sets out that providers are required to communicate regularly and at least monthly to aged care workers and responsible persons, as well as older people, that complaints and feedback are welcome.

For clarity, regular communication does not require individual contact with all relevant persons. Rather, regular communication may include a call to action printed in a monthly newsletter, announcements made at monthly staff or resident meetings, and similar collective mechanisms. It is for individual providers to determine the most effective mechanism.

Per paragraph (k) providers must review the system as mentioned in paragraph 165-15(p).

Subsection (2) outlines that the provider provides appropriate training to aged care workers and responsible persons where the training is provided at regular intervals, which must be at least annually as well as the following times:

- when the person becomes an aged care worker or responsible person of the provider
- when there is a change to how the system works that affects the person's roles and responsibilities in the system
- when there is a change to the person's role that affects the person's roles and responsibilities in the system.

Subdivision C—Managing complaints and feedback

Section 165-25 – Requirements for complaints management and resolution

Section 165-25 sets out the requirements for a provider to manage and resolve complaints.

Per paragraph (a), the provider must manage the complaint in accordance with their complaints and feedback management system. This includes practising open disclosure and prioritising restorative practices, as per 165-15(n).

As outlined under paragraph (b), the provider must resolve each issue raised in the complaint, as soon as practicable, and take appropriate action in relation to the complaint.

In determining what action is appropriate, providers should collaborate with the complainant. Appropriate actions may include the following forms of restorative practices:

- mediation
- conciliation
- issuing an apology
- providing a written explanation of the incident
- undertaking to do or refrain from doing a given action
- rectification actions, including providing compensation

Paragraph (c) outlines that in resolving each issue raised in the complaint, the provider must use a resolution approach that:

- is consistent with the Statement of Rights
- is appropriate given the nature of the issue
- is centred around each individual to whom the provider delivers funded aged care services who is directly affected by the issue
- seeks to address the issue as raised in the complaint
- will contribute to the continuous improvement of the provider's delivery of funded aged care services

Per paragraph (d), unless the complaint was made anonymously, the provider must inform the following persons of the outcome of the complaint and the reasons for the complaint:

- the person who made the complaint
- if the complaint was made on behalf of an individual to whom the provider is delivering funded aged care services—the individual

Per paragraph (e), unless the complaint was made anonymously, the provider must inform the following persons of how the complaint can also be made to the Complaints Commissioner:

- the person who made the complaint
- if the complaint was made on behalf of an individual to whom the provider is delivering funded aged care services—the individual

As outlined in paragraph (f) the provider must take reasonable steps to inform any other person involved in the resolution of the initial complaint, how the complaint can also be made to the Complaints Commissioner.

Under paragraph (g) the provider must also take reasonable steps to inform persons about how a new complaint regarding the resolution of the initial complaint can be made to the Complaints Commissioner, and information on the availability of independent aged care advocates to assist with making a new complaint to the Complaints Commissioner.

Section 165-30 – Requirements for feedback management and resolution

Section 165-30 sets out the requirements for providers to manage and resolve feedback (in relation to any issues raised in the feedback).

It is intended that providers will only need to pursue a resolution approach in relation to feedback where issues are raised in the feedback, i.e. where the feedback raises concerns that require a response from the provider. Positive or neutral feedback which does not raise issues/concerns will not require the provider to utilise a resolution approach.

Feedback of this nature can be generally distinguished from a complaint in that feedback is generally focused more on continuous improvement and may relate to broader trends and concerns, whereas complaints generally focus on a specific incident or series of incident and seek a formal resolution specific to the complainant or other impacted individual.

Per paragraph (2)(a) the provider, in relation to any issues raised in feedback, must use a resolution approach that will contribute to the continuous improvement of the provider's delivery of funded aged care services.

Per paragraph (2)(b) unless the feedback was given anonymously, the provider must consult with the following persons:

- the person who gave the feedback
- if the feedback was given on behalf of an individual to whom the provider is delivering funded aged care services—the individual
- if the person who gave the feedback is an individual to whom the provider is delivering funded aged care services, and the individual has consented to the consultation – the individual’s supporter (if any)
- if the feedback was given on behalf of an individual to whom the provider is delivering funded aged care services and the individual has consented to the consultation – the individual’s supporter (if any).

Paragraph (3)(a) provides that the provider must inform the above persons how the initial feedback can also be given to the Complaints Commissioner.

Similarly, per paragraph (3)(b) the provider must inform any other person involved in the resolution of any issue raised by the initial feedback, how the feedback can also be given to the Complaints Commissioner.

Under paragraph (3)(c) the provider must also advise how a complaint or new feedback about the resolution of any issue raised by the initial feedback, can be made or given to the Complaints Commissioner.

Section 165-35 – Other requirements relating to complaints and feedback

Section 165-35 sets out other requirements relating to complaints and feedback.

Per paragraph (1)(a) if a registered provider receives a complaint or feedback, the provider must provide appropriate support and assistance, including access to advocates and language services, in relation to contacting the Complaints Commissioner for:

- the person who made the complaint or gave the feedback (other than anonymously)
- each individual to whom the provider delivers funded aged care services who is directly affected by an issue raised in the complaint or feedback.

Under paragraph (1)(b), the provider must take reasonable steps to ensure that:

- the person who made the complaint or gave the feedback, or on whose behalf the complaint was made or the feedback was given, is not adversely affected as a result
- that no older person who is affected by an issue raised in the complaint or feedback suffers any detriment, victimisation or reprisal as a result.

Subsection (2) sets out that a registered provider must use an open disclosure process in relation to complaints and feedback, and if things go wrong in managing and resolving complaints or feedback.

Subsection (3) provides that an individual who discloses information that qualifies for protection under section 547 of the Act (whistleblower protections) may elect to have the disclosure managed as a complaint or feedback.

Subsection (4) provides that where an individual makes an election under subsection (3), the provider must manage the disclosure as a complaint or feedback.

Subdivision D – Implementing and maintaining a whistleblower system and maintaining a whistleblower policy

Section 165-40 – Objects of this Subdivision

Section 165-40 sets out that the objects of this Subdivision are:

- to promote quality care and the safety of individuals by ensuring the provider's whistleblower system enables disclosures without fear of persecution, retribution or personal detriment
- to ensure that the confidentiality of disclosures is maintained, and that where relevant anonymity is maintained
- to ensure that the provider's whistleblower system acknowledges, assesses, manages and responds to concerns raised in such disclosures in a fair, transparent, accessible, safe, culturally safe and timely manner
- to ensure that such disclosures contribute to the continuous improvement of the provider's delivery of funded aged care services
- to ensure that aged care workers and any other persons are encouraged and supported to raise concerns about the provider's delivery of funded aged care services.

Section 165-45 – Requirements for system—general

Section 165-45 provides that a registered provider's whistleblower system must support the operation of Part 5 of Chapter 7 of the Act.

Paragraph (b) provides that the registered provider's whistleblower system must enable individuals to disclose information to the provider, a responsible person of the provider and an aged care worker of the provider.

Per paragraph (c), the provider must enable disclosures of information to be made orally and in writing, as well as anonymously.

Per paragraph (d), the provider must ensure the system is reviewed as required, and at least annually to ensure that it is meeting the general system requirements described above.

Section 165-50 – Requirements for registered providers—general

Section 165-50 sets out the general requirements for registered providers' whistleblower systems.

Per paragraph (1)(a) a registered provider must prepare and keep up to date documents detailing their whistleblower system and the roles and responsibilities of the provider's aged care workers and responsible persons.

Under paragraph (1)(b), the provider must give the document to the provider's aged care workers and responsible persons.

Paragraph (1)(c) sets out that the provider must ensure that their aged care workers and responsible persons are aware of and understand their roles and responsibilities in the system.

Per paragraph (1)(d) the provider must require their aged care workers and responsible persons to comply with the system.

Per paragraph (1)(e), the provider must provide appropriate training to their aged care workers and responsible persons on how the system works including:

- how to handle personal information and data
- how to recognise and respond to disclosures that qualify for protection under section 547 of the Act
- how to manage relationships and communicate with disclosers
- when and how to escalate disclosures in the system
- their roles and responsibilities in the system
- the penalties for contravening subsection 550(1) of the Act (confidentiality of identity of disclosers)

Subject to subsection (2), the rules allow for providers to exercise discretion in how frequently the training under paragraph (e) is provided, to allow providers with the flexibility to determine a frequency that is appropriate for their purposes. Annual training may be generally appropriate for many providers, but some providers may determine that training should be provided more frequently depending on their particular circumstances.

Paragraph (1)(f) outlines that the provider must communicate regularly and at least monthly to their aged care workers and responsible persons that whistleblower disclosures that qualify for protection are welcome.

For clarity, regular communication does not require individual contact with all relevant persons. Rather, regular communication may include a call to action printed in a monthly newsletter, announcements made at monthly staff or resident meetings, and similar collective mechanisms. It is for individual providers to determine the most effective mechanism. Paragraph (1)(g) requires the provider to review the system per subsection 165-45(d).

Subsection (2) outlines that the provider provides appropriate training to a person who is an aged care worker or responsible person of the provider if the training is provided:

- at regular intervals, which must be at least annually; and
- at the following times:
 - when the person becomes an aged care worker or responsible person of the provider
 - when there is a change to how the system works that affects the person's roles and responsibilities in the system
 - when there is a change to the person's role that affects the person's roles and responsibilities in the system

Section 165-55 – Requirements for registered providers—whistleblower policy

Section 165-55 sets out the requirements for registered providers' whistleblower policies.

Paragraph (a) provides that a registered provider must prepare and keep up to date a whistleblower policy that sets out the following:

- the effect of Part 5 of Chapter 7 of the Act
- that individuals may disclose information to the provider, or another person mentioned in section 547 of the Act, and how such disclosures may be made
- how the provider will manage disclosures that qualify for protection under section 547 of the Act that are made to the provider or a responsible person or aged care worker of the provider

- that individuals may also disclose information to the entities mentioned in subparagraphs 547(a)(i), (ii), (vi) and (vii) of the Act, and how such disclosures may be made
- how the provider will investigate disclosures
- how the provider will comply with the requirements mentioned in paragraphs 165-60(c) and (d)
- how the provider will comply with the obligations in section 553 of the Act
- what an individual who has made a disclosure that qualifies for protection under section 547 of the Act can do if they suspect that there has been a contravention of a provision of Part 5 of Chapter 7 of the Act.

Per paragraph (b), the provider must publish the policy in an accessible document.

Providers will satisfy the requirement to publish their policy if the policy is published online and publicly available. Providers should also consider making the policy available in a printed form at their premises (where applicable) to ensure it is accessible to older persons.

Accessibility of the document refers to both ensuring that the document can be understood by older persons who may have unique needs and preferences and ensuring that the document is easily able to be located and accessed by older persons.

Paragraph (c) outlines that the provider must give the policy to their aged care workers and responsible persons.

Under paragraph (d) the provider must give the policy to:

- individuals receiving funded aged care services from the provider
- a person who requests the policy and is a supporter of an individual receiving funded aged care services from the provider
- any other person who requests the policy.

Per paragraph (e) if it is necessary the provider must enable older people and their supporters to understand the policy. This may include translating the policy into another language or presenting the policy in an alternative appropriate format.

Similarly, paragraph (f) prescribes that providers must help older people and their supporters to understand how the whistleblower system works.

Paragraph (g) prescribes that providers must communicate regularly, and at least monthly to aged care workers and responsible persons, older people and their supporters that disclosures are welcome.

For clarity, regular communication does not require individual contact with all relevant persons. Rather, regular communication may include a call to action printed in a monthly newsletter, announcements made at monthly staff or resident meetings, and similar collective mechanisms. It is for individual providers to determine the most effective mechanism.

Subdivision E – Managing disclosures that qualify for protection under section 547 of the Act

Section 165-60 – Requirements- for managing disclosures

Section 165-60 sets out the requirements for providers to manage disclosures that qualify for protection under section 547 of the Act.

Where an individual makes a disclosure to a registered provider, responsible person or aged care worker of the provider, the provider must manage the disclosure in accordance with their whistleblower system.

Paragraph (b) provides that the provider must as soon as practicable after the disclosure is made, take appropriate action in relation to the disclosure.

Per paragraph (c) the provider must support:

- the individual who made the disclosure; and
- any other individual, or an entity, that employs or is otherwise associated with the individual who made the disclosure, and to which detriment might be caused, or a threat of detriment might be made, because of the disclosure.

Supporting individuals includes ensuring they are aware of the provider's whistleblower system and whistleblower policy, as well as ensuring they are aware of the general protections for whistleblowers under the Act.

Under paragraph (d) the provider must ensure fair treatment of any of their responsible persons or aged care workers who are mentioned in the disclosure or who are related to the disclosure.

Chapter 5 – Registered provider, responsible person and aged care worker obligations

Part 1 – Introduction

Section 165A-1 – Simplified outline of this Chapter

Section 165A-1 sets out that this Chapter provides for matters relating to registered provider, responsible person and aged care worker obligations under Part 4 of Chapter 3 of the Act.

Part 2 of this Chapter relates to reporting obligations, specifically on:

- vaccinations
- quality indicators
- complaints and feedback management
- complaints and feedback information on request; and
- prudential and financial matters;
- reportable incidents;
- the specialist aged care program CHSP;
- the specialist aged care program NATSIFACP; and
- governing bodies
- registered nurses
- the status of service delivery branches
- the MPSP
- the transition care program
- pricing information.

Part 3 of this Chapter relates to provider obligations, pertaining to notification of changes in circumstances. This part deals with changes in relation to which registered providers must give notice to the Commissioner, other circumstances where notice must be provided to the System Governor and information that must be included in a notice given to the Commissioner or the System Governor

Part 4 of this Chapter deals with the kinds of registered providers to which the obligation to notify of changes of circumstances relating to suitability applies.

Part 5 of this Chapter deals with obligations relating to suitability of responsible persons, and deals with the kind of registered providers to which the obligations apply and requirements for records of suitability matters

Part 6 of this Chapter relates to obligations relating to aged care workers, and deals with registered nurses and the delivery of direct care.

Part 7 of this Chapter relates to other obligations, and deals with requirements relating to cooperation by registered providers with the Pricing Authority.

Part 2 – Obligations relating to reporting, notifications and information

Division 1 – Preliminary

Section 165A-2 – No limitation on other requests

Section 165A-2 provides that nothing in this Part limits or affects the System Governor, the Commissioner or the Complaints Commissioner from requesting information from a registered provider under any other provision of the Rules or the Act.

Division 2 – Reportable incidents

Section 165A-5 – Purpose of this Subdivision

Section 165A-5 provides that this Subdivision is made for the purposes of paragraph 165A(2)(b) of the Act and specifies requirements that registered providers must comply with for reporting reportable incidents to the Commissioner.

Section 165A-10 – Application of Subdivision to registered providers

Section 165A-10 provides that for the purposes of subsection 165A(1) of the Act, every kind of registered provider is prescribed.

Section 165A-15 – Registered provider must notify reportable incidents in accordance with this Subdivision

Section 165A-15 provides that a registered provider must take all reasonable steps to ensure that reportable incidents are notified to the Commissioner in accordance with this Subdivision.

Section 165A-20 – Registered provider must ensure that aged care workers notify reportable incidents

Section 165A-20 provides that a registered provider must ensure that an aged care worker of the provider who becomes aware of a reportable incident notifies one of the following of that fact as soon as possible:

- one of the provider's responsible persons;

- a supervisor or manager of the aged care worker;
- the person specified for the purposes of paragraph 164-20(e) which is the person who is responsible to give notice to the Commissioner of a reportable incident.

Section 165A-25 – Priority 1 notice must be given within 24 hours

Subsection (1) provides that if a registered provider becomes aware of a reportable incident, and the provider has reasonable grounds to believe the incident is a priority 1 reportable incident, the provider must give the Commissioner a notice (a priority 1 notice) in accordance with subsection (4) (explained below) within 24 hours of becoming aware of the reportable incident.

The note following subsection 165A-25(1) of the rules clarifies that notice about certain incidents is not required and refers to section 165A-35, which sets out circumstances where a notice is not required.

Subsection (2) defines a priority 1 reportable incident. A priority 1 reportable incident includes a reportable incident that has caused an individual physical or psychological injury or discomfort that requires medical or psychological treatment.

Medical or psychological treatment (as defined under section 5-5) means treatment that may only be provided by a medical practitioner, nurse practitioner, registered nurse, psychologist or social worker. It does not include minor medical attention such as the application of an ice pack or bandage, nor the simple provision of emotional support following an incident. It also does not include treatment provided by the above listed persons where the treatment could also have been provided by a person without their relevant qualifications.

A priority 1 reportable incident also includes:

- an incident where there are reasonable grounds to report the incident to police;
- an incident of the kind covered by paragraph 16(1)(b) of the Act (relating to unlawful sexual contact or inappropriate sexual conduct inflicted on an individual); or
- an incident of the kind covered by paragraphs 16(1)(d) or 16(1)(h) of the Act (relating to unexpected deaths or unexplained absences).

Subsection (3) provides that for the purposes of paragraph (2)(a) in considering whether a reportable incident has caused an individual who has an impairment, physical or psychological injury or discomfort that requires medical or psychological treatment, a registered provider must not consider the impairment as:

- preventing the individual from being caused physical or psychological injury or discomfort
- reducing the degree of physical or psychological injury or discomfort caused

Subparagraph (3)(b) further provides that the registered provider must recognise and consider that each individual's experience of an incident will be unique and that an impairment may contribute to causing the individual physical or psychological injury or discomfort.

Subsection (3) is included to account for and provide clarity around circumstances where an incident involves conduct that is not acceptable and would ordinarily be expected to cause physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, even though the conduct may not have had such effect in the circumstances of that specific incident. For example, where a staff member sexually

penetrates an individual with an object, which would ordinarily be traumatic for a person, with psychological intervention recommended, although in this circumstance the individual did not display psychological or emotional distress because their level of cognitive function did not enable them to communicate the incident's impact. Although that individual may not have displayed the effect of such injury or discomfort, it is intended that such incidents would be considered to be a priority 1 reportable incident for the purposes of the SIRS and reported within a 24-hour period.

Subsection 165A-25(4) provides that subject to new subsection 165A-25(5) (explained below), the priority 1 notice must include the following information about the reportable incident:

- the name and contact details of the registered provider;
- a description of the reportable incident including the kind of reportable incident, the harm that was caused (or that could reasonably have been expected to have been caused) to each person affected by the incident and, if known, the consequences of that harm;
- the immediate actions taken in response to the reportable incident, including actions taken to ensure the safety, health, and well-being of the individuals affected by the incident, or the supporter of the individual, and whether the incident has been reported to police or any other body;
- any further actions proposed to be taken in response to the reportable incident;
- the name, position and contact details of the person giving the notice;
- if known, the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;
- the names of the persons directly involved in the reportable incident;
- if known, or the extent to which it is known, the level of cognition of the individuals/s directly involved in the reportable incident (any temporary or permanent medical or diagnosed condition/s which change or affect memory, thinking insight or judgement of the residential individual, which may include, but not be exclusive of, dementia, delirium, psychosis, intellectual disability).

Under subsection (5) the registered provider is not required to include information in the priority 1 notice if that information is not available within 24 hours.

Subsection (6) provides that the registered provider must give the Commissioner a notice, including the following information about the reportable incident, within five days after the start of the 24 hours, or within a different period that the Commissioner determines:

- any information required by subsection (4), not provided in the priority 1 notice;
- any further information specified by the Commissioner that is required to deal with the reportable incident.

Subsection (7) provides that the registered provider is not required to give a notice to the Commissioner under subsection (6) if the Commissioner decides otherwise.

Subsection (8) provides that a notice given under section 165A-25 must be in writing and in the approved form.

The note following subsection (8) clarifies that the Commissioner may approve forms for the purposes of this Division and refers to section 585 of the Act.

Section 165A-30 – Priority 2 notice must be given within 30 days

Subsection (1) provides that if a registered provider becomes aware of a reportable incident and the provider has not given a notice under section 165A-25, regarding priority 1 reportable incidents, the provider must give the Commissioner a notice (a priority 2 notice) in accordance with new subsection (2) (explained below) within 30 days of becoming aware of the incident.

The note following subsection (1) clarifies that notice about certain incidents is not required and refers to section 165A-35, which sets out circumstances where a notice is not required.

Subsection (2) provides that the priority 2 notice must include the following information about the reportable incident:

- the name and contact details of the registered provider;
- a description of the reportable incident including the kind of reportable incident, the harm that was caused (or that could reasonably have been expected to have been caused) to each person affected by the incident and, if known, the consequences of that harm;
- the actions taken in response to the reportable incident, including actions taken to ensure the safety, health and well-being of the individual affected by the incident, or the supporter of the individual, and whether the incident has been reported to police or any other body;
- any further actions proposed to be taken in response to the reportable incident;
- the name, position and contact details of the person giving the notice;
- if known, the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;
- the names of the persons directly involved in the reportable incident;
- if known, the level of cognition of residential individuals directly involved in the reportable incident.

Subsection (3) provides that if the Commissioner requires the registered provider to give a notice including specified further information about the reportable incident within a specified period, the provider must give the Commissioner a notice including that information within the specified period.

Subsection (4) provides that a notice given for the purposes of section 165A-30, must be made in writing and in the approved form.

The note following subsection (4) clarifies that the Commissioner may approve forms for the purposes of this Division and refers to section 585 of the Act, which sets out the requirements for the making of approved forms.

Section 165A-35 – Reporting not required in certain circumstances

Section 165A-35 provides that despite sections 165A-25 and 165A-30, which outline how and when a registered provider should provide a notice to the Commissioner about a reportable incident, the Commissioner may decide that a registered provider is not required to give a notice to the Commissioner about a reportable incident if the Commissioner is satisfied that:

- the same incident has been repeatedly alleged by an individual accessing funded aged care services to have occurred; and
- the allegation is the result of a delusion of the individual.

Before making any decision under 165A-35 the Commissioner is expected to seek and consider specialist clinical advice in accordance with paragraph 349(j) of the Act.

Section 165A-40 – Significant new information must be notified

Subsection 165A-40(1) provides that a registered provider must notify the Commissioner of significant new information relating to a reportable incident as soon as reasonably practicable after becoming aware of the information if:

- the provider notifies the Commissioner of a reportable incident under sections 165A-25 or 165A-30, which outline how and when a registered provider gives a notice to the Commissioner of a reportable incident; and
- the provider later becomes aware of significant new information.

Subsection (2) provides the notification must be made in writing and in the approved form.

The note following subsection (2) clarifies that the Commissioner may approve forms for the purposes of this Division and refers to section 585 of the Act.

Examples of significant new information relating to a reportable incident may include:

- where the level of harm to an individual is more significant than originally thought, for example:
 - where an injury was originally assessed to be minor bruising when reported, although it has now been determined that there is a broken bone;
 - where the harassment of an individual was originally reported to have caused no harm, although it is later found to have caused a significant psychological injury on the individual; or
 - where an individual later dies from injuries sustained from the incident.
- where it is later determined that the incident is also another kind of reportable incident, for example:
 - the incident was originally reported as neglect of an individual, although the neglect has led to the death of the residential individual so it would now also be considered an unexpected death;
 - the incident was originally reported as unreasonable use of force against an individual, although it is later found that there was also psychological or emotional abuse of the individual occurring at the same time.

Section 165A-45 – Final report about reportable incident must be given if required

Subsection (1) provides that, if required by the Commissioner, a registered provider must give the Commissioner a final report that includes specified information about a reportable incident.

Subsection (2) provides that the final report must be provided within 84 days (60 business days (assuming no public holidays), or 12 weeks) of the day the notice about the incident was first given to the Commissioner under sections 165A-25 or 165A-30 (which provide detail on when and how notices should be provided to the Commissioner), or within a different period as is specified by the Commissioner.

Subsection (3) provides that the final report must be made in writing, in the approved form, and contain the information specified by the Commissioner in subsection (1).

The note following subsection (3) clarifies that the Commissioner may approve forms for the purposes of this Division and refers to section 585 of the Act.

Division 3 – Provider Obligation- reporting to particular persons

Subdivision A – Vaccinations

Section 166-5 – Application of Subdivision to certain registered providers

Section 166-5 confirms that Subdivision A, as it pertains to vaccination reporting, applies to registered residential care providers.

Collecting this data on service staff and individuals is essential to preparing in-reach vaccination programs and outbreak preparedness planning and response. Reporting requirements also help to protect individuals, particularly during high peak seasons.

Section 166-10 – Reports about service staff—influenza vaccinations

Subsection (1) provides that a registered provider must on request by the System Governor or the Commissioner, give a report setting out the following information as at the reporting day specified in the request:

- the total number of service staff in relation to the approved residential care home;
- the number of those service staff who told the provider, either voluntarily or by law, that they have received the influenza vaccination for that year (whether or not through the provider's influenza vaccine program, if any).

Subsection (2) provides that the System Governor or the Commissioner may request a registered provider to give a report under subsection (1) at any time.

Subsection (3) provides that a request under subsection (2) must:

- be in writing; and
- specify a reporting day that is not more than 3 years before the request is made.

Subsection (4) provides that a registered provider must comply with a request to report under Subsection (2) within 7 days after the request is made, or within a longer period agreed in writing between the System Governor, or the Commissioner and the registered provider.

Section 166-15 – Reports about service staff—COVID-19 vaccinations

Subsection (1) provides that a registered provider must, on request by the System Governor or the Commissioner, give a report setting out the following information as at the reporting day specified in the request:

- the total number of service staff in relation to the approved residential care home; and
- the number of those service staff who have voluntarily informed the registered provider that they have, in the period specified in the request before the reporting day, received a COVID 19 vaccination.

Subsection (2) provides that the System Governor or the Commissioner may request a registered provider to give a report under subsection (1) at any time.

Subsection (3) provides that a request under subsection (2) must:

- be in writing; and
- specify a reporting day that is not more than 3 years before the request is made.

Subsection (4) provides that a registered provider must comply with a request to report under subsection (2) within 7 days after the request is made, or within a longer period, agreed in writing, between the System Governor, or the Commissioner and the registered provider.

Section 166-20 – Reports about individuals receiving residential care—influenza vaccinations

Subsection (1) provides that a registered provider must, on each influenza vaccination reporting day give the System Governor or the Commissioner a report in a form approved by the System Governor. The report must state the number of individuals accessing funded aged care services in an approved residential care home who have, voluntarily informed the registered provider that they have received the influenza vaccination for the calendar year that includes the influenza vaccination reporting day.

Subsection (2) defines influenza vaccination reporting day. For the purposes of this section, an influenza vaccination reporting day means 31 July each year.

The prescribed reporting day for the calendar year of 31 July aligns with the winter season when the risk and spread of common infectious respiratory diseases such as COVID-19 and influenza become greater.

Section 166-25 – Reports about individuals receiving residential care—COVID-19 vaccinations

Subsection (1) provides that a registered provider must, on request by the System Governor or the Commissioner, give a report in a form approved by the System Governor. The report must include the following information as at the reporting day specified in the request:

- per paragraph (1)(a), the total number of individuals accessing funded aged care services in an approved residential care home.
- per paragraph (1)(b), the number of those individuals who have voluntarily informed the registered provider, in the period specified in the request before the reporting day, that they had received one or more COVID19 vaccinations.
- of those individuals covered by paragraph (1)(b), the number of individuals who have informed the registered provider that they had received only one COVID19 vaccination.
- of those individuals covered by paragraph (1)(b), the number of individuals who have informed the registered provider that they had received two COVID19 vaccinations.

Subsection (2) provides that the System Governor or the Commissioner may request a registered provider to give a report under subsection (1) at any time.

Subsection (3) provides that a request under subsection (2) must:

- be in writing; and
- specify a reporting day that is not more than 3 years before the request is made.

Subsection (4) provides that a registered provider must comply with a request under subsection (2) within 7 days after the request is made, or such longer period as is agreed in writing, between the System Governor or the Commissioner and the registered provider.

Subdivision B – Quality Indicators

Section 166-105 – Application of Subdivision to certain registered providers

Subsection 166-105(1) confirms Subdivision C of this Part applies to a registered provider registered in provider registration category residential care. This is subject to subsection 166-105(2), which confirms Subdivision C of this Part does not apply to a registered provider delivering funded aged care services under a specialist aged care program.

Section 166-110 – Requirement to provide a quality indicators report

Subsection 166-110(1) confirms that a registered provider must give a quality indicators report on the quality indicators provided in this Subdivision to the System Governor for each reporting period, for the purposes of paragraph 166(1)(a) of the Act. The Note is a direction to section 166-115 for a quality indicators report reporting period.

Subsection 166-110(2) provides that information about the exclusion of any individuals, which are excluded for any reason, is required to be included by registered providers in the quality indicators report. The Note provides an example for registered providers to follow, with reference to paragraph 166-135(1)(b).

Section 166-112 – Requirements for the collection of information for quality indicators reports—measurements and assessments

Section 166-112 places requirements on providers with regard to measurement and assessment of information in the course of collecting information about individuals for the quality indicators report. The paragraphs under this section are in addition to a registered provider's reporting requirements, which specify a registered provider's requirement to provide a quality indicators report.

Paragraph 166-112(1)(a) confirms a registered provider must make measurements or other assessments relevant to indicating the quality of residential care. Paragraph 166-112(1)(b) confirms a registered provider must compile or otherwise derive information from those measurements and assessments mentioned in paragraph 166-112(1)(a).

Subsection 166-112(2) confirms that the measurements and assessments under paragraph 166-112(1)(a) may include the collection or use of personal information and health information about the individual accessing funded aged care services. This subsection specifies that such information is taken to have the same meaning of the Privacy Act. This reference clarifies that registered providers must handle such information accordingly.

Subsection 166-112(3) confirms that information compiled or otherwise derived under paragraph 166-112(1)(b) must not include personal information about the individual accessing funded aged care services.

Section 166-115 – Timeframes for reporting under this Subdivision

Section 166-115 provides the timeframe for the reporting period for a quality indicators report to be given to the System Governor for the purposes of subsection 166(4) of the Act. The reporting period for a quality indicators report given to the System Governor under this Subdivision is a quarter, which is a period of 3 months, beginning at the start of a financial

year. Additionally, a registered provider must give a quality indicators report to the System Governor within 21 days after the end of the reporting period.

Section 166-120 – Quality indicator—pressure injuries

Section 166-120 captures the quality indicator about pressure injuries, and the information from the assessment of individuals who acquired pressure injuries, distinguished by the relevant stages, in both residential care home spaces where funded aged care is delivered and spaces outside of the residential care home. Pressure injuries are to be reported in line with the requirements provided in this section and those provided in the Quality Indicator Program Manual, which is to be referred to in conjunction with the requirements outlined under this Subdivision. To maintain quality of data, this quality indicator also requires registered providers to report on individuals who were excluded under circumstances stated in paragraphs 166-120(1)(b) and (c).

Paragraph 166-120(1)(a) requires the number of individuals accessing funded aged care services that were assessed for pressure injuries to be included in the quality indicators report.

Paragraph 166-120(1)(b) requires the number of individuals accessing funded aged care services who were excluded because of withholding consent to undergo an observational assessment for pressure injuries throughout the reporting period, to be included in the quality indicators report. This data point, in conjunction with the data collected under paragraph 166-120(1)(c), increases the integrity of the other data points reported on under this quality indicator by capturing all individuals who were not assessed in the residential care home during the reporting period.

Paragraph 166-120(1)(c) requires the number of individuals accessing funded aged care services who were excluded because of an absence from accessing funded aged care services throughout the reporting period, to be included in the quality indicators report. This data point, in conjunction with the data collected under paragraph 166-120(1)(b), increases the integrity of the other data points reported on under this quality indicator by capturing all individuals who were not assessed in the residential care home during the reporting period.

Paragraph 166-120(1)(d) requires providers to report the number of individuals accessing funded aged care services who have one or more pressure injuries. The pressure injuries that are reported must be measured and reported against the sub-categories under paragraph 166-120(1)(e).

Paragraph 166-120(1)(e) requires registered providers to report an individual's pressure injuries against the following sub-categories:

- Stage 1 Pressure Injury;
- Stage 2 Pressure Injury;
- Stage 3 Pressure Injury;
- Stage 4 Pressure Injury;
- Unstageable Pressure Injury;
- Suspected Deep Tissue Pressure Injury;

These sub-categories are to be understood in the context of the Quality Indicator Program Manual, which provides descriptions of each sub-category, and further information on assessment and collection requirements.

Paragraph 166-120(1)(f) requires providers to report on the number of individuals accessing funded aged care services that have one or more pressure injuries acquired outside the approved residential care home during the reporting period. The intention of this data point is to capture which pressure injuries, if any, have been sustained outside the care of the residential care home. These pressure injuries are to be measured and reported against the sub-categories of paragraph 166-120(1)(g).

Paragraph 166-120(1)(g) requires registered providers to report each pressure injury acquired outside the approved residential care home during the reporting period against the following sub-categories:

- Stage 1 Pressure Injury;
- Stage 2 Pressure Injury;
- Stage 3 Pressure Injury;
- Stage 4 Pressure Injury;
- Unstageable Pressure Injury;
- Suspected Deep Tissue Pressure Injury.

The ‘Note’ under this section confirms for paragraphs 166-120(1)(e) and (g) the relevant sub-category of pressure injury is determined by reference to the ICD-10 Australian Modified Pressure Injury Classification System.

Subsection 166-120(2) outlines the assessment requirements that a registered provider must adhere to when preparing a quality indicators report for the purposes of subsection (1).

Paragraph 166-120(2)(a) confirms registered providers must identify a date once every reporting period when assessment for pressure injuries is to be carried out for each individual residing at the approved residential care home.

Paragraph 166-120(2)(b) confirms a registered provider must collect data relating to pressure injuries for each individual during a single observation assessment at approximately the same time every reporting period.

Paragraph 166-120(2)(c) confirms a registered provider must carry out assessment on or around the same time each reporting period and complete assessment as part of the individual’s routine personal care (such as bathing and toileting).

Subsection 166-120(3) confirms a registered provider must inform the individual they seek to assess for pressure injuries acquired by the individual and ensure the individual provides consent to be assessed before the assessment takes place.

Section 166-125 – Quality indicator—restrictive practices

Section 166-125 captures the quality indicator about restrictive practices, and the information from the assessment of individuals who were subject to restrictive practices in various circumstances, except for instances of chemical restraint, in line with requirements provided in this section and those provided for in the Quality Indicator Program Manual.

The purpose of this quality indicator is to record instances where an individual who is in the care of the registered provider is subject to a form of restraint. To maintain quality of data, this quality indicator also requires the reporting of individuals who were excluded from assessment of restrictive practices for relevant reasons.

Subsection 166-125(1) lists the type of information a quality indicators report must include in relation to restrictive practices. Paragraph 166-125(1)(a) confirms a registered provider must include a collection date within the reporting period in a quality indicators report. Paragraph 166-125(1)(b) confirms a registered provider must confirm the number of individuals whose records were assessed for the use of restrictive practices other than chemical restraint throughout the collection period. As noted in the Quality Indicator Program Manual, this includes physical restraint, mechanical restraint, environmental restraint and seclusion. These are defined under section 17-5.

Paragraph 166-125(1)(c) confirms a registered provider must provide the number of individuals excluded because of an absence from accessing funded aged care services throughout the collection period. Capturing exclusions under this quality indicator maintains the integrity of data captured in the relevant subsections under this section.

Paragraph 166-125(1)(d) confirms circumstances that must be reported on by a registered provider when individuals are subject to a restrictive practice other than chemical restraint. Subparagraph 166-125(1)(d)(i) ensures individuals subject to a restrictive practice on any occasion are captured under this section. Additionally, registered providers must also report on individuals who are subject to restrictive practices on any occasion that takes place only within a secured area per subparagraph 166-125(1)(d)(ii). The Note for this section refers to section 17-5 for the purpose of referencing practices and interventions that are restrictive practices in relation to individuals.

Subsection 166-125(2) confirms that for the purposes of section (1), the collection period for this quality indicator is a 3-day period during the reporting period. Subsection 166-125(3) outlines the assessment requirements that a registered provider must adhere to when preparing a quality indicators report for the purposes of this subsection.

Paragraph 166-125(3)(a) confirms a registered provider must identify and record a collection date which is to take place during each reporting period. Paragraph 166-125(3)(b) confirms a registered provider must ensure that the collection date is varied between reporting periods and unpredictable to staff directly involved in the care of an individual. Paragraph 166-125(3)(c) confirms a registered provider must ensure that the 3-day collection period consists of the selected collection date and the 2 days before that date. Paragraph 166-125(3)(d) confirms a registered provider must ensure that the 3-day collection period is the same for all individuals accessing funded aged care services at the approved residential care home.

Subsection 166-125(4) provides that registered providers must review an individual's existing record over the 3-day collection period and assess whether the individual was subject to the use of restrictive practices other than chemical restraint at any stage during the collection period.

Section 166-130 – Quality indicator—unplanned weight loss

Section 166-130 captures the quality indicator about unplanned weight loss, and the assessment of individuals who fall into either the category of significant unplanned weight loss, or the category of consecutive unplanned weight loss, in line with requirements provided in this section and those provided for in the Quality Indicator Program Manual. The categories are distinguished because consecutive unplanned weight loss may indicate different health and care trends than a single recording of significant unplanned weight loss.

Subsection 166-130(6) ensures where an individual is assessed in one category, this does not prevent the same individual from being assessed and reported from under the other category.

Subsection 166-130(1) confirms this quality indicator must include information on unplanned weight loss, with the information reported under the category of significant unplanned weight loss, or consecutive unplanned weight loss.

Subsection 166-130(2) details the information that a registered provider is to report on for the purposes of paragraph 166-130(1)(a), which is the category of significant unplanned weight loss. Paragraph 166-130(2)(a) confirms a registered provider must report on the number of individuals who were assessed for significant unplanned weight loss. Paragraph 166-130(2)(b) confirms a registered provider must report on the number of individuals who were excluded from assessment of significant unplanned weight loss because of withholding consent to be weighed on the finishing weight collection date. Paragraph 166-130(2)(c) confirms a registered provider must report on the number of individuals excluded from assessment of significant unplanned weight loss because of receiving end-of-life care. Paragraph 166-130(2)(d) confirms a registered provider is to report on the number of individuals excluded from the assessment of significant unplanned weight loss because the individual's previous or finishing weight were not recorded, including any comments on why any such weights were not recorded. Paragraph 166-130(2)(e) confirms a registered provider is to report on individuals who experienced a 5% or higher decrease in weight between the finishing weight and the previous weight.

Subsection 166-130(3) provides information collection requirements for providers when preparing a quality indicators report for the purposes of paragraph 166-130(1)(a). Paragraph 166-130(3)(a) requires providers to identify each individual's previous weight using the approved residential care home's weight records of individuals in the residential care home. Paragraph 166-130(3)(b) requires providers to collect and record the finishing weight for each individual residing at the approved residential care home in the final month of the current reporting period using a calibrated scale. Paragraph 166-130(3)(c) requires providers to seek the consent of the individuals concerned before making the assessment required and must record any refusal to provide consent by an individual being assessed for their finishing weight. Paragraph 166-130(3)(d) requires registered providers to weigh the individuals at or around the same time each month and at or around the same time of the day and ensure that the individual is wearing clothing of a similar weight. Paragraph 166-130(3)(e) requires providers to ensure for each individual who provided their consent for the making of the assessment, compare their finishing weight from the current reporting period with their previous weight and calculate the percentage weight loss.

Subsection 166-130(4) details the information that a registered provider is to report on for the purposes of paragraph 166-130(1)(b), which is the category of consecutive unplanned weight loss. Paragraph 166-130(4)(a) requires registered providers to report on the number of individuals who were assessed for consecutive unplanned weight loss. Paragraph 166-130(4)(b) requires registered providers to report on the number of individuals who were excluded because of withholding consent to be weighed on any weight collection date. Paragraph 166-130(4)(c) requires registered providers to report the number of individuals who were excluded because of receiving end of life care. Paragraph 166-130(4)(d) requires registered providers to report the number of individuals who were excluded because any of the required weights were not recorded, including comments on why any such weights were not recorded. Paragraph 166-130(4)(e) requires registered providers to report the number of

individuals who experienced any decrease in weight between the previous weight, starting weight, middle weight and finishing weight.

Subsection 166-130(5) provides information collection requirements for providers when preparing a quality indicators report for the purposes of paragraph 166-130(1)(b). Paragraph 166-130(5)(a) requires providers to measure consecutive unplanned weight loss as the weight loss of any amount measured every month over 3 consecutive months of a reporting period, and compare the 3 monthly weights against each other and against the finishing weight from the previous reporting period. Such collection and comparison is necessary for maintaining the integrity of data under this paragraph. Paragraph 166-130(5)(b) requires providers to use their approved residential care home's weight records in identifying each individual's previous weight. Paragraph 166-130(5)(c) requires providers, within the first month of the reporting period, to collect and record the starting weight of each individual residing at the approved residential care home using a calibrated scale. Paragraph 166-130(5)(d) requires registered providers to, in the second month of the reporting period, collect and record the middle weight of each individual residing at the approved residential care home using a calibrated scale. Paragraph 166-130(5)(e) requires providers to, in the third and final month of the reporting period, collect and record the finishing weight of each individual at the approved residential care home using a calibrated scale. To avoid unnecessary repeated measurement and collection of weights, paragraph 166-130(5)(f) allows providers to use the previous weight and finishing weights that are already recorded and collected to assess significant unplanned weight loss for assessing consecutive unplanned weight loss, and are not required to collect these weights again. Paragraph 166-130(5)(g) requires providers to seek the consent of the individuals concerned before making the assessment required and must record any refusal to provide consent by an individual being assessed for their finishing weight. Paragraph 166-130(5)(h) requires providers to weigh individuals at or around the same time each month and at around the same time of the day and ensure that the individual is wearing clothing of a similar weight. Paragraph 166-130(5)(i) requires providers to compare previous, starting, middle and finishing weight of all individuals who consented for the making of the assessment to determine whether there has been a weight loss in every month over 3 consecutive months of a reporting period.

Subsection 166-130(6) confirms that where an individual is assessed under one category of unplanned weight loss, this does not limit the ability to be assessed and reported under the other category of unplanned weight loss.

Section 166-135 – Quality indicator—falls and major injury

Section 166-135 captures the assessment of individuals who experience falls and falls resulting in major injury, in line with requirements provided in this section and those provided for in the Quality Indicator Program Manual. To maintain quality of data, this quality indicator also requires the inclusion of individuals who were excluded for relevant reasons.

Subsection 166-135(1) details what information on falls and falls resulting in major injury must be included in a quality indicators report. Paragraph 166-135(1)(a) requires providers to report the number of individuals accessing funded aged care services whose records were assessed for falls and falls resulting in major injury. Paragraph 166-135(1)(b) requires providers to report the number of individuals accessing funded aged care services who were excluded because of an absence from accessing funded aged care services at the approved

residential care home throughout the reporting period. Paragraph 166-135(1)(c) requires providers to report the number of individuals accessing funded aged care services who experienced one or more falls at the approved residential care home during the reporting period. Paragraph 166-135(1)(d) requires providers to report the number of individuals accessing funded aged care services who experienced one or more falls at the approved residential care home resulting in major injury during the reporting period.

Subsection 166-135(2) details collection requirements for providers when preparing a quality indicators report. Paragraph 166-135(2)(a) confirms providers must identify and record a collection date for the reporting period. Paragraph 166-135(2)(b) confirms providers must ensure the collection date is in the 21 days after the end of the reporting period. This is in order to review records for the entire reporting period.

Section 166-140 – Quality indicator—medication management

Section 166-140 captures the assessment of individuals who are assessed for medication management under the respective categories of polypharmacy and antipsychotics, with the relevant reporting and collection requirements clarified for the respective categories. Such requirements are to be read with the Quality Indicator Program Manual, which provides guiding explanations for the requirements. To maintain quality of data, this quality indicator also requires the inclusion of individuals who were excluded for relevant reasons.

Subsection 166-140(1) confirms the two categories of medication management which a quality indicators report must include: polypharmacy under paragraph 166-140(1)(a); and antipsychotics under paragraph 166-140(1)(b).

Subsection 166-140(2) provides reporting information that providers must include in a quality indicators report for the category of polypharmacy. Paragraph 166-140(2)(a) confirms providers must include the collection date in the reporting period. Paragraph 166-140(2)(b) confirms providers must include the number of individuals assessed for polypharmacy. Paragraph 166-140(2)(c) confirms providers must include the number of individuals excluded from assessment because they were admitted in hospital on the collection date. Paragraph 166-140(2)(d) confirms providers must include the number of individuals prescribed 9 or more medications based on a review of either the individual's medication chart or the individual's administration record, as reviewed on the collection date.

Subsection 166-140(3) provides reporting information that providers must include in a quality indicators report for the category of antipsychotics. Paragraph 166-140(3)(a) confirms providers must include the collection date in the reporting period. Paragraph 166-140(3)(b) confirms providers must include the number of individuals assessed for antipsychotic medications. Paragraph 166-140(3)(c) confirms providers must include the number of individuals excluded from assessment because they were admitted in hospital for at least 6 days prior to the collection date. Paragraph 166-140(3)(d) confirms providers must include the number of individuals that received an antipsychotic medication based on a review of either the individual's medication chart or the individual's administration record, as reviewed on the collection date. Paragraph 166-140(3)(e) confirms providers must include the number of individuals that received an antipsychotic medication for a medically diagnosed condition of psychosis based on a review of either the individual's medication chart or the individual's administration record, as reviewed on the collection date.

Subsection 166-140(4) confirms requirements for a review of records for the category of polypharmacy, for the purposes of paragraph 166-140(2)(a). It confirms the collection of data can take place on any date during the reporting period, and when the collection is taken, it must involve a single review for each individual's medication charts and administration records.

Subsection 166-140(5) provides collection requirements for the category of polypharmacy. Providers must identify and record a collection date for the reporting period and use each individual's medication charts and administration records as at the identified collection date.

Subsection 166-140(6) confirms collection date requirements for antipsychotics, for the purposes of paragraph 166-140(3)(a). It confirms the collection date is the final day in the collection period which for that subsection is a 7-day period during the reporting period.

Subsection 166-140(7) provides requirements for the collection and assessment of data under the category of antipsychotics.

Paragraph 166-140(7)(a) confirms that providers must identify a collection date during the reporting period, which must fall between the second week and the final day of the reporting period. This timing ensures that data is not influenced by early-period anomalies.

Paragraph 166-140(7)(b) confirms that providers must assess and review all individuals' medication charts and administration records during a 7-day assessment period that includes the collection date and the 6 preceding days. This aligns with the Quality Indicator Program Manual's requirement to capture antipsychotic administration over a consistent timeframe to support accurate reporting.

Paragraph 166-140(7)(c) confirms that the collection date must vary between reporting periods and must not be identified to staff directly involved in the care of individuals accessing funded aged care services. This requirement is intended to prevent behavioural changes or documentation practices that could influence the validity of the data collected.

Paragraph 166-140(7)(d) confirms that the assessment and review must be conducted by staff who are not directly involved in the care of individuals receiving funded aged care services. This separation of roles supports objectivity and aligns with the Quality Indicator Program Manual's emphasis on independent data collection to ensure the reliability and comparability of reported outcomes.

Section 166-145 – Quality indicator—activities of daily living

Section 166-145 captures the assessment of individuals receiving funded aged care services in relation to their functional ability to perform activities of daily living (ADLs). The section outlines reporting requirements for providers to identify individuals who have experienced a decline in ADL function, as measured by the Barthel Index. These requirements are to be read in conjunction with the Quality Indicator Program Manual, which provides further guidance on assessment tools, scoring, and exclusions.

Subsection 166-145(1) confirms the categories of information that must be included in a quality indicators report for activities of daily living. Paragraph 166-145(1)(a) confirms providers must include the number of individuals assessed for ADL function. Paragraph 166-145(1)(b) confirms providers must include the number of individuals excluded from

assessment due to receiving end-of-life care. Paragraph 166-145(1)(c) confirms providers must include the number of individuals excluded because they did not access funded aged care services at any time during the reporting period. Paragraph 166-145(1)(d) confirms providers must include the number of individuals excluded because an ADL assessment was not recorded in the previous reporting period, including commentary on why the previous assessment was not recorded. Paragraph 166-145(1)(e) confirms providers must include the number of individuals who were assessed and received a total score of zero in the previous reporting period. Paragraph 166-145(1)(f) confirms providers must include the number of individuals who were assessed for and experienced a decline in their total ADL score by one or more points.

Subsection 166-145(2) confirms that providers must ensure the collection of ADL information involves a single assessment for each individual, completed around the same time in each reporting period. This consistency supports comparability and reliability of data. The assessment must be compared to the individual's total ADL score from the previous reporting period to determine whether a decline has occurred. Subsection 166-145(3) outlines the method for conducting and comparing ADL assessments. Paragraph 166-145(3)(a) confirms providers must identify each individual's ADL total score from the previous reporting period using care records maintained by the approved residential care home. Paragraph 166-145(3)(b) confirms providers must conduct the ADL assessment using the Barthel Index of Activities of Daily Living assessment tool, ensuring all questions are completed. Paragraph 166-145(3)(c) confirms providers must compare the total score from the previous reporting period with the current reporting period to determine whether the individual experienced a decline of one or more points. The 'Note' lists the fundamental skills that are typically needed to manage basic physical needs. These include, grooming and personal hygiene such as oral care, dressing, toileting and continence, ambulating and movement, and eating.

Section 166-150 – Quality indicator—incontinence care

Section 166-150 captures the assessment of individuals receiving funded aged care services in relation to incontinence and associated skin integrity. The section outlines reporting requirements for identifying individuals with incontinence and those who experience Incontinence Associated Dermatitis (IAD), using the Ghent Global IAD Categorisation Tool. These requirements are to be read in conjunction with the Quality Indicator Program Manual, which provides guidance on assessment tools, scoring, exclusions, and reporting. Subsection 166-150(1) confirms the categories of information that must be included in a quality indicators report for incontinence care. Paragraph 166-150(1)(a) confirms providers must report the number of individuals assessed for incontinence care. Paragraph 166-150(1)(b) confirms providers must report the number of individuals excluded from assessment due to absence from accessing funded aged care services throughout the reporting period. This includes hospitalisation, leave, or any other reason that prevents participation in care during the full reporting period. Paragraph 166-150(1)(c) confirms providers must report the number of individuals excluded from IAD assessment because they did not have incontinence. Only individuals identified as incontinent are assessed for IAD. Paragraph 166-150(1)(d) confirms providers must report the number of individuals with incontinence and IAD, categorised using the Ghent Global IAD Categorisation Tool, which includes the following categories:

- 1A: persistent redness without clinical signs of infection
- 1B: persistent redness with clinical signs of infection
- 2A: skin loss without clinical signs of infection

- 2B: skin loss with clinical signs of infection

Paragraph 166-150(1)(e) confirms providers must report the number of individuals identified as having incontinence, regardless of whether IAD is present.

Paragraph 166-150(1)(f) confirms providers must report the number of individuals who have both incontinence and IAD. This data supports monitoring of skin integrity and quality of continence care.

Subsection 166-150(2) provides requirements for providers when preparing a quality indicators report for the purpose of subsection 166-150(1).

Paragraph 166-150(2)(a) confirms providers must identify a date once every reporting period to assess each individual for incontinence as part of routine care. The assessment must be conducted around the same time each quarter to ensure consistency. Paragraph 166-150(2)(b) confirms that IAD assessments must be conducted by staff who understand the Ghent Tool and have the necessary skills and experience to apply it accurately and safely. This ensures clinical validity and protects each individual. Paragraph 166-150(2)(c) confirms that if personal care workers observe or identify signs of redness or skin loss during routine care, such as bathing or toileting, they must escalate the concern to appropriately trained staff for further assessment. Paragraph 166-150(2)(d) confirms providers must consult with a suitably qualified health practitioner if there is uncertainty about the presence or severity of IAD.

Subsection 166-150(3) confirms that the collection of information must involve a single assessment for each individual as part of routine care, conducted around the same time every reporting period.

Section 166-155 – Quality indicator—hospitalisation

Section 166-155 captures the assessment of individuals receiving funded aged care services in relation to hospitalisation events, including emergency department presentations and hospital admissions. This indicator supports monitoring of care quality, identification of potentially preventable hospitalisations, and continuous improvement in clinical and care practices. These requirements are to be read in conjunction with the Quality Indicator Program Manual, which provides further guidance on definitions, exclusions, and data collection methods.

Subsection 166-155(1) confirms the required information that must be included in a quality indicators report for hospitalisation. Paragraph 166-155(1)(a) confirms providers must report the number of individuals assessed for hospitalisation. Paragraph 166-155(1)(b) confirms providers must report the number of individuals excluded from assessment due to absence from accessing funded aged care services throughout the reporting period. This includes individuals who were hospitalised, on leave, or otherwise not present for throughout the reporting period. Paragraph 166-155(1)(c) confirms providers must report the number of individuals who had one or more emergency department presentations during the reporting period. Paragraph 166-155(1)(d) confirms providers must report the number of individuals who had one or more emergency department presentations or hospital admissions during the reporting period. This broader category captures all hospitalisation events and supports analysis of care outcomes and responsiveness at the approved residential care home.

Subsection 166-155(2) outlines requirements for conducting assessments and ensuring data quality. Paragraph 166-155(2)(a) confirms providers must ensure that the collection of hospitalisation data involves a single review of care records for each individual, covering the entire reporting period. Paragraph 166-155(2)(b) confirms providers must complete the review of care records within 21 days after the end of the reporting period. This timeframe ensures timely reporting and supports the accuracy of submitted data.

Section 166-160 – Quality indicator—workforce

Section 166-160 captures information on the composition and continuity of the workforce delivering funded aged care services. This quality indicator supports monitoring of workforce stability, availability, and retention across staff categories. It provides insight into staffing patterns that influence the quality and consistency of care. These requirements are to be read in conjunction with the Quality Indicator Program Manual, which provides further guidance on definitions, data collection, and reporting.

Subsection 166-160(1) confirms that a quality indicators report must include information on the workforce of a registered provider, reported against subcategories of staff delivering funded aged care services. Paragraph 166-160(1)(a) confirms providers are to report on service managers, defined in the Quality Indicator Program Manual as staff who manage the operations of a residential aged care service. This includes leading staff teams to ensure the provision of quality care, in line with the aged care standards. Paragraph 166-160(1)(b) confirms providers are to report on nurse practitioners and registered nurses, who provide clinical care, assessments, and supervision of other care staff. Both of these roles have the same meaning as the definitions provided in the *Health Insurance Act 1973*. Paragraph 166-160(1)(c) confirms reporting on enrolled nurses, who provide nursing care under the supervision of registered nurses and are defined under the Act. Paragraph 166-160(1)(d) confirms reporting on personal care workers and nursing assistants, who provide direct personal care and support with daily living activities. The Quality Indicator Program Manual provides guidance on personal care works, while nursing assistants are defined under the Act.

Subsection 166-160(2) outlines the reporting requirements of providers when reporting under each staff subcategory. Paragraph 166-160(2)(a) confirms providers must report the number of staff who worked any number of hours during the reporting period. This includes casual, part-time, and full-time staff, and reflects overall workforce participation. Paragraph 166-160(2)(b) confirms providers must report the number of staff who were employed at the start of the reporting period and worked at least 120 hours during the reporting period. This measure reflects workforce stability and continuity of care, as it captures staff who were consistently present and active throughout the quarter. Paragraph 166-160(2)(c) confirms providers must report the number of staff who were employed at the start of the reporting period and did not work for at least 60 consecutive days during the reporting period. This measure identifies staff who were effectively absent for a significant portion of the reporting period, which may indicate turnover, extended leave, or disengagement.

Subsection 166-160(3) confirms that, for the purposes of subsection (1), registered providers must review workforce records within 21 days after the end of the reporting period. This is in order to review records for the entire reporting period, and ensure timely and accurate reporting of staffing data.

Section 166-165 – Quality indicator—Consumer Experience Assessment

Section 166-165 captures the experience of individuals receiving funded aged care services, as assessed through the Quality of Care Experience – Aged Care Consumers (QCE-ACC) Tool, developed by Flinders University. This indicator supports the measurement of how well funded aged care services meet the needs, preferences, and expectations of each individual. The section outlines reporting requirements for participation, exclusion, and scoring across defined experience categories. These requirements are to be read in conjunction with the Quality Indicator Program Manual, which provides detailed guidance on assessment methods, scoring, and reporting.

Subsection 166-165(1) confirms the categories of information that must be included in a quality indicators report for consumer experience.

Paragraph 166-165(1)(a) confirms providers must report the number of individuals excluded from the Consumer Experience Assessment due to absence from the service throughout the reporting period. Paragraph 166-165(1)(b) confirms providers must report the number of individuals excluded because they chose not to complete the Consumer Experience Assessment in the reporting period.

Paragraph 166-165(1)(c) confirms providers must report the number of individuals who were offered the Consumer Experience Assessment through one of the assessment versions under this paragraph. Individuals can complete the Consumer Experience Assessment through the self-completion, using the QCE-ACC Self Complete Version. Individuals can complete the Consumer Experience Assessment through interviewer facilitation, using the QCE-ACC Interviewer Facilitated Version. Individuals can complete the Consumer Experience Assessment through a proxy, using the QCE-ACC Proxy Version. These versions ensure accessibility for individuals with varying levels of cognitive and physical ability.

Paragraph 166-165(1)(d) confirms providers must report the number of individuals who completed the assessment and their scores, grouped into five experience categories. Scores are derived from six questions rated on a five-point scale from “never” to “always,” with total scores reflecting overall experience. The five experience categories are:

- excellent: score between 22 and 24;
- good: score between 19 and 21;
- moderate: score between 14 and 18;
- poor: score between 8 and 13;
- very poor: score between 0 and 7.

Subsection 166-165(2) confirms that providers must use the QCE-ACC Tool to collect consumer experience data. This tool is designed to capture meaningful feedback from individuals accessing funded aged care and is endorsed for use under the QI Program.

Subsection 166-165(3) confirms that providers must collect consumer experience data from each individual once every reporting period. This includes the exclusions given by individuals who refuse to participate in the Consumer Experience Assessment. This ensures regular monitoring and supports service improvement over time.

Subsection 166-165(4) outlines requirements for providers when offering and administering the QCE-ACC Tool assessment. Paragraph 166-165(4)(a) confirms providers must offer the QCE-ACC Self Complete Version to suitable individuals at the approved residential care home at or around the same time each reporting period. Paragraph 166-165(4)(b) confirms that individuals with no or mild cognitive impairment must be allowed to self-complete the QCE-ACC Self Complete Version. Paragraph 166-165(4)(c) confirms that providers must arrange interviewer-facilitated completion for individuals requiring assistance with reading or writing, using the QCE-ACC Interviewer Facilitated Version, at or around the same time every reporting period. Paragraph 166-165(4)(d) confirms that providers must arrange proxy completion for individuals unable to complete the assessment themselves, such as those with moderate or severe cognitive impairment, using the QCE-ACC Proxy Version, at or around the same time every reporting period.

Section 166-170 – Quality indicator—Quality of Life Assessment

Section 166-170 captures the experience of individuals accessing funded aged care services in relation to their perceived quality of life. This quality indicator uses the Quality of Life Aged Care Consumers (QOL-ACC) Tool, developed by Flinders University, to assess and report on each individual's wellbeing across six domains. The section outlines reporting requirements for participation, exclusion, scoring, and assessment methods. These requirements are to be read in conjunction with the Quality Indicator Program Manual, which provides detailed guidance on assessment tools, scoring, and reporting.

Subsection 166-170(1) confirms the categories of information that must be included in a quality indicators report for quality of life. Paragraph 166-170(1)(a) confirms providers must report the number of individuals who were offered a Quality of Life Assessment through one of the assessment versions under this paragraph. Individuals can complete the Quality of Life Assessment through the QOL-ACC Self Complete version. Individuals can complete the Quality of Life Assessment through interviewer facilitation, using the QOL-ACC Interviewer Facilitated Version. Individuals can complete the Quality of Life Assessment through a proxy, using the QOL-ACC Proxy Version. These versions ensure accessibility for individuals with varying levels of cognitive and physical ability.

Paragraph 166-170(1)(b) confirms providers must report the number of individuals excluded from the assessment due to absence from accessing funded aged care services throughout reporting period. This includes hospitalisation, leave, or other reasons for non-participation.

Paragraph 166-170(1)(c) confirms providers must report the number of individuals excluded because they chose not to complete the Quality of Life Assessment in the reporting period.

Paragraph 166-170(1)(d) confirms providers must report the number of individuals who completed the assessment and their scores, grouped into five experience categories:

- excellent: score between 22 and 24;
- good: score between 19 and 21;
- moderate: score between 14 and 18;
- poor: score between 8 and 13;
- very poor: score between 0 and 7.

Subsection 166-170(2) confirms that providers must use the QOL-ACC Tool to collect quality of life data. This validated tool is designed to capture meaningful feedback from each individual accessing funded aged care services and is endorsed for use under the QI Program.

Subsection 166-170(3) confirms that providers must collect quality of life data from each individual once every reporting period. This includes the exclusions given by individuals who refuse to participate in the Quality of Life Assessment. This ensures regular monitoring and supports improvement at the approved residential care home over time.

Subsection 166-170(4) outlines requirements for providers administering the QOL-ACC assessment. Paragraph 166-170(4)(a) confirms providers must offer the QOL-ACC Self Complete Version to suitable individuals at the approved residential care home around the same time each reporting period. Paragraph 166-170(4)(b) confirms providers must allow individuals with no or mild cognitive impairment to self-complete the QOL-ACC Self Complete Version. Paragraph 166-170(4)(c) confirms that interviewer-facilitated completion must be arranged for individuals requiring assistance with reading or writing, using the QOL-ACC Interviewer Facilitated Version, at or around the same time every reporting period. Paragraph 166-170(4)(d) confirms that proxy completion must be arranged for individuals unable to complete the assessment themselves, such as those with moderate or severe cognitive impairment, using the QOL-ACC Proxy Version, at or around the same time every reporting period.

Section 166-175 – Quality indicator—allied health

Section 166-175 captures the assessment and delivery of allied health services to individuals accessing funded aged care services in residential care homes. This indicator supports monitoring of access to allied health professionals and the alignment between recommended and delivered services. Under this section, providers are obliged to report on data under subsection 166-175(1) for the purpose of a quality indicator report. The remaining subsections under this section are reporting requirements which are satisfied under the Quarterly Financial Reporting requirements. This means that for the remaining subsections, providers are not required to collect and report data for the purpose of a quality indicator report, as this would lead providers to be reporting on such data more than once into the Government Provider Management System. All subsections and their requirements are to be read in conjunction with the Quality Indicator Program Manual, which provides data

collection guidance, and reporting standards for allied health services. Subsection 166-175(1) confirms the categories of information that must be included in a quality indicators report for allied health. Paragraph 166-175(1)(a) confirms providers must report the number of individuals who were assessed for services delivered by an allied health professional during the reporting period. Assessment may occur through routine care planning, clinical review, or multidisciplinary team input. Allied health professionals include physiotherapists, occupational therapists, speech pathologists, dietitians, podiatrists, and others as defined under the Rules.

Paragraph 166-175(1)(b) confirms providers must report the number of individuals excluded from assessment due to absence from accessing funded aged care services throughout the reporting period. This includes hospitalisation, leave, or other reasons for non-participation.

Paragraph 166-175(1)(c) confirms providers must report the number of allied health and therapy services that were recommended to be delivered by an allied health professional. Recommendations may be documented in care and services plans under paragraph 148(e) of the Act, which requires providers to plan for services that maintain or restore an individual's ability to perform daily tasks.

Paragraph 166-175(1)(d) confirms providers must report the number of recommended allied health services that were actually received during the reporting period, reported against the subcategories set out in Subsection 166-175(3). This comparison supports analysis of service delivery gaps and informs continuous improvement efforts.

The Note directs to section 148 of the Act to ensure reference is made to Delivery of funded aged care services requirements.

Subsection 166-175(2) confirms that providers must collect and report the number of allied health professional labour hours, and represent this as minutes of care and services to individuals each day. This is reported separately as allied health professional employee labour hours, and allied health professional agency labour hours. This subsection is a requirement for providers under this division, however these data points are already reported on by providers under the Quarterly Financial Reporting requirements. As such, providers do not need to report this data into GPMS for the purposes of a quality indicators report.

Subsection 166-175(3) confirms a provider must report against each of the following subcategories of allied health professionals:

- physiotherapist;
- occupational therapist;
- speech pathologist;
- podiatrist;
- dietitian;
- allied health assistant;
- other allied health professionals.

Subsection 166-175(4) confirms the health professionals which are included under other allied health professionals in subsection 166-175(3). These are:

- art therapists;
- audiologists;
- exercise physiologists;

- music therapists;
- chiropractors;
- counsellors;
- osteopaths;
- psychologists;
- social workers

Subsection 166-175(5) confirms a provider must collect information as to recommended funded aged care services in the service type allied health and therapy by undertaking a single review of all individual's care records for the entire reporting period, and only report once per allied health discipline. This means that if multiple occasions of an allied health service are recommended against any of the subcategories set out in Subsection 166-175(3) during the reporting period, the recommended service is only counted once for each individual. It also means that if multiple occasions of a recommended allied health service are received against any of the subcategories set out in Subsection 166-175(3) during the reporting period, the received service is only counted once for each individual.

Section 166-180 – Quality indicator—lifestyle officers

Section 166-180 captures the assessment of lifestyle officers, which includes the number of hours worked by lifestyle officers while providing care directly to individuals, and working generally as agency staff. This also includes information on occupied bed days for a provider for the reporting period. The subsections under this section are reporting requirements which are satisfied under the Quarterly Financial Reporting requirements. This means that for this section, providers are not required to collect and report data for the purpose of a quality indicators report, as this would lead providers to be reporting on such data more than once into GPMS. All subsections and their requirements are to be read in conjunction with the Quality Indicator Program Manual, which provides data collection guidance, and reporting standards for allied health services.

Subsection 166-180(1) confirms a quality indicators report must include the total labour hours worked in direct care by lifestyle officers, and the total labour hours worked as agency staff by lifestyle officers. The 'Note' under this subsection confirms a lifestyle officer can include a diversional officer, a recreation officer, and an activities officer. This information is already reported by a provider through their reporting requirements under Quarterly Financial Reporting.

Subsection 166-180(2) confirms a registered provider must also provide information on the number of occupied bed days for a provider for the reporting period. This too is satisfied by a provider's reporting requirements under Quarterly Financial Reporting.

Section 166-185 – Quality indicator—enrolled nursing

Section 166-185 captures reporting requirements for enrolled nursing, in relation to direct care staff members that deliver funded aged care services:

- enrolled nursing total direct care hours;
- registered nursing total direct care hours;
- personal care workers and nursing assistants total direct care hours.

The subsections under this section are reporting requirements which are satisfied under the Quarterly Financial Reporting requirements. This means that for this section, providers are not required to collect and report data for the purpose of a quality indicators report, as this would lead providers to be reporting on such data more than once into GPMS. All subsections and their requirements are to be read in conjunction with the Quality Indicator Program Manual, which provides data collection guidance, and reporting standards for allied health services.

Subsection 166-185(1) confirms a quality indicators report must include information on enrolled nursing total direct care hours, registered nursing total direct care hours, and personal care workers and nursing assistants total direct care hours. These reporting requirements are satisfied by the reporting obligations under Quarterly Financial Reporting.

Subsection 166-185(2) confirms direct care staff members covered under this section are those specified in paragraphs (a) to (d) of the definition of direct care staff members under the Act.

Subdivision C – Complaints and feedback management report

Section 166-205 – Application of Subdivision

Section 166-205 confirms that the complaints and feedback reporting requirements apply to the following provider registration categories:

- personal and care support in the home or community
- nursing and transition care
- residential care

Subsection (2) confirms that this Subdivision applies to feedback received by a registered provider that is managed in accordance with section 165-30 and raises an issue referred to in subsection 165-30(2). This application provision ensures, registered providers are not required to respond to each and every piece of feedback received, including neutral or positive feedback.

Section 166-210 – Requirements for reporting information relating to complaints and feedback management

Section 166-210 sets out the requirements for providers to report information relating to complaints and feedback management.

Subsection (1) provides that a registered provider must give a complaints and feedback management report to the Commissioner within 4 months after the end of the reporting period for the registered provider.

Subsection (2) confirms that the reporting period for a registered provider is:

- the period of 12 months starting on 1 July of a year; or
- another 12-month period determined for the registered provider by the System Governor in accordance with the Rules.

Subsection (3) requires that the report be in the approved form, be signed by a governing body of the registered provider and include the below required information, being a summary of the management of complaints and feedback.

Subsection (4) sets out that the following information must be included in a report:

- information about each complaint and feedback received, including the number and nature of complaints and feedback received and the nature of the complaints and feedback
- information about the actions taken to resolve complaints or in response to feedback received, including any subsequent improvements made by the registered provider in relation to complaints and feedback
- information about an evaluation of the effectiveness of the actions taken and their related outcomes in relation to each complaint and feedback
- information about the number of days taken to resolve each complaint or feedback
- information about the education and training that has been delivered to the staff of the registered provider in relation to each complaint and feedback
- an analysis of the patterns of, and underlying reasons for, complaints.

These above reporting requirements implement the recommendations of the Royal Commission's Final Report, which identified a lack of transparency and accountability in how providers manage complaints and feedback about what providers are doing and how well they are doing it.

In providing information on each complaint and feedback received, it is not intended that providers would provide exhaustive details or personal identifying information that may be subject to privacy considerations. Instead, it is expected that providers will provide the requested information on each complaint and feedback received in summary form, for example, a table could be provided with columns headings correlating to the requested information in subparagraphs (4)(a) to (4)(e) and a new row for each complaint or feedback.

It is the policy intent that requiring providers to report on the evaluation of the effectiveness of actions taken will assist providers to reflect on actions taken throughout the reporting period to respond to complaints and feedback and consider any opportunities for improvement. Reporting this information will assist the Commission in focusing provider education on any areas for improvement while acknowledging what is already working well. This evaluation may include considering whether the provider used open disclosure in its response, and the use and effectiveness of any restorative practices used.

Additionally, it is the policy intent that requiring providers to undertake an analysis of complaints will involve considering all complaints received within the reporting period, identifying patterns and trends and taking steps to address any underlying reasons or causes. This will assist providers in their efforts towards continuous improvement.

Subdivision D – Complaints and feedback information on request

Section 166-215 – Application of Subdivision to all registered providers

Section 166-215 confirms that the below requirements for reporting complaints and feedback management on request apply to every kind of registered provider.

Subsection (2) provides that this Division applies to feedback received by a registered provider that is managed in accordance with section 165-30 and raises an issue referred to in subsection 165-30(2). This is to ensure that registered provider reporting requirements do not extend to positive or neutral feedback received by the provider.

Section 166-220 – Requirements for reporting information on request relating to complaints and feedback management

Section 166-220 sets out the requirements for reporting information on request relating to complaints and feedback management.

Subsection (1) provides that a registered provider must on request by the System Governor or the Commissioner provide a complaints and feedback management report.

Subsection (2) outlines that the System Governor or the Commissioner may request a complaints and feedback management report at any time.

Subsection (3) provides that a registered provider must comply with the request under Subsection (1) within 14 days, or a longer period where that is specified in the request.

Subsection (4) provides that the report must be in the approved form, signed by the governing body of the registered provider and include the below prescribed information.

Per subsection (5), the report must include the following information:

- information about each complaint and feedback received, including the number of complaints and feedback and the nature of the complaints and feedback
- information about the action taken to resolve complaints or in response to feedback received including, any subsequent improvements made by the registered provider in relation to complaints and feedback
- information about an evaluation of the effectiveness of the actions taken and the related outcomes in relation to each complaint and feedback
- information about the number of days taken to resolve each complaint and feedback
- information about the education and training that has been delivered to the staff of the registered provider in relation to each complaint and feedback
- an analysis of the patterns of, and underlying reasons for, complaints.

In providing information on each complaint and feedback received, it is not intended that providers would provide exhaustive details or personal identifying information that may be subject to privacy considerations. Instead, it is expected that providers will provide the requested information on each complaint and feedback received in summary form. For example, a table could be provided with column headings correlating to the requested information in paragraphs (5)(a) to (5)(e) and a new row for each complaint/feedback.

For the avoidance of doubt, the complaints and feedback management report will contain the same information in the same format, whether it be provided as part of the annual reporting obligation under section 166-210 of the Rules or upon request from the System Governor or Commissioner under this section.

Enabling the System Governor and the Commissioner to request a report ensures that all providers are subject to accountability and transparency measures, where reasonable and appropriate, even where they may not be required to report annually.

Subdivision E— Prudential and financial

Section 166-310 – Aged care financial report—general

Section 166-310 sets out the requirements for registered providers to submit an aged care financial report to the System Governor each reporting period, ensuring transparency and accountability among registered providers in relation to financial obligations.

Subsection 166-310(1) provides that subject to subsection 166-310(2):

- this section applies to every kind of registered provider prescribed in the Act.
- registered providers must give a report about their financial and prudential matters, which is referred to as the ***aged care financial report*** in the Rules, to the System Governor each reporting period for the registered provider.

Subsection 166-310(2) provides that the requirements of this section do not apply in respect of the delivery of funded aged care services provided under the specialist aged care programs listed under this subsection, which are CHSP, NATSIFACP and TCP. The ‘Note’ provides that requirements relating to an annual prudential compliance statement are found in section 166-360 of the rules.

Requirements for an aged care financial report

Subsection 166-310(3) sets out the requirements for an aged care financial report produced by the registered provider. The report must:

- be in the approved report form and
- be signed by a governing body of the registered provider and
- be given to the System Governor within 4 months after the end of each reporting period for the registered provider; and
- if section 166-315 of the rules applies, the report must include a financial support statement; and
- if section 166-345 of the rules applies, include a general purpose financial report; and
- if section 166-360 of the rules applies, the report must include an annual prudential compliance statement.

The Note confirms the term ***governing body*** is defined in section 7 of the Act, and provides that the effect of the definition is that for registered providers who are not a body corporate with a board of directors, such as State and Territory governments, the Aged Care Financial Report can be signed by a person or group of persons responsible for the executive decisions of the registered provider.

Subsection 166-310(4) provides that the System Governor may, in relation to paragraph 166-310(3)(a), approve different forms depending on the specified provider registration categories or the specific kinds of registered providers.

Additional requirements if registered in provider registration category residential care

Subsection 166-310(5) sets out additional requirements for registered residential care providers. The aged care financial report for providers registered in the residential care provider registration category will need to include the following information in addition to subsection 166-310(3):

- subject to section 166-335 of the Rules, a care minutes performance statement;
- the amount of accommodation payments and accommodation contributions paid to the registered provider;
- the amounts of those accommodation payments and contributions mentioned in paragraph (5)(b) paid as refundable deposits and daily payments;
- the amounts of accommodation bonds and accommodation charges paid to the registered provider;
- the extent of building, upgrading and refurbishment of residential care homes.

Requirement to comply with a notice for further information

Subsection 166-310(6) provides that a registered provider must comply with a notice under subsection 166-310(8) within the period specified in the notice. If no period is specified in the notice, it is assumed that the period is set to within 28 days after the day when the notice is given.

Subsection 166-310(7) provides that a registered provider complies with a notice under subsection 166-310(8) only if the provider gives the information in a form (if any) approved by the System Governor for the purposes of subsection 166-310(8).

System Governor may request further information

Subsection 166-310(8) provides that the System Governor may issue a written notice to a registered provider requiring them to give the System Governor information about a matter, as specified in the notice, if the information is in relation to this section.

Subsection 166-310(9) prescribes that a notice under subsection 166-310(8) may require a registered provider to give updated information about a matter in a period that is the same as, or different to, the reporting period in relation to a report under this section.

Compliance with this section for part of reporting period

Subsection 166-310(10) states that a registered provider is considered compliant if they meet the reporting requirements of this section, during the part of the reporting period they were registered or expanded into a new registration category.

Section 166-315 – Aged care financial report—provision of a financial support statement

Section 166-315 sets out the circumstances in which a registered provider must submit a financial support statement as part of its aged care financial reporting obligations.

Subsection 166-310(1) provides that, subject to subsection 166-315(1A), a registered provider that satisfies the following criteria is a registered provider prescribed in paragraph 166(1)(a) of the Act;

- is registered in provider registration category residential care; and
- is part of or is financially reliant on a related corporate entity; and
- is not a government entity or a local government authority; and
- is required under section 166-310 of the rules to give the System Governor an aged care financial report for the provider for a reporting period.

Subsection 166-315(2) confirms this section does not apply to registered providers that deliver funded aged care services under the MPSP.

Financial support statement to be given with aged care financial report

Subsection 166-315(3) provides that if a registered provider is required to give the System Governor an aged care financial report for the provider for a reporting period, the provider must also provide a financial support statement with the report that is signed within the period of 4 months starting on the day after the end of the reporting period.

Subsection 166-315(4) provides that subsection 166-315(3) does not apply to a registered provider in relation to a reporting period if the aged care financial report for the year includes an explanation of why the provider did not comply with subsection 166-315(3).

Financial support statement to be given on request

Subsection 166-315(5) provides that the System Governor may issue a written notice to a registered provider at any time, requiring the provider to give the System Governor a financial support statement for the provider signed within the period for signing specified in the notice. The Note details the section of the rules (subsection 166-320(4)) that advises on who must sign a financial support statement.

Subsection 166-315(6) provides that a registered provider must comply with a notice under subsection 166-315(5) within the prescribed period specified in the notice. If a period is not specified in the notice, it is assumed to be within 28 days after the day when the notice is given.

Subsection 166-315(7) provides that subsection 166-315(6) does not apply to a registered provider in relation to a notice under subsection 166-315(5) if at, or before the end of the period, the registered provider has given the System Governor a written explanation of why they were not able to comply with the notice.

System Governor may request further information and documents

Subsection 166-315(8) provides that the System Governor may issue a written notice to a registered provider at any time, requiring them to give information about a matter specified in the notice, if the information is about a matter required under this section.

Subsection 166-315(9) provides that a registered provider must comply with a notice mentioned under subsection 166-315(8) within the period specified in the notice. If no period was specified, it is assumed to be within 28 days after the day when the notice is given.

Section 166-320 – Aged care financial report—what is a financial support statement

Section 166-320 defines the nature, content, and signatory requirements of a financial support statement for registered providers prescribed under subsection 166-315(1). This section ensures that where a registered provider is financially reliant on a related corporate entity, the System Governor receives a clear and authoritative statement about the availability of financial support.

Subsection 166-320(1) provides that a financial support statement is a written statement made by the ultimate holding company of a registered provider of a kind that is prescribed under subsection 166-315(1). The statement must meet the requirements set out in subsections 166-320(2), (4), and (5).

Subsection 166-320(2) provides requirements for the financial support statement which must be satisfied by one of this subsection's paragraphs. Paragraph 166-320(2)(a) provides that the statement must either state that the ultimate holding company is willing and able to provide financial support to the provider while the provider remains registered, to enable it to pay specified debts. Alternatively, paragraph 166-320(2)(b) provides the statement must state that the ultimate holding company is not willing and able to provide such support to the provider, while the provider remains a registered provider.

Subsection 166-320(3) provides the scope of debts of the provider in relation to a financial support statement under paragraph 166-320(2)(a). Paragraph 166-320(3)(a) provides that the debts are any debts of the provider that are outstanding immediately before the start of the day when the statement is given to the System Governor (referred to as the *giving day*). Subparagraph 166-320(3)(b)(i) provides that the debts are also any debts of the provider that become due in the period between the giving day and the day before the provider gives the System Governor another financial support statement. Alternatively, subparagraph 166-320(3)(b)(ii) provides that if the provider never gives the System Governor another statement for the provider after the giving day, the debts are those that become due on or after the giving day. This ensures that the statement provides ongoing assurance until it is replaced.

Subsection 166-320(4) sets out the signatory requirements for a financial support statement. Paragraph 166-320(4)(a) provides that if the ultimate holding company is a body corporate incorporated under the *Corporations Act 2001*, the statement must be signed by a director of the body corporate for the purposes of that Act. Paragraph 166-320(4)(b) provides that in all other cases, the statement must be signed by a member of the governing body of the ultimate holding company. This ensures that the statement is endorsed by a person with appropriate authority and accountability.

Subsection 166-320(5) provides that the financial support statement must be in a form approved by the System Governor, if such a form has been specified.

Section 166-325 – Aged care financial report—permitted uses reconciliation

Section 166-325 sets out the circumstances in which a registered provider may be required to include a permitted uses reconciliation in its aged care financial report. This reconciliation provides transparency about how refundable deposits and accommodation bonds have been used during the reporting period.

Subsection 166-325(1) provides that a form approved by the System Governor for an aged care financial report for a registered provider may require such a report to include a permitted uses reconciliation. The permitted uses reconciliation should set out information about reportable uses of refundable deposits and accommodation bonds by the registered provider during a reporting period or reporting periods for the registered provider.

Subsection 166-325(2) details a reportable use of funds for the purpose of subsection 166-325(1). Paragraph 166-325(2)(a) confirms that a reportable use of funds includes any permitted use of refundable deposits or accommodation bonds. These are uses that comply with the restrictions set out in section 310 of the Act, and section 287-101 of the Rules. Paragraph 166-325(2)(b) extends this to include use of other funds (other than refundable deposits or accommodation bonds) such that, if the funds had been refundable deposits or accommodation bonds, the use would have qualified as permitted uses of refundable deposits or accommodation bonds. The ‘Note’ refers to section 310 of the Act for the permitted uses of refundable deposits, and section 287-101 of the Rules for the permitted uses of accommodation bonds.

Subsection 166-325(3) provides that the System Governor may approve different forms for the permitted uses reconciliation in relation to specified registration categories or specified kinds of registered providers.

Section 166-335 – Aged care financial report—care minutes performance statement

Section 166-335 prescribes the requirement for registered providers to submit a care minutes performance statement alongside their aged care financial report.

Subsection 166-335(1) provides that, subject to subsection (1A), for the purposes of paragraph 166(1)(a) of the Act, a registered provider is prescribed if the provider:

- is registered in the provider registration category residential care; and
- is required under section 166-310 of the rules to give the System Governor an aged care financial report for the provider for a reporting period.

Subsection 166-335(2) confirms that this section does not apply to registered providers delivering funded aged care services under the Multi-Purpose Service Program (MPSP).

Subsection 166-335(3) provides that a registered provider registered in the registration category residential care must submit an aged care financial report must also submit a care minutes performance statement that satisfies the requirements in subsections 166-335(4), (5) and (6).

Care minutes performance statement to be given with aged care financial report

Subsection 166-335(4) provides that the provider must give the System Governor the care minutes performance statement when giving the aged care financial report. The care minutes performance statement must be given in accordance with requirements in subsection 166-335(4).

Requirements for a care minutes performance statement

Subsection 166-335(5) outlines the content and format requirements for the care minutes performance statement. The care minutes performance statement for a reporting period for the registered provider must:

- be in writing; and
- be in a form approved by the System Governor; and
- not contain false or misleading information; and
- include the total direct care hours for each reporting period quarter as delivered by
 - registered nurses; and
 - enrolled nurses; and
 - personal care workers and nursing assistants; and
- include the total direct care expenses for each reporting period quarter as delivered by:
 - registered nurses; and
 - enrolled nurses; and
 - personal care workers and nursing assistants; and
- include 24/7 registered nursing coverage across the reporting period by calendar month and expressed as a percentage; and
- if there is a variance in the data submitted under paragraph 166-335(5)(f) throughout the reporting period – the registered provider must include an explanation for the variance; and
- if there is a variance between the care minutes reported in the care minutes performance statement and the care minutes reported in the previous quarterly financial reports – the registered provider must include an explanation for the variance; and
- subject to subsection 166-335(6), include a signed audit report for the submitted care minutes performance statement by an independent auditor.

Auditing of care minutes performance statement

Subsection 166-335(6) sets out the audit requirements for the care minutes performance statement. Paragraph 166-335(6)(a) confirms the statement must be audited by either a registered company auditor under the *Corporations Act 2001*, or a person approved by the System Governor under subsection 166-335(6). Paragraph 166-335(5)(b) confirms the audit must be conducted in accordance with ASAE 3000 (Assurance Engagements Other than Audits or Reviews of Historical Financial Information), as published by the Australian Auditing and Assurance Standards Board.

Subsection 166-335(6) provides that the System Governor may approve a person to audit a care minutes performance statement if the System Governor is satisfied that the person has appropriate qualifications and expertise.

Subsection 166-335(8) provides that the System Governor may revoke the approval under subsection 166-335(7) if the System Governor is satisfied that the person is no longer a fit and proper person to audit the care minutes performance statement.

Section 166-340 – Quarterly financial report (QFR)

Section 166-340 prescribes the requirement for registered providers to submit a quarterly financial report to the System Governor, promoting transparency of financial performance of registered providers.

Scope of this section

Subsection 166-340(1) provides that for the purposes of the quarterly financial report (QFR) every kind of registered provider is prescribed, subject to subsections 166-340(2) and (3).

Subsection 166-340(2) confirms that the requirements of this section do not apply to providers delivering funded aged care services under CHSP or TCP.

Subsection 166-340(3) confirms that the requirements of this section also do not apply to delivery of funded aged care services NATSIFACP where the provider is not registered in the provider registration category residential care category.

Subsection 166-340(4) provides that a registered provider of a kind prescribed under this section must give a quarterly financial report to the System Governor for each quarter of a reporting period for the registered provider. The ‘Note’ to this subsection refers to section 166-355 for the definition of the reporting period.

Requirements for a quarterly financial report

Subsection 166-340(5) outlines the requirements for the quarterly financial report. Paragraph 166-340(5)(a) confirms the report must be in the approved report form. Paragraph 166-340(5)(b) confirms the report must be signed by a member of the governing body of the registered provider. The ‘Note’ clarifies that the term ***governing body*** is defined in section 7 of the Act.

Subsection 166-340(6) provides that the System Governor may, for the purposes of the QFR, approve different forms in relation to specified provider registration categories or specified kinds of registered providers.

Timeframes to give System Governor a quarterly financial report

Subsection 166-340(7) sets out the timeframes for submitting the quarterly financial report. Paragraph 166-340(7)(a) confirms that for the quarter ending 31 December, the report must be submitted within 45 days after the end of the quarter. Paragraph 166-340(7)(b) confirms that for all other quarters, the report must be submitted within 35 days after the end of the quarter.

Subsection 166-340(8) provides that the following is a quarter of a reporting period for the registered provider. Paragraph 166-340(8)(a) provides that a quarter is the period of 3 months beginning on the first day of the reporting period for the registered provider. Paragraph 166-

340(8)(b) provides that each successive 3-month period after the end of the period mentioned in paragraph 166-340(8)(a) constitutes a quarter.

Requirement to comply with a notice for further information

Subsection 166-340(9) provides that a registered provider must comply with a notice under subsection 166-340(11) within the period specified in the notice to provide further information or, if no period is specified in the notice, within 28 days after the day when the notice is given.

Subsection 166-340(10) provides that a registered provider complied with that notice to provide further information under subsection 166-340(11) only if the provider gives the information in a form (if any) approved by the System Governor for the purposes of that subsection.

System Governor may request further information

Subsection 166-340(11) provides that the System Governor may, by notice in writing, require a registered provider to give the System Governor information about a matter, as specified in the notice, if the information is about a matter required in the QFR.

Subsection 166-340(12) provides that a notice under subsection 166-340(11) may require a registered provider to give updated information about a matter in relation to a period that is the same as the reporting period to which a report under this section relates or different to the reporting period to which a report under this section relates.

Compliance with this section for part of reporting period

Subsection 166-340(13) states that a registered provider is considered compliant if they meet the reporting requirements of this section, during the part of the reporting period they were registered or expanded into a new registration category.

Section 166-345 – Aged care financial report – general purpose financial report

Section 166-345 prescribes the requirement for certain registered providers to submit a general purpose financial report to the System Governor. This section supports financial transparency and accountability in the delivery of residential aged care services

Scope of this section

Subsection 166-345(1) prescribes that, subject to subsection 166-345(2), the requirements regarding the general purpose financial report (GPFR) in this section applies to a registered provider registered in the registration category residential care.

Subsection 166-345(2) outlines exemptions to the requirements of this section. Paragraph 166-345(2)(a) confirms that the requirements of this section do not apply to government entities or local government authorities. Paragraph 166-345(2)(b) confirms that the requirements of this section do not apply to providers delivering funded aged care services under a specialist aged care program.

Subsection 166-345(3) provides that registered providers prescribed by this section must give a GPFR to the System Governor for each reporting period for the registered provider.

Requirements for a general purpose financial report

Subsection 166-345(4) sets out the content and format requirements for the general purpose financial report. Paragraph 166-345(4)(a) confirms the report must be a general purpose financial report as defined in section 6 of the Statement of Accounting Concepts SAC 1. Paragraph 166-345(4)(b) confirms the report must comply with the Australian Accounting Standards in force at the time of preparation. Paragraph 166-345(4)(c) confirms the report must give a true and fair view of the financial position and performance of the provider for the reporting period for each approved residential care home in relation to the registered provider. Paragraph 166-345(4)(d) confirms the report must treat the provider, in relation to its residential care services, as a distinct reporting entity under SAC 1. Paragraph 166-345(4)(e) confirms the report must be submitted at the same time as the aged care financial report under section 166-310 of the rules.

Subsection 166-345(5) provides that if a GPFR deals with a matter other than funded aged care services delivered through the service group residential care, the GPFR must be prepared as if the funded aged care services delivered through the service group residential care it relates to were a reportable segment for the purposes of the Australian accounting standards related to segment reporting in force at the time the GPFR is prepared.

Subsection 166-345(6) provides that if all the information about each residential care home approved in relation to the registered provider is already included in the provider's aged care financial report for the reporting period, it does not need to be duplicated in the general purpose financial report for the reporting period.

Subsection 166-345(7) provides requirements for a registered provider to give a copy of its most recently audited GPFR to each person who asks for a copy. These persons include:

- an individual accessing funded aged care services at the approved residential care home; or
- an individual who has an access approval in respect for a residential care home and is considering accessing funded aged care services through the residential care home; or
- a supporter of an any such individual mentioned in the above points.

Requirement to comply with a notice for further information

Subsection 166-345(8) provides that a registered provider must comply with a notice under subsection 166-345(10) within the period specified in the notice or, if no period is specified in the notice, within 28 days after the day the notice is given.

Subsection 166-345(9) provides that a registered provider complies with a notice under subsection 166-345(10) only if the provider gives the information in a form (if any) approved by the System Governor for the purposes of that subsection.

System Governor may request further information

Subsection 166-345(10) provides that the System Governor may, by notice in writing, require a registered provider to give the System Governor information about a matter, as specified in the notice, if the information is about a matter required in the GPFR.

Subsection 166-345(11) provides that a notice under subsection 166-345(10) may require a registered provider to give updated information about a matter in relation to a period that is:

- the same as the reporting period to which a report under this section relates; or
- different to the reporting period to which a report under this section relates.

Compliance with this section for part of reporting period

Subsection 166-345(12) states that a registered provider is considered compliant if they meet the reporting requirements of this section, during the part of the reporting period they were registered or expanded into a new registration category.

Subsection 166-345(13) confirms that registered providers covered by this section must publish the general purpose financial report for the relevant reporting period on the registered provider's website, supporting public transparency and accountability.

Section 166-350 – Aged care financial report – general purpose financial report audit requirements

Section 166-350 sets out the audit requirements for general purpose financial reports submitted by registered providers.

Subsection 166-350(1) provides the requirements a general purpose financial report must have under paragraphs 166-350(1)(a) and (b). Paragraph 166-350(1)(a) confirms that the audit must be conducted by either a registered company auditor within the meaning of the *Corporations Act 2001*, or a person approved by the System Governor under subsection 166-350(2). Paragraph 166-350(1)(b) confirms that the report must also include both an audit opinion about the general purpose financial report from a registered company auditor or a person approved under subsection 166-350(2) and a statement from the registered company auditor or the person approved under subsection 166-350(2) as to whether the report complies with paragraphs 166-345(4)(b) and (c) of the rules.

Subsection 166-350(2) provides that the System Governor may approve a person to audit a GPFR if the System Governor is satisfied that the person has appropriate qualifications and experience.

Subsection 166-350(3) provides that the System Governor may revoke an approval under subsection 166-350(2) if the System Governor is satisfied that the person is no longer a fit and proper person to audit a GPFR.

Section 166-355 – Financial and prudential reports—reporting period

Section 166-355 provides the reporting period applicable to all financial and prudential reports submitted by registered providers to the System Governor under this subdivision and provides the process by which a registered provider may apply to the System Governor for an alternative reporting period.

Subsection 166-355(1) provides that, for the purposes of subsection 166(4) of the Act, a reporting period will apply for all reports given to the System Governor by a registered provider under this subdivision. Paragraph 166-355(1)(a) provides the default reporting period for all reports is the financial year, and specifies the financial year as the 12-month period beginning on 1 July and ending on 30 June.

Paragraph 166-355(1)(b) provides that if under subsection 166-355(3), the System Governor determines an alternative 12-month period (beginning on the first day of a month) as the reporting period, that period is considered to be the reporting period for all reports given to the System Governor by the registered provider under this subdivision.

Subsection 166-355(2) provides that a registered provider may apply to the System Governor for a determination to have a different 12-month period to the financial year, as the reporting period under this subdivision. Some registered providers may be a subsidiary or service run by a parent company that does not run on the Australian financial year (such as multinational parent companies that run on a 1 April to 31 March financial year). As such, the government allows some providers, in certain circumstances, to report over a different 12-month period to the Australian financial year (1 July to 30 June).

Subsection 166-355(3) outlines the process for the System Governor to consider such an application. Paragraph 166-355(3)(a) confirms that the System Governor must either make, or refuse to make, the determination. Paragraph 166-355(3)(b) confirms that the System Governor must notify the provider in writing of the decision within 28 days, or within 28 days, excluding any period during which further information is requested and received.

Subsection 166-355(4) confirms that the System Governor may only approve an alternative reporting period if satisfied, on reasonable grounds, that it would be impracticable for the provider to comply with the reporting requirements in relation to the standard financial year.

Subsection 166-355(5) confirms that if the System Governor refuses to make a determination, the provider must be given a written statement of reasons for the decision.

Section 166-360 – Aged care financial report—annual prudential compliance statement—general

Section 166-360 prescribes the requirement for certain registered providers to submit an annual prudential compliance statement to the System Governor.

Scope of this section

Subsection 166-360(1) confirms that, for the purposes of paragraph 166(1)(a) of the Act, a registered provider is prescribed under this section if the provider is registered in the provider registration category residential care and receives or has received lump sum payments, wholly or partly as a lump sum, from individuals in the form of a refundable deposit, accommodation bond, or entry contribution.

Subsection 166-360(2) provides that a registered provider prescribed in subsection (1) must give the System Governor an APCS for a reporting period for the registered provider. The APCS must include the following information:

- if the lump sum is a refundable deposit—information about refundable deposits and refundable deposit balances referred to in section 166-365 of the rules;
- if the lump sum is an accommodation bond—information about accommodation bonds and accommodation bond balances referred to in section 166-365 of the rules;
- information about other fees referred to in section 166-375 of the rules;
- the statements and other information referred to in section 166-380 of the rules.

Requirements for an annual prudential compliance statement

Subsection 166-360(3) provides requirements regarding the APCS. The APCS for a reporting period for the registered provider must:

- be in writing; and
- be in a form approved by the System Governor; and
- include the information in subsection (2); and
- not contain false or misleading information; and
- include a declaration that the registered provider has only charged the amount of refundable deposit the registered provider is permitted to charge; and
- if the registered provider has not complied with paragraph (e), include the number of times the provider has not complied with this requirement and the reason for the non-compliance; and
- if the registered provider is required to prepare an ACFR for the reporting period – be included in the ACFR for the registered provider for the reporting period; and
- if paragraph (g) does not apply to the registered provider:
 - be signed by a person who is one of the registered provider’s responsible persons and is authorised by the registered provider to sign the statement; and
 - be given to the System Governor within 4 months after the end of the reporting period of the registered provider.

The APCS is for providers to demonstrate their compliance with the Financial and Prudential Standards and other such rules around refundable deposits (including refunding on time).

Section 166-365 – Annual prudential compliance statement—information about refundable deposits and accommodation bonds that must be include

Section 166-365 prescribes the detailed financial information that must be included in a registered provider’s annual prudential compliance statement where the provider receives refundable deposits, accommodation bonds, or entry contributions from individuals.

Subsection 166-365(1) confirms that this section applies in addition to section 166-360, and specifically where a registered provider receives refundable deposits, accommodation bonds, or entry contributions.

Subsection 166-365(2) outlines the specific information that must be included in the annual prudential compliance statement for the reporting period.

Paragraph 166-365(2)(a) requires the total number of refundable deposit balances, accommodation bond balances, or entry contribution balances held by the provider at the end of the reporting period to be included.

Paragraph 166-365(2)(b) requires the total value of those balances held by the provider at the end of the reporting period to be included in the annual prudential compliance statement.

Paragraph 166-365(2)(c) requires the total value of refundable deposits, accommodation bonds, or entry contributions received during the reporting period to be included in the annual prudential compliance statement.

Paragraph 166-365(2)(d) requires the total amount deducted by the registered provider during the reporting period from refundable deposit balances, accommodation bond balances or entry contribution balances to be included in the annual prudential compliance statement. This includes:

- refundable deposit balances or accommodation bond balances—any general deductions under section 307 of the Act or section 287-90 of the rules;
- refundable deposit balances only—any retention amounts deducted under section 308 of the Act by the registered provider during the reporting period from refundable deposit balances;
- accommodation bond balances only—any accommodation bond retention amounts deducted under section 287-95 of the Rules by the registered provider during the reporting period from accommodation bond balances.

Paragraph 166-365(2)(e) requires the total amount deducted from refundable deposits or accommodation bonds received during the reporting period, including general deductions and retention amounts to be included in the annual prudential compliance statement. This includes:

- for refundable deposit balances or accommodation bond balances—any general deductions under section 307 of the Act or section 287-90 of the rules.
- for refundable deposit balances only—any retention amounts deducted under section 308 of the Act by the registered provider during the reporting period from refundable deposit balances received during the reporting period.
- for accommodation bond balances only—any accommodation bond retention amounts deducted under section 287-95 of the rules by the registered provider during the reporting period from accommodation bond balances.

Paragraph 166-365(2)(f) requires details of any transfers of refundable deposits (made under 312 of the Act), accommodation bonds (made under section 287-103 of the rules), or entry contributions, including the amount transferred, the date of transfer, and any amount retained to be included in the annual prudential compliance statement.

Paragraph 166-365(2)(g) requires the total value of refundable deposit balances, accommodation bond balances, and entry contribution balances refunded during the reporting period to be included in the annual prudential compliance statement.

Paragraph 166-365(2)(h) requires detailed reporting where refunds were not made in accordance with legislative requirements, including the number of instances, reasons for delay, and any applicable formal agreements to be included in the annual prudential compliance statement. This includes the following:

- the total number of refundable deposit balances, accommodation bond balances or entry contribution balances that were not refunded in accordance with subsection

311(3) of the Act, subsection 287-102(2) of the rules or subsection 287-160 of the Rules.

- where entry contribution balances were not refunded in accordance with an applicable formal agreement with an individual, the number of entry contributions that were refunded under the formal agreement applying in respect of the relevant entry contribution balance.
- the reason or reasons for the delay in refunding the refundable deposit balances, accommodation bond balances or entry contribution balances.
- in respect of each reason provided—the total number of instances of delay attributable to the reason.

Paragraph 166-365(2)(i) requires information about any period during which the provider was not permitted to charge a refundable deposit or accommodation bond for entry by an individual to any aged care service, the following must be included in the annual prudential compliance statement:

- the period or periods during which the registered provider was not permitted to charge a refundable deposit or accommodation bond; and
- the funded aged care service in respect of which each period specified applies.

Paragraph 166-365(2)(j) requires information about how refundable deposits and accommodation bonds were used during the reporting period.

Paragraph 166-365(2)(k) requires confirmation of whether any use of refundable deposits or accommodation bonds was not permitted under section 310 of the Act or section 287-101 of the rules to be included in the annual prudential compliance statement.

Paragraph 166-365(2)(l) requires the total amount expended on capital expenditure for which the use of refundable deposits (under section 310 of the Act) or accommodation bonds (under section 287-101 of the rules) was permitted to be included in the annual prudential compliance statement.

Paragraph 166-365(2)(m) requires the total amount expended on investment in financial products for which the use of refundable deposits or accommodation bonds was permitted under section 310 of the Act or section 287-101 of the rules to be included in the annual prudential compliance statement.

Paragraph 166-365(2)(n) requires the total amount expended on loans for which the use of refundable deposits or accommodation bonds was permitted under section 310 of the Act or section 287-101 of the rules to be included in the annual prudential compliance statement.

Paragraph 166-365(2)(o) requires information about the total amount expended by the registered provider (whether or not obtained from refundable deposits or accommodation bonds) during the reporting period on repaying debt accrued to be included in the annual compliance statement. The purposes for reporting under this paragraph include either capital expenditure of the kind described in paragraph 166-365(2)(l) of the rules, or refunding refundable deposit balances, accommodation bond balances or entry contribution balances.

Paragraph 166-365(2)(p) requires information about the total amount expended on repaying debt accrued before 1 October 2011, where the debt was incurred for the purpose of

delivering funded aged care services to individuals to be included in the annual compliance statement.

Paragraph 166-365(2)(q) requires the total amount expended on each permitted use of refundable deposits or accommodation bonds under section 310 of the Act or section 287-101 of the Rules to be included in the annual prudential compliance statement.

Paragraph 166-365(2)(r) requires the amount returned to the provider during the reporting period from the sale, disposal, or redemption of financial products (covered by subsection 310(3) of the Act, or subsection 287-101(4) of the rules) invested in after 1 October 2011, whether or not the funds originated from refundable deposits or accommodation bonds, to be included in the annual compliance statement.

Paragraph 166-365(2)(s) requires confirmation that, for each accommodation agreement involving a room priced above the maximum accommodation payment amount, the provider had a current approval from the Pricing Authority at the time the individual agreed to the higher price to be included in the annual compliance statement.

Paragraph 166-365(2)(t) requires information confirming that any overpaid amount resulting from a reduction in a resident's daily accommodation contribution or refundable contribution was refunded within 28 days of the provider becoming aware of the reduced amount to be included in the annual compliance statement.

Paragraph 166-365(2)(u) requires information about any overpayment of accommodation payments or contributions from prior reporting periods that the provider became aware of during the current reporting period to be included in the annual compliance statement.

The Note confirms paragraph 166-365(2)(h) of the rules does not apply to a registered provider that has transferred their refundable deposit balance to another registered provider under section 312 of the Act.

Section 166-375 – Annual prudential compliance statement—information about other fees that must be included

Section 166-375 prescribes the information that must be included in a registered provider's annual prudential compliance statement regarding fees charged to individuals, other than accommodation payments, accommodation contributions, or individual contributions.

Paragraph 166-375(a) requires the provider to report any fees charged to individuals during the reporting period that are not individual contributions, accommodation payments, or accommodation contributions.

Paragraph 166-375(b) requires the provider to report the total value of each such fee charged during the reporting period.

Paragraph 166-375(c) requires the provider to specify what each fee purports to cover, providing clarity on the purpose and nature of the charges.

Paragraph 166-375(d) requires the provider to confirm whether, for individuals accessing ongoing funded aged care services, an annual review of each individual's higher everyday

living agreement was conducted during the reporting period, in accordance with subsection 284-11(4) of the rules.

Section 166-380 – Annual prudential compliance statement—Financial and Prudential Standards

Section 166-380 prescribes the statements and other information that must be included in a registered provider's annual prudential compliance statement in relation to compliance with financial and prudential obligations. This section ensures that providers are accountable for meeting key legislative and regulatory requirements and that any non-compliance is transparently reported and explained.

Paragraph 166-380(a) requires the provider to include a statement about whether it has complied during the reporting period with the following:

- the Financial and Prudential Standards;
- section 287-20 of the rules and subsections 293(1), 311(1) and (2), and section 313 of the Act;
- Division 3 of Part 4 of Chapter 4 of the Act; and
- section 287-101 of the rules or subsection 310(1) of the Act.

Paragraph 166-380(b) requires the provider to include a statement explaining why it has not complied with any of the Financial and Prudential Standards, if applicable.

Paragraph 166-380(c) requires the provider to report on any non-compliance with disclosure conditions applicable under sections 155-30, 155-35, 166-365, 166-375, and 166-385 of the rules. The provider must include:

- the total number of non-compliance occasions;
- the reasons for each failure to comply; and
- for each reason, the total number of non-compliance instances attributable to that reason.

Paragraph 166-380(d) requires the provider to report the minimum liquidity amount, as set out in its liquidity management strategy, at the end of the most recent quarter of the reporting period.

Paragraph 166-380(e) requires the provider to report the date on which its liquidity management strategy was last reviewed and assessed.

Paragraph 166-380(f) requires the provider to report the date on which its financial and prudential management system was last reviewed and assessed.

Paragraph 166-380(g) requires the provider to include an audit opinion, provided by the independent auditor referred to in section 166-385, on whether the provider has complied with the requirements of this Subdivision during the reporting period. This is reiterated in the Note below this paragraph.

Section 166-385 – Annual prudential compliance statement—audit requirements

Section 166-385 sets out the audit requirements for the annual prudential compliance statement submitted by registered providers. This section ensures that the information provided in the statement is independently verified by a qualified auditor, supporting the integrity and reliability of financial and prudential reporting.

Subsection 166-385(1) confirms that the annual prudential compliance statement must be supported by an independent audit. Paragraph 166-385(1)(a) specifies that the audit must be conducted by a registered company auditor within the meaning of the *Corporations Act 2001*. Paragraph 166-385(1)(b) provides that the audit may alternatively be conducted by a person approved by the System Governor under subsection 166-385(2).

Subsection 166-385(2) confirms that the System Governor may approve a person to audit an annual prudential compliance statement if satisfied that the person has appropriate qualifications and experience.

Subsection 166-385(3) confirms that the System Governor may revoke an approval granted under subsection 166-385(2) if the person is no longer considered a fit and proper person to conduct such audits.

This section exists to provide added assurances of the accuracy of the information provided to the System Governor in the ACPS.

Subdivision F— CHSP

Section 166-600 – Application of Subdivision

Section 166-600 provides that the reporting requirements in Subdivision F apply to registered providers section who deliver funded aged care services under CHSP and are registered in one or more of the following registration categories:

- home and community services
- assistive technology and home modifications
- advisory and support services
- personal and care support in the home or community
- nursing and transition care.

Section 166-605 – Annual financial declaration statement

Subsection 166-605(1) provides that CHSP providers must give the System Governor an annual financial declaration statement for each financial year.

Subsection 166-605(2) provides that CHSP providers must give the annual financial declaration statement for the financial year for the provider to the System Governor by 31 August of that year.

Subsection 166-605(3) provides that the annual financial declaration statement must be in a report form approved by the System Governor.

Subsection 166-605(4) sets out the information that must be included in the annual financial declaration statement:

- certification that all financial assistance granted by the System Governor was spent for the purposes specified in the grant agreement;
- the amount of financial assistance the System Governor has granted the registered provider under the grant agreement, excluding GST;
- the registered provider's expenditure for the delivery of funded aged care services, excluding GST;
- any surplus and uncommitted funds in the financial year;
- any surplus and uncommitted funds from the previous financial year.

Subsection 166-605(5) provides that CHSP providers must also include a statement of compliance with the annual financial declaration statement. The statement of compliance states that the financial assistance granted under the grant agreement was only spent on individuals with an assessment approval for funded aged care services in one or more service groups for the individuals and the classification types for the service groups under section 65 of the Act.

Subsection 166-605(6) provides that the annual financial declaration statement must be certified by the registered provider's governing body.

Subsection 166-605(7) provides that CHSP providers must not include the provider's own funds or funds from other aged care programs in the annual financial declaration statement.

CHSP financial reporting is used to determine that funding has been spent by the provider in accordance with the CHSP Grant Agreement and the Act, and expenditure only relates to CHSP service delivery in accordance with the Activity Work Plan and CHSP Grant Agreement.

Section 166-610 – Monthly performance report

Subsection 166-610(1) provides that CHSP providers must submit a monthly performance report to the System Governor for each month.

Subsection 166-610(2) provides that CHSP providers must submit the monthly performance report in the form approved by the System Governor.

Subsection 166-610(3) provides that the monthly performance report must include:

- client level data and service delivery information for all activities described in Item B of the grant agreement, including:
 - the output measure as per the service type; and
 - the My Aged Care ID for each individual; and
- any individual fees or contributions paid to the registered provider under Part 3 of Chapter 4 of the Act.

Subsection 166-610(4) provides that CHSP providers must submit the monthly performance report 14 days after the end of each month. However, CHSP providers may elect to provide the performance report more frequently, for example on a fortnightly basis.

Section 166-615 – Annual wellness and reablement report

Subsection 166-615(1) provides that CHSP providers must give the System Governor a Wellness and Reablement Report. The Wellness and Reablement Report is a report on the CHSP provider's progress in embedding wellness and reablement approaches as part of service delivery in accordance with the CHSP Grant Agreement.

Wellness and reablement are person-centred, holistic approaches to service delivery. They build on people's strengths, capacity and goals to promote greater independence and autonomy. Wellness and reablement approaches are based on the premise that, even for individuals who experience frailty, older people want to improve their physical, social and emotional wellbeing, and remain living at home, connected to their community. These approaches support older people to live with purpose, make autonomous choices, and participate in meaningful activities which supports their wellbeing.

Subsection 166-615(2) provides that the System Governor may request the CHSP provider to give the Wellness and Reablement report at any time.

Subsection 166-615(3) provides that the CHSP provider must comply with a request for a Wellness and Reablement report within 28 days after the request is made.

Subsection 166-615(4) provides that the Wellness and Reablement Report must be in a form approved by the System Governor.

Section 166-620 – Compliance report

Subsection 166-620(1) provides that CHSP providers must give to the System Governor a compliance report relating to the CHSP provider's management of the grant of financial assistance under section 264 of the Act.

Subsection 166-620(2) provides that the System Governor may request the CHSP provider to give the compliance report at any time.

Subsection 166-620(3) provides that the CHSP provider must give the compliance report to the System Governor 14 days after the request is made.

Subsection 166-620(4) provides that the compliance report must be in a form approved by the System Governor.

Section 166-625 – Service delivery report

Subsection 166-625(1) provides that where the System Governor requests a service delivery report from a CHSP provider, the provider must give a report about service delivery to the System Governor.

Subsection 166-625(2) provides that the System Governor may request the service delivery report at any time.

Subsection 166-625(3) provides that the CHSP provider must give the service delivery report within 21 days after the request is made.

Subsection 166-625(4) provides that the service delivery report must be in an approved form.

Section 166-627 – Exemption process for certain reports

Subsection 166-627(1) provides that this section prescribes the exemption process for the submission of the following:

- annual financial declaration statement;
- monthly performance report;

- compliance report;
- annual wellness and reablement report.

Subsection 166-627(2) provides that a registered provider may apply to the System Governor for an exemption from the reporting requirements in subsections 166-605(1), 166-610(1), 166-615(1) or 166-620(1), if the provider is affected by extenuating circumstances.

Subsection 166-627(3) sets out the requirements for making an application for exemption. The application:

- may be in a form approved by the System Governor; and
- must be made to the System Governor at least 14 days before the due date for the relevant report.

The provider's discretion under subsection 166-627(3) for making an application for exemption in a form approved by the System Governor is provided in acknowledgment that in extenuating circumstances, such as a natural disaster, providers may be unable to access an approved form and may instead make the application via phone call. Notwithstanding, the application for exemption must still be made at least 14 days before the due date for the relevant report.

Subsection 166-627(4) provides that the System Governor must decide to grant or refuse an exemption within:

- 14 days after receiving any additional information requested under subsection 166-627(5); or
- 14 days after the end of the period allowed for providing additional information if it is not supplied; or
- otherwise, 14 days after receiving the notice.

Subsection 166-627(5) provides that the System Governor may, by written notice, request further information or documents from the registered provider to consider the application.

Subsection 166-627(6) provides that if the registered provider does not provide the requested information or documents within 14 days (or a longer period specified in the notice), the application is taken to have been withdrawn. The notice must include a statement explaining this effect.

Subsection 166-627(7) provides that the System Governor may grant an exemption only if satisfied that the provider is affected by extenuating circumstances.

Subsection 166-627(8) provides that if the System Governor decides to grant an exemption, the System Governor must determine the period for which the exemption is in force.

Subsection 166-627(9) provides that the exemption period may be for the financial year, or for a duration no longer than 12 months.

Subsection 166-627(10) provides that if an exemption is granted, the System Governor must give the provider written notice stating:

- that an exemption has been granted;
- the period for which the exemption is in force; and

- the reasons for the decision.

Subsection 166-627(11) provides that if an exemption is refused, the System Governor must give the provider written notice stating:

- that an exemption has not been granted;
- the due date for the report; and
- the reasons for the decision.

Section 166-628 – Child safety compliance statement

Subsection 166-628(1) provides that a registered CHSP provider must give a report known as the child safety compliance statement to the System Governor each year.

Subsection 166-628(2) provides that the child safety compliance statement must be given to the System Governor by 31 March each year.

Subsection 166-628 (3) provides that information in the child safety compliance statement must include:

- a declaration that the registered provider has delivered grant activities consistent with the Child Safety supplementary term in the provider's grant agreement;
- the activity name;
- the activity ID;
- the statement type in relation to the incidental contract term in the grant agreement;
- the reporting start date;
- the reporting end date.

Subsection 166-628(4) provides that if the registered provider has not complied with the Child Safety supplementary term in the grant agreement, the provider must include in the child safety compliance statement a description of the noncompliance and the reasons for it.

Subsection 166-628(5) provides that the child safety compliance statement must be in a report form approved by the System Governor.

Subdivision G – NATSIFACP

Section 166-630 – Application of Subdivision

Section 166-630 provides that the reporting requirements in Subdivision G apply to providers delivering funded aged care services under NATSIFACP who are registered in one or more of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- personal and care support in the home or community;
- nursing and transition care;
- residential care;
- advisory and support services.

Section 166-635 – Annual financial declaration statement

Subsection 166-635(1) provides that NATSIFACP providers must give the System Governor an annual financial declaration statement for each financial year for the provider.

Subsection 166-635(2) provides that the annual financial declaration statement can be given to the System Governor either annually or at such other time as agreed between the System Governor and the NATSIFACP provider.

Subsection 166-635(3) provides that the annual financial declaration statement must be in the report form approved by the System Governor.

Subsection 166-635(4) specifies the information required in the annual financial declaration statement, including:

- certification the provider complied with the statutory funding condition in relation to the use of financial assistance granted;
- the amount of financial assistance granted by the System Governor on behalf of the Commonwealth;
- the amount of expenditure for delivering funded aged care services by the provider;
- the amount, if any, of unspent grant funding in the financial year;
- any System Governor approved unspent funds from the previous financial year.

The Note following subsection 166-635(4) states that it is a statutory funding condition that the financial assistance granted to a registered provider is used only for the purpose of delivering funded aged care services to individuals in the circumstances mentioned in subsection 267(1) of the Act.

Subsection (5) provides the annual financial declaration statement must be signed by a member of the registered provider's governing body.

Section 166-640 – Audited income and expenditure report

Subsection 166-640(1) provides that NATSIFACP providers must give an audited income and expenditure report to the System Governor for each financial year.

Subsection 166-640(2) provides that the audited income and expenditure report must be prepared by:

- a registered company auditor within the meaning of the *Corporations Act 2001*; or
- a member of: the Institute of Public Accountants; or the Institute of Chartered Accountants in Australia.

Subsection 166-640(3) provides that NATSIFACP providers must include an audited income and expenditure statement when giving the audited income and expenditure report to the System Governor.

Subsection 166-640(4) sets out the requirements for the audited income and expenditure statement. It must:

- be in accordance with the Australian accounting standards in force at the time the report is prepared; and
- be based on proper accounts and records of the registered provider; and
- verify the provider complied with the statutory funding condition in relation to the use of financial assistance granted by the System Governor; and
- include other matters as specified in the funding agreement; and

- include an audit opinion; and
- include the amount of financial assistance granted by the System Governor, on behalf of the Commonwealth, for the financial year; and
- include the amount of individual fees and contributions paid to the provider by individuals for the financial year; and
- include salary expenditure; and
- include rent or lease expenditure; and
- include outbreak management expenditure; and
- include vehicle lease and maintenance costs; and
- include other expenditure; and
- include total expenditure.

Section 166-645 – Service activity report

Subsection 166-645(1) provides that NATSIFACP providers must give a service activity report to the System Governor every 6 months. The service activity report is a report about the NATSIFACP provider's progress in providing funded aged care services in accordance with the grant agreement.

Subsection 166-645(2) provides that the service activity report must be given to the System Governor twice every financial year on:

- 27 January for the 6 month period ending 31 December; and
- 27 July for the 6 month period ending 30 June.

Subsection 166-645(3) provides that the service activity report must be in a report form approved by the System Governor. Subsection (3) also prescribes that the service activity report must include:

- information about labour worked hours data and labour cost for the reporting period for the following staff:
 - registered nurses;
 - enrolled nurses;
 - personal care workers;
 - allied health professionals; and
- information about the number of occupied beds for the reporting period; and
- de-identified profiles of each aged care worker of the provider; and
- the number of individuals accessing funded aged care services by service type; and
- the number and type of health profession visits during the reporting period; and
- the number and type of traditional or cultural events individuals accessing funded aged care services were supported to engage in during the reporting period.

Section 166-646 – Child safety compliance statement

Subsection 166-646(1) provides that NATSIFACP providers must give a child safety compliance statement to the System Governor each year.

Subsection 166-646(2) provides that the child safety compliance statement must be given to the System Governor by 31 March each year.

Subsection 166-646(3) provides that the child safety compliance statement must include the following information:

- a declaration that the registered provider has delivered grant activities consistent with the Child Safety supplementary term in the registered provider's grant agreement;
- the activity name;
- the activity ID;
- the statement type in relation to the incidental contract term in the grant agreement;
- the reporting start date;
- the reporting end date.

Subsection 166-646(4) provides that if the registered provider has not complied with the Child Safety supplementary term in the registered provider's grant agreement, the registered provider must provide a description of the non-compliance and set out the reasons for the noncompliance in the child safety compliance statement.

Subsection 166-646(5) provides that the child safety compliance statement must be in a report form approved by the System Governor.

Subdivision H – Multi-Purpose Service Program

Section 166-720 – Application of Subdivision to certain registered providers

Section 166-720 provides that Subdivision H applies to registered providers delivering funded aged care services under MPSP.

Section 166-725 – Annual Activity Report

Subsection 166-725(1) requires providers delivering services under the MPSP to submit an annual activity report to the System Governor each financial year. The annual activity report must include the matters specified in subsection 166-725(4).

Subsection (2) requires providers to submit an annual activity report for the financial year to the System Governor by 31 July each year, or at such other time as agreed between the System Governor and the registered provider.

Subsection (3) provides that the annual activity report must be in a form approved by the System Governor.

Subsection (4) prescribes the information that must be included in the annual activity report for each approved residential care home of the provider:

- the number of individuals who have accessed funded aged care services in, or from, the approved residential care home;
- the number of individuals who commenced accessing funded aged care services without an access approval and were later approved through the alternative entry pathway under subsection 71(2) of the Act;
- the number of individuals waiting to access such funded aged care services;
- any fees or contributions charged to individuals who accessed funded aged care services delivered in, or from, an approved residential care home;
- the service types delivered;

- the service types of aged care services delivered;
- the activities undertaken by the residential care home to prevent and manage disease outbreaks.

Subsection (5) outlines that providers delivering services under the MPSP must provide the information prescribed in subsection (4) for each residential care home they operate.

Section 166-730 – Annual statement of financial compliance and income and expenditure

Subsection 166-730(1) requires providers delivering services under the MPSP to give an annual statement of financial compliance and income and expenditure to the System Governor each financial year.

Subsection 166-730(2) requires providers to submit this statement to the System Governor by 31 October each year, or at such other time as agreed between the System Governor and the registered provider.

Subsection 166-730(3) provides that the annual statement of financial compliance and income and expenditure must be in a report form approved by the System Governor.

Subsection 166-730(4) prescribes the information that must be included in the annual statement of financial compliance and income and expenditure:

- the amount of subsidy received under Division 5 of Part 2 of Chapter 4 of the Act to deliver funded aged care services at each approved residential care home;
- individual fees or contributions paid to the provider under Part 3 of Chapter 4 of the Act by individuals accessing funded aged care services at each approved residential care home;
- the amount of expenditure on each of the following:
 - salaries or wages of aged care workers and responsible persons;
 - any labour costs in addition to salaries in wages such as superannuation benefits, leave loadings, payroll tax, workers compensation and other liability insurance, cost of subsidised services to employees and training costs;
 - non-salary related other expenditure;
 - capital expenditure;
 - disease outbreak management activities.

Section 166-735 – Service demographics report

Subsection (1) requires providers delivering services under the MPSP to submit a service demographics report to the System Governor for the financial year. The service demographics report must include the matters specified in subsections (4) and (5).

Subsection (2) requires providers to submit this report to the System Governor by 31 July each year, or at such other time as agreed between the System Governor and the registered provider.

Subsection (3) provides that the service demographics report must be in a form approved by the System Governor.

Subsection (4) provides that the service demographics report must include a list of individuals who accessed funded aged care services delivered by the registered provider for the financial year.

Subsection (5) provides that the service demographics report must also include the following information:

- for each individual who accessed funded aged care service delivered by the provider, the service types, including the services where specified in the individual's access approval are delivered;
- the classification type for the service group for each individual;
- demographic information, where requested in the report form approved by the System Governor, including:
 - the name of the individual; and
 - the gender of the individual; and
 - the date of birth of the individual; and
 - whether the individual is an Aboriginal or Torres Strait Islander Person; and
 - whether the individual has been diagnosed with dementia or has suspected dementia symptoms;
- whether the individual had an access approval when they commenced accessing services;
- the date on which the individual commenced accessing funded aged care services;
- the date on which the individual ceased accessing funded aged care services;
- the reason for ceasing any funded aged care services.

Subsection (6) outlines that providers must give the System Governor a service demographics report for each approved residential care home operated by the registered provider.

Subdivision J — Transition Care Programme

Section 166-740 – Application of Subdivision to certain registered providers

Section 166-740 provides that Subdivision J applies to registered providers delivering funded aged care services under the TCP.

Section 166-745 – Annual accountability report

Subsection 166-745(1) provides that TCP providers must provide an annual accountability report to the System Governor each financial year.

Subsection 166-745(2) provides that the annual accountability report for a financial year for the provider must be given to the System Governor annually or at such other time as agreed between the System Governor and the registered provider.

Subsection 166-745(3) provides that the annual accountability report must be in a form approved by the System Governor.

Subsection 166-745(4) prescribes the information that must be included in the annual accountability report for the financial year, including:

- any subsidy received under section 249 of the Act;

- any income derived from any individual fees and contributions under Part 3 of Chapter 4 of the Act;
- State or Territory direct funding;
- State or Territory in-kind contributions;
- other income including:
 - donations; and
 - interest; and
 - expenditure recoveries and reimbursements; and
 - client fees; and
 - any other income not specified in subparagraph (i) and (ii) of this paragraph or paragraph (a) to (d) of this subsection;
- total income;
- salary expenditure;
- non-salary expenditure, including:
 - office costs; and
 - operating costs; and
 - service agreements; and
 - consumables and equipment for client use; and
 - travel; and
 - capital costs;
- other expenditure, including:
 - asset related expenses including depreciation; and
 - any other expenditure not specified in subparagraph (i) of this paragraph or paragraph (g) and (h) of this subsection;
- total expenditure;
- TCP activity for the financial year, including:
 - total clients; and
 - total care days; and
 - total residential care days; and
 - total home-based care days;
- surplus analysis and itemisation of surplus by income source including:
 - Commonwealth government; and
 - State government; and
 - Territory government; and
 - client contributions; and
 - any income specified in paragraph (e) of this subsection;
- the Commonwealth surplus expressed as a number of care days;
- any explanatory notes or commentary on the following:
 - income;
 - expenditure;
 - activity for the financial year;
 - surplus analysis;
 - additional activity;
- feedback, complaints and improvements including:
 - the most common kinds of positive feedback; and

- the most common kinds of complaints; and
- improvements made by the provider;
- information in respect of whether the Fair Work Commission wage increase component of the Commonwealth subsidy has been passed on to any eligible workers;
 - whether the outbreak management supplement has been used for equipment and activities for the management of outbreaks;
- certification that the information provided in the report is true and correct.

Subsection 166-745(5) provides that the reporting period for the provider is the period specified under section 166-645 of the rules.

Subdivision K – Governing bodies

Section 166-800 – Application of this Subdivision

Subsection 166-800(1) provides that the governing body reporting requirements apply to providers delivering care in the provider registration categories of nursing and transition care and residential care.

Reporting under this subdivision is not required for providers outside of the stated categories. This is in recognition that the care provided by providers in the nursing and transition care and residential care categories is sufficiently complex and clinical as to warrant the increased scrutiny provided by sections 166-805 and 166-810. Scrutiny of providers outside of these categories, particularly where they provide clinical care, will continue to be provided through other reporting requirements under these rules and the Act.

Subsection 166-800(2) provides that the governing body reporting requirements do not apply to services provided under MPSP or NATSIFACP.

Section 166-805 – Governing bodies must prepare and provide statements

Section 166-805 sets out that providers must give a report to the System Governor within 4 months after the end of the reporting period.

Subsection (2) provides this section does not apply to registered providers that deliver funded aged care services under the MPSP.

Subsection 166-805(3) provides that the reporting period for a registered provider is:

- the period of 12 months starting on 1 July of a year; or
- another 12 month period that starts on the first day of a month of a year that is determined for the registered provider by the System Governor.

Pursuant to this section the first reporting period will be 1 July 2025 to 30 June 2026, with the first statement under this section to be prepared and provided by 31 October 2026.

Per subsection (4), the report must be in the approved form and signed by a member of the provider's governing body on behalf of all members of the governing body. The report must include the required information as set out in subsection (4), and include any other statements or information required by the approved form.

Per subsection (5), the following information must be included in the report:

- whether the governing body of the provider believes that the provider has complied with the conditions, obligations and requirements of the provider under the Act.

Where the governing body of the provider believes that there is non-compliance with the Act, the report must include the details of:

- each condition, obligation or requirement that the governing body believes that the provider has failed to comply with
- the reasons why the provider has failed to comply with the condition, obligation or requirement
- the actions that the provider has taken, has started to take or will take to rectify the non-compliance.

Section 166-810 – Requirements for certain registered providers to give information relating to reporting periods

Section 166-810 sets out the requirements for registered providers to give additional information relating to reporting periods.

Paragraph 166-810(1)(a) provides for providers to report on information about the kind of feedback and complaints received by the registered provider in the reporting period.

Paragraph 166-810(1)(b) confirms providers must report on information about improvements made by the registered provider in the reporting period in relation to quality of care.

Paragraph 166-810(1)(c) confirms providers must report on information about initiatives that the registered provider has implemented in the reporting period to support a diverse and inclusive environment for individuals accessing funded aged care services and aged care workers.

Paragraph 166-810(1)(d) confirms providers must report on the representation of different demographic groups in the membership of the governing body of the provider, where the member has consented to that information being provided.

Paragraph 166-810(1)(e) provides that providers must report on whether in the reporting period, the registered provider was a government entity or a local government authority.

Paragraph 166-810(1)(f) provides that for registered providers that are not government entities or local government authorities, it must be reported whether the registered provider is subject to subsection 157(2) of the Act. Subsection 157(2) of the Act relates to the membership of governing bodies requirements, including requirements that a majority of members are independent non-executive members, and that at least one member of the governing body has experience in clinical care.

Paragraph 166-810(1)(g) then in turn requires registered providers that are subject to the requirements of subsection 157(2) of the Act, to report on whether there has been compliance with the requirements of subsection 157(2).

Per Paragraph 166-810(1)(h) it must be reported as to whether subsection 157(3) or (4) of the Act applied to the registered provider during the reporting period. That is whether the governing body of the provider had fewer than 5 members and the provider delivers funded aged care services to fewer than 40 individuals, or where a relevant determination has been issued by the Aged Care Quality and Safety Commissioner.

Subsection (2) provides that a registered provider registered in the registration category nursing and transition care must provide the information prescribed in subparagraphs (1)(a) to (c) in respect of each service delivery branch operated by the registered provider.

Subsection (3) provides that a registered provider providing residential care must provide the information prescribed in subsections (1)(a) to (c) in respect of each residential care home operated by the registered provider.

Section 166-815 – Service provided during part only of reporting period

This section provides that if a registered provider was responsible for the operations of a residential care home during only part of a reporting period, the provider is taken to have complied with sections 166-805 and 166-810 for that reporting period if the provider complied with those sections for the part of the reporting period during which they were responsible for the home.

Subdivision L – Registered nurses

Section 166-850 – Application of this Subdivision

Section 166-850 provides that this Subdivision applies to a registered provider registered in the registration category residential care, other than where that registered provider is only delivering funded aged care services under a specialist aged care program.

Section 166-855 – Reporting requirements relating to registered nurses

Section 166-855 sets out the requirements for registered providers to report on registered nursing obligations.

Subsection (1) provides that for the purposes of paragraph 166(1)(a) of the Act, a registered provider must give the System Governor a report about the obligation in subsection 175(1) of the Act ('24/7 RN report') in relation to each approved residential care home of the provider within 7 days after the end of each calendar month, or within a longer period specified by the System Governor by notice in writing given to the provider. Provision for an alternative period longer than 7 days after the end of each calendar month is intended to provide a mechanism for the System Governor to allow additional time for a registered provider to submit their 24/7 RN report if required, such as if there is a natural disaster or disease outbreak.

Subsection (2) provides that a registered provider is not required to provide a report under subsection (1) in relation to an approved residential care home for a calendar month if, during that calendar month, the registered provider did not deliver funded aged care services to at least one individual in the home.

Subsection (3) clarifies that a registered provider must provide the report required under subsection (1) in relation to an approved residential care home regardless of whether the registered provider has been granted an exemption from the obligation in subsection 175(1) of the Act in relation to that home. This ensures that accurate data is collected for policy purposes about provision of 24/7 RN care across the residential care sector.

Subsection (4) provides that the report must be in the form approved by the System Governor, and must specify in relation to each approved residential care home, whether a registered

nurse was on site and on duty at all times for each day during the calendar month on which at least one individual received funded aged care services in the home.

Paragraph (4)(c) provides that the report must advise if a registered nurse was not on site and on duty at all times on each day during the calendar month and must further specify:

- each period of 30 minutes or more that a registered nurse was not on site and on duty at the home, and for each such period,
- the reasons why a registered nurse was not on site or on duty (or both) during that period; and
- the alternative arrangements that were made for the period to ensure the clinical needs of the individuals in the home were met, or a statement that no alternative arrangements were made.

This specified information is relevant to ensuring the health and safety of individuals receiving funded aged care services.

Subdivision M – Status of service delivery branches

Section 166-900 – Application of this Subdivision

Section 166-900 provides that this Subdivision applies to a registered provider registered in one or more of the following categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community;
- nursing and transition care.

Section 166-905 – Reporting requirements relating to service delivery branches

Section 166-905 provides that for the purposes of paragraph 166(1)(a) of the Act, this Subdivision prescribes:

- the reports a registered provider must give to the System Governor in relation to a service delivery branch of the provider; and
- the requirements relating to those reports.

Section 166-910 – Report for opening of a service delivery branch

Subsection 166-910(1) provides that a registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

- the provider intends to begin delivering funded aged care services through a service delivery branch; and
- either:
 - the provider has not previously delivered any funded aged care services through this service delivery branch; or
 - the provider has previously given a report to the System Governor in accordance with section 166-925 in relation to closure of the service delivery branch.

The Note following subsection 166-910(1) provides that a separate notification must be given to the System Governor to establish a service delivery branch account for the service delivery branch, see subsection 203(1) of the Act.

Subsection 166-910(2) sets out the information that must be included in the report:

- the name of the service delivery branch;
- the date the provider proposes to begin delivering funded aged care services through the service delivery branch;
- the address of the service delivery branch;
- the contact details for the service delivery branch.

Subsection 166-910(3) provides that the report must be given no later than the day the provider begins delivering funded aged care services through the service delivery branch.

Section 166-915 – Report for change to a service delivery branch

Subsection 166-915(1) provides that a registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

- the provider has given a report to the System Governor in accordance with section 166-910 for a service delivery branch of the provider; and
- there has been a change to any information relating to the service delivery branch that was included in the report given to the System Governor in accordance with section 166-910.

Subsection 166-915(2) sets out the information that must be included in the report:

- the name of the service delivery branch;
- any updated information relating to the service delivery branch that was included in the report given under section 166-910.

Subsection 166-915(3) provides that the report must be given within 28 days after the day the change in paragraph 166-915(1)(b) has occurred.

Section 166-920 – Report for merger of service delivery branches

Subsection 166-920(1) provides that a registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

- the provider has given a report to the System Governor in accordance with section 166-910 for 2 or more service delivery branches of the provider; and
- the provider intends to merge 2 or more of these service delivery branches into a single service delivery branch of the provider.

Subsection 166-920(2) sets out the information that must be included in the report:

- the names of the service delivery branches that the provider proposes to merge, specifying;
 - the name of the service delivery branch through which the provider proposes to continue delivering funded aged care services; and
 - the name of each service delivery branch the provider intends to close;
- the date the provider proposes to merge the service delivery branches;
- in relation to the individuals (if any) accessing funded aged care services through the service delivery branches that the provider proposes to merge:

- whether the provider has notified the individuals of the proposed merger; and
- whether the provider has given a cessation notification to the System Governor and the Commissioner for each individual accessing funded aged care services through each service delivery branch mentioned in subparagraph 166-920(2)(a)(ii).

Subsection 166-915(3) provides that the report must be given at least 90 days, or such smaller number of days as is agreed in writing between the System Governor and the registered provider, before the date of the proposed merger.

Section 166-925 – Report for closure of a service delivery branch

Subsection 166-925(1) provides that a registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

- the provider has given a report to the System Governor in accordance with section 166-910 for a service delivery branch of the provider; and
- the provider intends to close the service delivery branch.

Subsection 166-925(2) provides that despite subsection 166-925(1), a registered provider does not have to give a report in accordance with this section in relation to a service delivery branch if:

- the provider intends to merge the service delivery branch with one or more other service delivery branches of the provider; and
- a report under section 166-920 has been given in relation to the service delivery branch.

Subsection 166-925(3) sets out the information that must be included in the report:

- the name of the service delivery branch;
- the date the provider proposes to close the service delivery branch;
- in relation to the individuals (if any) accessing funded aged care services through the service delivery branch:
 - whether the provider has notified the individuals of the proposed closure; and
 - whether the provider has given a cessation notification to the System Governor and the Commissioner for each individual.

Subsection 166-925(4) provides that the report must be given at least 28 days before the date of the proposed closure.

Section 166-930 – Report if provider no longer intends to open, merge or close service delivery branch

Subsection 166-930(1) provides that a registered provider must give a report, in an approved form, to the System Governor in accordance with this section if:

- the provider has given a report (the original report) to the System Governor in accordance with sections 166-910, 166-920 or 166-925; and
- the provider no longer intends to proceed with the opening, merger or closure described in the original report.

Subsection 166-930(2) sets out the information that must be included in the report:

- a description of the original report, including:
 - the name of each service delivery branch included in the original report; and

- whether the original report was in relation to an opening, merger or closure; and
- the proposed date of the opening, merger or closure that was included in the original report;
- a statement the provider no longer intends to proceed with the opening, merger or closure described in the original report;
- the reason why the provider no longer intends to proceed with the opening, merger or closure described in the original report.

Subsection 166-930(3) provides that the report must be given no later than:

- for an opening or closure—the proposed date of the opening or closure; and
- for a merger—28 days before the proposed date of the merger.

Subdivision N – Pricing information

Section 166-1000 Application of this Subdivision

Section 166-1000 provides that subject to subsection (2), this Subdivision applies to a registered provider registered in one or more of the following provider registration categories:

- home and community services;
- assistive technology and home modifications;
- advisory and support services;
- personal and care support in the home or community; nursing and transition care

Subsection (2) clarifies that the requirements in this Subdivision do not apply in respect of the delivery of funded aged care services delivered under any specialist aged care program.

Section 166-1005 Pricing information

Section 166-1005 sets out that for the purposes of the reporting obligation (see paragraph 166(1)(a) of the Act), a registered provider must:

- provide a report (with the information specified in subsection (3)) to the System Governor for each reporting period; and
- do so within 30 days of the end of the relevant reporting period; and
- do so in the approved form.

Subsection (2) provides that for the purposes of the reporting obligation under this section, a reporting period is a period of 2 months commencing on 1 January, 1 March, 1 May, 1 July, 1 September or 1 November of a year.

Subsection (3) sets out the information that must be included in a report is the most frequently charged price during standard business hours that the provider charges individuals for each service in the following service types:

- allied health and therapy
- care management
- domestic assistance
- home maintenance and repairs

- home or community general respite
- meals
- nursing care
- personal care;
- restorative care management;
- social support and community engagement;
- therapeutic service for independent living;
- transport.

Subsection (4) provides that a registered provider is not required to report on a price for a service in accordance with subsection (1) if:

- the registered provider is not currently delivering the service and has not delivered the service in the last 12 months
- the service is delivered under a specialist aged care program.

Part 3—Provider obligation—notifying of change in circumstances

Division 1—Obligation to notify

Section 167-5 – Purpose of this Part

Section 167-5 provides that this Part is made for the purposes of section 167 of the Act and prescribes:

- changes of a kind in relation to which prescribed kinds of registered providers must give notice to the Commissioner under that section; and
- circumstances in relation to which a notice must also be given to the System Governor under that section; and
- information that must be included in a notice given to the Commissioner or the System Governor under that section.

This part outlines when a registered provider’s change in circumstances must be actively reported to the Commissioner and System Governor. They are changes that are relevant to the provider’s ongoing registration and of which the Commissioner and System Governor require notification during the registration period, not just upon renewal of registration. A notice is required to be given within 14 days after the registered provider becomes aware of the change in circumstances. To ensure that notice requirements are proportionate, in some cases the requirement is imposed only on certain kinds of providers, as indicated in the table in section 167-10 below.

The notifications in this part broadly replicate requirements for material change notifications under the old Act and the Commission Act.

Section 167-10 – Notifying the Commissioner—kinds of registered providers and changes

Section 167-10 provides that the following table prescribes the kinds of registered providers and kinds of changes that those providers must give notice to the Commissioner under subsection 167(1) of the Act.

Kinds of registered providers and changes

Item	Column 1 Kind of registered providers	Column 2 Kinds of changes
1	every kind of registered provider	a change referred to in section 167-20 relating to the provider's suitability to be a registered provider
2	every kind of registered provider	a change referred to in section 167-25 relating to the suitability of a responsible person of the provider
3	every kind of registered provider	a change referred to in section 167-30 of responsible persons of the provider
4	every kind of registered provider	a significant change referred to in section 167-35 relating to the organisation arrangements of the provider
5	a registered provider to whom section 157 of the Act applies	a significant change referred to in section 167-40 relating to the governance arrangements of the provider
6	every kind of registered provider	a change referred to in section 167-45 relating to the scale of operations of the provider
7	a registered provider registered in the following provider registration categories: (a) home and community services; (b) assistive technology and home modifications; (c) advisory and support services; (d) personal and care support in the home or community; (e) nursing and transition care	a change referred to in section 167-50 relating to intended service types

Kinds of registered providers and changes

Item	Column 1 Kind of registered providers	Column 2 Kinds of changes
8	a registered provider registered in the following provider registration categories: (a) personal and care support in the home or community; (b) nursing and transition care; (c) residential care	a change referred to in section 167-55 relating to associated providers
9	every kind of registered provider, except government entities	a change referred to in section 167-60 relating to financial and prudential matters, except a change prescribed in item 10 of this table
10	a registered provider that: (a) is registered in the provider registration category residential care; and (b) is not a government entity or a local government authority; and (c) is not delivering aged care services through the specialised aged care program NATSIFACP	a change referred to in section 167-65 relating to liquidity
11	a registered provider registered in the provider registration category residential care	a change referred to in section 167-70 relating to approved residential care homes

Section 167-15 – Notifying the System Governor—circumstances

Section 167-15 provides that for the purposes of subsection 167(2) of the Act, the circumstances in which a notice must also be given to the System Governor under that subsection are the circumstances in which a notice must be given to the Commissioner under subsection 167(1) of the Act relating to the following:

- the circumstances prescribed by item 4, of the table in section 167-10, to the extent that the circumstances relate to entering into administration;
- the circumstances prescribed by item 9 of the table in section 167-10 (relating to financial and prudential matters);

- the circumstances prescribed by item 10 of the table in section 167-10 (relating to liquidity);
- the circumstances prescribed by item 11 of the table in section 167-10 (relating to approved residential care homes).

Changes in a registered provider's circumstances that are relevant to the System Governor's functions are outlined in this section. These changes must be notified to both the Commissioner and the System Governor. Note that this will not require two separate notices being sent, rather the single notice can be sent to both parties.

Division 2 - Changes in circumstances

Section 167-20 – Suitability of a registered provider

Section 167-20 provides requirements for the suitability of a registered provider.

Subsection (1) provides that the change prescribed in item 1 of the table in section 167-10 is any change in circumstances for a registered provider that materially affects, or may materially affect, the provider's suitability to be a registered provider, taking into account the matters referred to in paragraph 109(1)(b) of the Act (which deals with suitability of registered providers).

The note points the reader to section 167-10, which relates to notifying the Commissioner.

Subsection (2) provides that for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- the date on which a responsible person for the provider first became aware of the change of circumstances that materially affects the provider's suitability to be a registered provider; and
- how the provider became aware of the change of circumstances; and
- details about the change of circumstances.

Examples of changes in circumstances that may materially affect the suitability of a registered provider are as follows:

- A court or tribunal has made a finding in proceedings brought against the registered provider that it failed to comply with a law of the Commonwealth or the State or Territory in which it operates. Details that should be included in the notice are a description of the nature of the proceedings and the finding made, the reference number for the proceedings and a copy of the judgment or order (if available).
- The registered provider was a registered NDIS provider but its registration was suspended. Details that should be included in the notice are the date of suspension and the reasons for the suspension attaching copies of relevant documents.

Section 167-25 – Suitability of a responsible person of a registered provider

Section 167-25 provides requirements for notifying of changes that may affect the suitability of a responsible person of a registered provider. These arrangements were recommended by

the Royal Commission which stated that in the absence of express obligations, the regulator is less likely to know who is controlling or directing the activities of approved providers.

Subsection (1) provides that the change prescribed in item 2 of the table in section 167-10 is any change in circumstances relating to a responsible person of a registered provider that materially affects, or could materially affect, the responsible person's suitability to be a responsible person of the provider, having regard to the matters referred to in subsection 13(1) of the Act (which deals with suitability matters in relation to an individual).

'Materially affects' in this context refers to a change that affects the responsible person's suitability in an important or noticeable way.

The note points readers to section 167-10, which relates to notifying the Commissioner.

Subsection (2) provides that for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- the name of the responsible person; and
- the date the provider first became aware of the change in circumstances; and
- how the provider became aware of the change in circumstances; and
- details of the change of circumstances; and
- whether, after considering those matters, the provider is reasonably satisfied that the responsible person continues to be suitable to be a responsible person of the provider; and
- what, if any, action the provider has taken, or proposes to take, in relation to the responsible person.

Section 167-30 – Change of responsible persons of a registered provider

Section 167-30 provides requirements for a change of responsible persons of a registered provider.

Subsection (1) provides that the change prescribed in item 3 of the table in section 167-10 is any change of responsible persons of a registered provider, including:

- an individual becoming a responsible person of the provider; and
- an individual ceasing to be a responsible person of the provider.

The registered provider must notify the Commissioner when an individual ceases to be a responsible person of the provider regardless of whether that individual ceases or continues to be employed or engaged by the provider in any other capacity.

The note points the reader to section 167-10, which relates to notifying the Commissioner.

Subsection (2) provides that for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- for a change relating to an individual becoming a responsible person of the provider:
 - the name and contact details of the individual; and

- a description of the individual's responsibilities in their capacity as a responsible person of the provider; and
- a statement to the effect that the provider has had regard to the suitability matters in relation to the individual, as referred to in subsection 13(1) of the Act, and that the provider is satisfied that the individual is suitable to be involved in the delivery of funded aged care services; and
- for a change relating to an individual ceasing to be a responsible person of the provider:
 - the name of the individual ceasing to be a responsible person; and
 - the reason that the individual has ceased to be a responsible person of the provider; and
 - the name and contact details of another individual (if any) who is carrying out, or will carry out, the responsibilities of the individual ceasing to be a responsible person.

It is required that the notice include the name and contact details of another individual who is carrying out, or will carry out, the responsibilities of the outgoing responsible person. This individual's details should be provided regardless of whether that individual is a temporary or permanent appointment.

Section 167-35 – Organisation arrangements of a registered provider

Section 167-35 provides requirements for changes to organisation arrangements of a registered provider.

Subsection (1) provides that the change prescribed in item 4 of the table in section 167-10 is any change of the following kind to the organisation of a registered provider:

- if the provider is not a government entity—any significant change to the provider's legal and business structure, including any of the following:
 - a restructure of the organisation of the provider;
 - a sale, acquisition, or merger relating to the provider;
- for any registered provider (including a government entity)—the entering into of an agreement by the provider with another entity in which the other entity agrees to deliver services that support the management or governance function of the provider;
- for any registered provider (including a government entity)—any significant change to an agreement (including the cessation of a such an agreement) by the provider with another entity in which the other entity agrees to deliver services that support the management or governance of the provider;
- if the provider is not a government entity—any of the following events:
 - the provider enters into administration;
 - the provider appoints a restructuring practitioner (within the meaning of the *Corporations Act 2001*);
 - an insolvency event (within the meaning of the *Aged Care (Accommodation Payment Security) Act 2006*) occurs in relation to the provider.

Note 1 points the reader to section 167-10, which relates to notifying the Commissioner.

Note 2 points the reader to section 167-15, which relates to notifying the System Governor of matters relating to entering administration.

Changes that affect the organisational arrangements of the registered provider such as, for example:

- the commencement of a subcontracting arrangement under which a third party delivers services that support the management or governance function of the registered provider, such as payroll, accounting or other administrative services (noting that other subcontracting arrangements, which are considered to be associated provider, are dealt with under section 167-55);
- a sale relevant to the business of the registered provider (noting that a notice is not required each time shares in a corporate registered provider are sold);
- a change to the holding company of the registered provider; or
- an insolvency event;

are relevant to the registered provider's ongoing registration as these changes may affect the suitability of the registered provider to deliver funded aged care services.

Subsection (2) provides that to avoid doubt, the circumstances referred to in paragraph (1)(b) relating to the provider entering into an agreement do not include the entering into of an agreement for the delivery of funded aged care services. The requirements for notifying in relation delivery of funded aged care services by an associated provider are dealt with under section 167-55.

Subsection (3) provides that for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- for a change to the provider's legal or business structure—details about the change to the provider's legal or business structure; and
- for an event referred to in paragraph (1)(b) or (c) (which relate to agreements):
 - a detailed statement about the services that the other entity is to provide to the registered provider; and
 - the nature and duration of the agreement; and
 - if the notification is about the cessation of the agreement—the reason and date of cessation; and
- for an event set out in paragraph (1)(d) of this section (which relates to administration, restructuring and insolvency):
 - the date on which the event occurred; and
 - the type of administration (where applicable); and
 - the name of the administrator or restructuring practitioner (where applicable).

Examples of the type of detail to be included in a notice to the Commissioner are as follows:

- If a registered provider that is a company becomes subject to a form of insolvent administration, the notice should specify the form, such as, for example, a voluntary administration or liquidation, and should provide the name and contact details for the administrator or liquidator and the date of their appointment.

- If a change to the corporate business structure of a registered provider involves a change to its holding company, the notice should specify the name, ACN, ABN and contact details of the new holding company. It should also specify whether the new holding company is also a registered provider.

Section 167-40 – Governance arrangements of a registered provider

Section 167-40 provides requirements for changes in governance arrangements of a registered provider.

Subsection (1) provides that the change prescribed in item 5 of the table in section 167-10 is any change to the governance of a registered provider that would result in the registered provider no longer complying with subsection 157(2) of the Act.

Note 1 points the reader to sections 157-5 and 157-10, which prescribe the kinds of registered providers to whom section 157 of the Act applies.

Note 2 points the reader to section 167-10, which relates to notifying the Commissioner.

Subsection (2) provides that for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- a statement that the provider no longer complies with a condition of registration set out in paragraph 157(2)(a) or (b) of the Act (whichever is relevant to the provider); and
- the names of incoming and outgoing members in relation to the non-compliance; and
- information on steps being taken to return to compliance, including whether an application under subsection 159(1) of the Act (which relates to determinations that certain conditions relating to the governing body of a registered provider do not apply) has been submitted, or will be submitted.

Section 167-45 – Change relating to the scale of operations of a provider

Section 167-45 provides requirements for a change relating to the scale of operations of a provider.

Subsection (1) provides that the change prescribed in item 6 of the table in section 167-10 is any of the following changes:

- for a registered provider other than a registered provider registered in the provider registration category residential care—a change to the local government area in which the provider delivers a funded aged care service;
- for a registered provider (including a registered provider registered in the provider registration category residential care)—a significant increase or decrease in the number of aged care workers of the provider that materially affects the provider’s ability to deliver funded aged care services.

Note 1 points the reader to section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

With respect to the changes in local government area (LGA) for providers operating in a home or community setting, this information is captured as part of the registration process and on the provider register and will play an important role in understanding the aged care sector. For example, it will provide the Commission a sense of the scale of operation a provider and their capacity to deliver funded aged care services. A change for, example, of a small entity such as a sole trader from delivering funded aged care in one LGA to nationwide may be a risk signal or trigger the Commission look into whether they have the workforce or associated providers to manage in the increase in service delivery.

With respect to changes to the number of aged care workers of a registered provider, it is recognised that these changes will be relative to the circumstances of each registered provider. An identical increase or decrease in the number of workers may be significant for one registered provider while insignificant for another. For example, the resignation of five workers may not materially affect the ability of a large, registered provider in a major metropolitan area to deliver funded aged care services. However, this change may have a material effect on service delivery for a smaller provider (where the reduced number of workers represents a greater proportion of its overall workforce) or a provider in a regional or remote area where replacement workers are more difficult to source.

Subsection (2) provides that for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- details of the change; and
- the aged care funded services that will be, or are likely to be, affected by the change; and
- any other anticipated effects of the change; and
- the reason for the change; and
- any actions that the provider has taken or will take to manage the effect on services, or other anticipated effects.

It is required that the notice to the Commissioner include information about the funded aged care services affected by the change, as well as any other anticipated effects. With respect to the example above about a change in circumstances involving the resignation of workers, examples of other anticipated effects might include the following:

- Increased expenditure on temporary contract workers to fill roles while permanent replacement workers can be recruited. If the period for recruitment is likely to be long, due to worker shortages, the provider may anticipate being unable to fulfil commitments in its continuous improvement plan due to the diversion of funds to meet the increased cost of temporary contract workers and the availability of permanent workers to implement planned improvements.
- The provider may have to delay scheduled advanced training so that newly recruited workers are included.

Section 167-50 – Changes relating to intended service types

Section 167-50 provides requirements for changes relating to intended service types.

Subsection (1) provides that the change prescribed in item 7 of the table in section 167-10 is any change relating to a registered provider's intended service types.

Note 1 points the reader to section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

Note 2 points the reader to Division 4 of Part 4 of Chapter 4 of the rules for provisions relating to starting and ceasing the provision of funded aged care services to a particular individual and continuity of those services.

Subsection (2) provides that for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- the relevant service type; and
- the date on which the provider expects the change to take effect.

Once registered, a provider may deliver all service types within the registration categories in which it has been registered however, in its application for registration, or renewal of registration, the provider must specify each service type it intends to deliver (within a category). The service types delivered by a registered provider are relevant to the provider's suitability to deliver funded aged care services and, accordingly, any changes to those service types are relevant to its ongoing registration.

For example, the Commissioner decided to register a provider in the registration category home and community services in circumstances where the provider specified that it was delivering the transport service type only. If the provider intends to expand its services to include meals (a service type within the same category), being a service type different in nature and with specific obligations applicable to it, this may affect the provider's suitability to deliver funded aged care services. The Commissioner may have concerns that the provider is not suitable to deliver the additional meal service type or that the provider should be the subject of additional conditions or other regulatory oversight to manage and monitor its capacity and capability to deliver the additional service type. Further, the delivery of that additional service type may affect the provider's suitability to continue to deliver the transport service type. A requirement to notify the change enables the Commissioner to assess the effect of the change on the provider's suitability to deliver all services.

Further examples of service types on which specific requirements are imposed are care management and restorative care management. If a provider notifies the Commissioner of its intention to deliver these service types, the Commissioner will need to consider the provider's suitability having regard to the specific requirements applicable to these service types in the context of all other requirements applicable to the services the provider was delivering previously.

Section 167-55 – Changes relating to arrangements with associated providers

This section provides requirements for changes relating to arrangements with associated providers.

Subsection (1) provides that the change prescribed in item 8 of the table in section 167-10 is any of the following changes:

- the commencement of a new arrangement between the registered provider and an associated provider for the delivery of funded aged care services by the associated provider on behalf of the registered provider;

- the variation or extension of an existing such arrangement between the registered provider and an associated provider;
- the cessation of an existing such arrangement between the registered provider and an associated provider.

The note points the reader to section 167-10, which relates to notifying the Commissioner.

The requirement to notify the above changes to arrangements with associated providers to the Commissioner is imposed on registered providers in the registration categories of:

- personal care and care support in the home or community;
- nursing and transition care; and
- residential care.

All providers must specify, in their application for registration and renewal, the nature and extent of the relationship between the provider and its associated providers. It is considered proportionate to impose the requirement to notify the Commissioner of changes to associated provider arrangements during the registration period only on providers in registration categories that contain more complex services.

These are the categories containing service types that require greater access to the individual to deliver and, therefore, pose a greater risk of harm to the individual. In addition, they are the categories to which the Aged Care Quality Standards apply. A registered provider will still need to meet the conditions, obligations and duties of the Act even where they engage an associated provider for service delivery. Given this, and the nature of the service delivery in these categories, it is important that the Commissioner is notified about new or varied arrangements that occur during the registration period, as well as the details of the associated provider that will deliver services under those arrangements to have oversight of risks to service delivery.

For example, a change to an arrangement under which an associated provider delivers the service type nursing (being a service type in the registration category nursing and transition care) requires notification to the Commissioner with 14 days (not only upon renewal of registration) because of the risk inherent in that service type. By contrast, a change to an arrangement where an associated provider delivers a gardening service (being a service in the service type home maintenance and repairs in the registration category home and community services) does not need to be notified to the Commissioner within 14 days. In the case of a gardening service, it is sufficient if that information is updated only at the time of renewal of registration

Subsection (2) provides that subsection (1) does not apply to circumstances where the registered provider has entered into an arrangement with an associated provider for:

- the supply of labour under a labour hire arrangement; or
- the delivery of services that support the management or governance function of the registered provider; or
- the delivery of services that do not include services in the service types relating to one of the following provider registration categories:
 - residential care;
 - personal and care support in the home or community;
 - nursing and transition care.

The exclusion of arrangements for the supply of labour recognises that there is a distinction between a provider who enters into an arrangement with a third party (associated provider) to deliver a service type (and all relevant activities associated with it including the procurement of workers) and a provider who engages a third party to assist the provider with only the procurement of workers to enable that provider to deliver the service type.

For example, a provider who engages a third party contractor to deliver all nursing services (including the sourcing of nurses) is covered by this section and must notify the Commissioner when those arrangements commence, cease or are varied. A provider who engages a third party labour hire business to supply all or some nurses to the provider to enable that provider (not the third party) to deliver the nursing services is covered by the exclusion and notification to the Commissioner is not required.

It should also be noted that independent contractors are aged care workers because they fall within the definition of aged care worker as an individual engaged by a registered provider. Given this, and the exclusion of supply of labour, a single individual worker who is engaged as an independent contractor is unlikely to be in scope of this notification requirement, depending on the nature of the arrangement.

Paragraph 167-55(2)(c) makes clear that the notification requirement only applies to the services in:

- personal care and care support in the home or community;
- nursing and transition care; and
- residential care

not for services that that provider may deliver in other registration categories.

Where there are goods, services or elements of service delivery are supplied by another entity to support the delivery of funded aged care services, the intent is not to capture this information in this requirement for associated provider notification. This is because they are typically low risk services or goods that are available in the mainstream market and are funded through age care to support an older person's independence in the home or community or the functioning (e.g. low-cost assistive technology or taxi vouchers) of a residential care home (e.g. gardening or maintenance).

Subsection (3) provides for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- in all circumstances—information about the associated provider, including:
 - the associated provider's business name; and
 - the associated provider's ABN; and
 - the associated provider's ACN (if any); and
 - the associated provider's business location; and
- in circumstances relating to the delivery of funded aged care services in a residential care home—information about the residential care home, including:
 - the name of the residential care home; and
 - the address of the residential care home; and
- in circumstances relating to the commencement of a new arrangement:
 - details of the services to be delivered under the new arrangement; and
 - the reasons for the new arrangement; and

- the time period for the new arrangement (including the commencement date and expiry date of the arrangement); and
- in circumstances relating to the variation or extension of an arrangement:
 - details of the variation or extension, including any new commencement dates or expiry dates for the arrangement; and
 - the reason for the variation or extension; and
- in circumstances relating to the cessation of an arrangement:
 - the date on which the arrangement ceased or will cease; and
 - the reason for the cessation.

Section 167-60 – Changes relating to financial and prudential matters

Section 167-60 provides requirements for changes relating to financial and prudential matters.

Subsection (1) provides that the change prescribed in item 9 of the table in section 167-10 is any change to a registered provider's capacity to deliver funded aged care services that the provider is registered to deliver, including:

- the inability to pay the entitlements of the provider's aged care workers;
- any change that materially affects an existing or anticipated revenue source;
- any instance in which the provider is unable to pay the provider's debts as and when those debts become due and payable.

The note points the reader to section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

Note that information is material if omitting, misstating or obscuring it could be reasonably expected to influence decisions of the governing board, individuals, the Commissioner or System Governor in relation to the provider.

Subsection (2) provides that subsection (1) does not apply to circumstances set out in section 167-65 (which relates to liquidity).

Subsection (3) provides for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- details about the change; and
- the impact that the provider expects that the change to have on the provider's ability to deliver funded aged care services; and
- details about any mitigating strategies the provider has attempted, or will attempt, to manage this impact.

Section 167-65 – Changes relating to liquidity

Subsection (1) provides that the change prescribed in item 10 of the table in section 167-10 is any circumstance where the registered provider is not maintaining, or is at risk of not maintaining, the provider's default minimum liquidity amount for a quarter or evaluated minimum liquidity amount for a quarter.

The note points the reader to section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

Subsection (2) provides that for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- the provider's current and expected liquidity for the relevant quarter; and
- the reason for the reduction, or expected reduction in liquidity; and
- the provider's Liquidity Management Strategy; and
- the provider's plan to increase liquidity to a level that is sufficient for the purposes set out in subsection (1).

The note explains that the standards in relation to financial and prudential matters are set out in the Financial and Prudential Standards made by the Commissioner under subsection 376 (1) of the Act.

Section 167-70 – Changes relating to approved residential care homes

Section 167-70 provides requirements for changes relating to approved residential care homes.

Subsection (1) provides that the change prescribed in item 11 of the table in section 167-10 is any of the following changes relating to an approved residential care home of a registered provider:

- a change that may affect whether the approved residential care home of the provider continues to meet the definition of residential care home in the Act;
- a change to a building or the premises that comprise the approved residential care home that presents a risk to the delivery of quality and safe residential care;
- a planned construction or renovation activity relating to the approved residential care home that the provider reasonably expects will affect the delivery of funded aged care services at the residential care home;
- an unplanned event relating to the approved residential care home that the provider reasonably expects will cause sustained disruption to the delivery of funded aged care services at the residential care home;
- a change in the ownership of the premises at which the residential care home is located or a change to any agreement between the owner of the premises and the registered provider to use the premises as a residential care home;
- for any provider other than a provider referred to in paragraph (g)—a reduction in the availability of the total number of beds covered by the approval of the approved residential care home that the provider expects will continue for a continuous period of at least 3 months, except where the approved residential care home only delivers funded aged care services under a specialist aged care program;
- for a registered provider in the 2023 MM category known as MM 6 or MM 7—a reduction in the availability of the total number of beds covered by the approval of the approved residential care home for any period of time, except where the approved residential care home only delivers funded aged care services under a specialist aged care program;

- a change in circumstances that causes beds that were unavailable as referred to in paragraph (1)(f) or (g) to become available.

Note 1 points the reader to section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

Note 2 points readers to section 136 of the Act, which relates to varying the approval of a residential care home of a registered provider.

A sustained disruption to the delivery of funded aged care services caused by an unplanned event (as specified in paragraph 167-70(2)(d) of the Rules) is intended to cover disruptions that are not intermittent and continue for a period that is greater than one week in duration. Examples include a natural disaster, such as a fire or flood, that destroys critical equipment or infrastructure at the residential care home requiring partial or full closure of the home, or the discovery of mould in certain areas of the home that requires closure of part of the home, while remediation works are carried out. A minor disruption such as, for example, the intermittent interruption of electricity supply for a day or two, that can be managed by the registered provider utilising alternative power sources, is not a sustained disruption requiring notice to the Commissioner.

The Commissioner must be notified of a change in the ownership of the premises at which the residential care home is located or a change to an agreement between the owner of the premises and the registered provider, that allows the registered provider to use the premises. This is because at the time the Commissioner approved that residential care home it was required to be satisfied that the registered provider either owned or had the right to use the premises as a residential care home. Any change in ownership of the home, or agreements to use it, are relevant to the enduring approval of the home. See section 113-5 of the Rules.

Subsection (2) provides that for the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

- the name of the approved residential care home; and
- the street address of the residential care home; and
- a description of the change of circumstances; and
- for circumstances referred to in paragraph (1)(f) or (g):
 - the number of beds in respect of which the registered provider is, or will be, unable to provide residential care; and
 - the period during which the registered provider is, or will be, unable to provide residential care for those beds; and
- the reason for the change to the availability of beds; and details of the change in ownership, and in circumstances where the registered provider is not the owner of the premises used for the provision of services and there is a change in ownership, the information must include the date and details of the type of agreement under which permission to use the premises is given.

Part 4—Responsible person obligation—change in circumstances relating to suitability

Section 169-5 – Kinds of registered provider to which the obligation applies

Section 169-5 provides that for the purposes of 169(1)(a) of the Act, every kind of registered provider is prescribed except a provider that is a sole trader. This is because sole traders will not need to notify themselves of a change in circumstance relating to their suitability. Instead, they will follow the rules relating to change in circumstances set out in Part 3 of Chapter 5 of these rules.

Part 5—Obligations relating to suitability of responsible persons

Section 172-5 – Kinds of registered provider to which the obligation applies

Section 172-5 provides that, for the purposes of subsection 172(1) of the Act, every kind of registered provider is prescribed.

Section 172-10 – Requirements for records of suitability matters

Section 172-10 provides that, for the purposes of paragraph 172(1)(b) of the Act, a registered provider must keep a record of its consideration of suitability matters in relation to a person that includes the following:

- the name of the person in relation to whom the suitability matters were considered;
- the date or dates on which the suitability matters were considered in relation to the person;
- the outcome of the provider's consideration of each suitability matter in relation to the person;
- the reasons for reaching that outcome.

Part 6—Obligations relating to aged care workers etc.

Division 1—Registered nurses

Subdivision A—Preliminary

Section 175 of the Act provides that registered providers registered in the provider registration category residential care, including when providing certain kinds of specialist aged care programs, must ensure that a registered nurse (within the meaning of the *Health Insurance Act 1973*) is on site and on duty at all times at each approved residential care home operated by them ('24/7 registered nurse requirement'). Enacting this requirement continues to respond in part to Recommendation 86 of Royal Commission.

The inclusion of an exemption framework from the 24/7 registered nurse requirement is consistent with Recommendation 86 of the Royal Commission, which recommended that providers should be able to apply for an exemption in certain circumstances. The Royal Commission highlighted the need to allow for exemptions to be granted to homes in regional, rural and remote areas where the provider is unable to recruit sufficient numbers of staff with the requisite skills to meet the 24/7 registered nurse requirement.

Subdivision A specifies arrangements for the granting of exemptions from the 24/7 registered nurse requirement, including matters relating to the application process and the circumstances in which an exemption may be granted. It also provides for conditions that may apply to exemptions and the revocation of exemptions.

Section 175-5 – Specialist aged care programs to which the registered nurse obligation does not apply—MPSP and TCP

Section 175-5 provides that for the purposes of paragraph 175(2)(b) of the Act, a registered provider delivering funded aged care services at an approved residential care home under any of the following specialist aged care programs is prescribed:

- MPSP;
- TCP.

The effect of this section is that the 24/7 registered nurse requirement applies to homes where ‘mainstream’ residential care is delivered and also to homes where residential care is delivered through the NATSIFACP specialist aged care program. Government policy is that the 24/7 registered nurse care requirement is not to apply to homes that solely deliver residential care in the form of TCP and MPSP.

Section 175-10 – Purpose of this Division

Section 175-10 provides that for the purposes of subsection 175(3) of the Act, this Division provides for:

- the circumstances in which an exemption from subsection 175(1) of the Act may be granted to a registered provider in relation to a residential care home; and
- the period for which an exemption may be in force; and
- the conditions that apply to that exemption.

Subdivision B—Process for granting exemptions

Section 175-15 – Application for exemption

Subsection (1) provides that a registered provider may apply to the System Governor for an exemption from subsection 175(1) of the Act in relation to an approved residential care home at which the provider provides funded aged care services.

Subsection (2) provides that the application must:

- be in a form approved by the System Governor; and
- include the following information:
 - the name of the registered provider;
 - the name of the home through which the provider provides funded aged care services;
 - the name and street address of the home;
 - any other information required by the approved form; and
- be accompanied by any other documents required by the approved form.

This provision is aimed at ensuring that applications for the exemption include the necessary information in writing that will enable the System Governor to determine whether the criteria under section 175-25 (discussed below) are met.

Section 175-20 – System Governor may request further information or documents

Subsection (1) provides that if the System Governor receives an application under section 175-15 from a registered provider, the System Governor may, by notice in writing given to the provider, request further information or documents specified in the notice for the purposes of considering the application.

Further information or documents requested in a notice under subsection (1) may contain personal information. This personal information will be limited to:

- the name and contact details of the staff member who is responding to the notice on behalf of the provider; and
- the name and contact details of a person (or persons) with whom a provider has entered or proposes to enter into an arrangement to provide clinical care services as part of the reasonable steps the approved provider is taking to ensure the clinical care needs of individuals in the facility will be met during the period for which an exemption is in force.

This information related to arrangements to provide clinical care services will only be requested where not adequately specified in an approved provider's application under section 175-15. This personal information is required so that the System Governor (or delegate) may contact the person (or persons) to confirm the arrangement as set out by the approved provider in their application. This will enable the Secretary to be satisfied of the criteria under subsection 175(4) of the Act and subsection 175-25 of these Rules in considering an application for an exemption from the 24/7 registered nurse requirement.

To avoid doubt, personal information about individuals receiving funded aged care services will not be requested or provided under a section 175-20 notice.

Subsection 175-20(2) outlines the effect of a provider failing to comply with the request within 14 days after being notified by the System Governor, or within a longer period if specified in the notice. If the provider does not comply with the notice within the timeframe required in the notice, the application for exemption is taken to be withdrawn. Where a notice requesting information or documents is issued under section 175-20, the notice must set out the consequences of not complying with such a request.

If an approved provider's application is withdrawn by operation of subsection 175-20(2), the provider is not prevented from making another application for exemption at any time after the withdrawal.

Section 175-25 – Decision whether to grant exemption

Section 175-25 provides the relevant considerations for the System Governor's decision to grant an exemption from the 24/7 registered nurse requirement. Section 175-25 sets out the criteria for the granting of an exemption, matters the System Governor must have regard to in making a decision on the exemption application, the period an exemption may apply for and the conditions that apply to an exemption.

Criteria for granting exemption

Subsection (1) provides that if the System Governor receives an application under section 175-15 from a registered provider for an exemption from subsection 175(1) of the Act

in relation to an approved residential care home, the System Governor may grant the exemption only if:

- the home is located in the 2023 MM category known as MM 5, MM 6 or MM7; and
- there are no more than 30 operational beds in the home on the day of the System Governor's decision; and
- the System Governor is satisfied that the provider has taken reasonable steps to ensure that the clinical care needs of the individuals residing in the home will be met during the period for which the exemption is in force; and
- the registered provider has given to the System Governor the reports required under section 166-855 in relation to the residential care home for each calendar month.

The criteria in paragraphs 175-25(1)(a) and (b) relate to the location and size of the home. These criteria recognise the unique challenges faced by providers operating small homes in small rural towns, remote communities and very remote communities to attract and retain registered nurses.

The criterion in paragraph(1)(c) corresponds with the requirement under paragraph 175(4)(b) of the Act, that the System Governor must be satisfied that the provider has taken reasonable steps to ensure that the clinical care needs of the individuals in the home will be met during the period for which the exemption is in force. This criterion is central to the intent of the 24/7 registered nurse requirement, which is that individuals living in homes have access to clinical care when they need it.

Under this criterion, the System Governor will need to assess whether the application for exemption demonstrates that the steps undertaken by the provider are reasonable in the circumstances to ensuring the clinical care needs of the individuals in the home will be met during the period of the exemption.

For example, reasonable steps may, for a particular provider and their home, involve the provider establishing an arrangement with a local hospital that is close by to have an registered nurse on call to attend to the clinical care needs of individuals at the home, while having a sufficient number of enrolled nurses and/or nursing assistants and/or personal care workers on site to provide clinical care other than that which is specifically within a registered nurse's scope of practice.

Subsection (2) provides that in deciding whether to grant the exemption, the System Governor must have regard to:

- any variation to the registration of the registered provider by the Commissioner under paragraph 123(1)(a) of the Act to vary a condition to which the registration is subject to under section 143 of the Act; and
- any variation to the registration of the registered provider by the Commissioner under paragraph 123(1)(b) of the Act; and
- any notice given to the registered provider by the System Governor or Commissioner under:
 - Part 11 of Chapter 6 of the Act; or
 - Division 2 of Part 10 of Chapter 6 of the Act; and
- any notice given to the registered provider under Part 5 of the Regulatory Powers Act (as applied by section 448 of the Act); and

- if the registered provider has given an undertaking under section 114 of the Regulatory Powers Act (as applied by section 458 of the Act); and
- if the registered provider has given an undertaking under section 463 of the Act; and
- whether the registered provider has been convicted of an offence against the Act; and
- whether the registered provider has been found liable to pay a civil penalty under this Act.

Subsection (2) is intended to ensure the System Governor has sufficient relevant information from the Commissioner and in relation to the provider's compliance history under the Act to properly consider whether a provider has previously taken and is currently taking reasonable steps to ensure that the clinical care needs of individuals at the home will be met.

Common law procedural fairness will apply. For example, if the System Governor proposes to refuse to grant an exemption on the basis of information provided by the Commissioner or on the basis compliance history, the information will be put to the provider and the provider will be given an opportunity to comment before an adverse decision is made.

Subsection (3) provides that the System Governor may grant an exemption to a registered provider in relation to a home for which the registered provider has previously been granted an exemption. This is to align with paragraph 175(4)(d) of the Act and will allow for a home to be granted more than one exemption over time. This means that a provider that has an exemption in force in respect of a home, which is due to expire, will not be prevented from re-applying for another exemption. It will also allow for a provider of a home that currently has an exemption in force to request that the exemption be revoked under section 175-45 (discussed below) in circumstances where the provider is able to recruit sufficient registered nursing staff to meet the 24/7 registered nurse requirement. Equally, it allows a provider to reapply in the future if their circumstances change and they are no longer able to meet the 24/7 registered nurse requirement in respect of that home.

Period of exemption

Subsection (4) provides that if the System Governor decides to grant an exemption, the System Governor must decide the period for which the exemption is to be in force.

Subsection (5) provides that the period:

- must not be longer than 12 months; and
- must not begin before the day on which the System Governor grants the exemption.

The requirements under subsections (4) and (5) that the period of an exemption be no longer than 12 months aligns with paragraph 175(4)(c) of the Act.

Conditions that apply to exemption

Subsection (6) provides that the following conditions apply to an exemption:

- the registered provider must give the System Governor notice in writing of any material change to the information given to the System Governor:
 - in the application for the exemption; or
 - in response to a request by the System Governor under subsection 175-20(1);

- any additional conditions that the System Governor decides to impose on the exemption.

In accordance with paragraph 175(4)(e) of the Aged Care Act, subsection (6) provides for conditions to apply where an exemption from the 24/7 registered nurse requirement has been granted.

Paragraph 6(a) provides that a provider who has been granted an exemption must notify the System Governor in writing of any material change to the information given to the Secretary in either the application for the exemption, or any additional information or documents that were provided to the System Governor in response to a request under subsection 175-20(1).

This condition aims to ensure the System Governor is notified of any material change to the information that was provided to them by the provider for the purposes of determining whether an exemption should be granted. For example, a material change may be the cessation of an arrangement with a local hospital that is close by to have a registered nurse on call to attend to the clinical care needs of individuals at the home that formed part of the reasonable steps taken to ensure the clinical care needs of individuals during the period of the exemption.

This condition will allow the System Governor to assess whether, despite the material change, the clinical care needs of the care individuals at the home will continue to be met. If the System Governor is not satisfied that, following the material change, the clinical care needs of the individuals at the home are being or will be met, the System Governor may revoke the exemption (see section 175-50 discussed below).

Paragraph (6)(b) also allows the System Governor to impose additional conditions on the exemption. It is important to enable the System Governor to impose other conditions where appropriate to satisfy themselves as far as possible that the reasonable steps taken to ensure that the clinical care needs of individuals during the period of the exemption will be effective for the entire period of the exemption. For example, it may be necessary to impose a condition of an exemption that particular arrangements that form part of the reasonable steps are formalised through written agreement for the duration of the exemption, where only informal arrangements are in place at the time of the application.

Section 175-30 – Notice of decision

Section 175-30 requires that, where the System Governor has approved an exemption from section 175 of the Act in respect of a home of a provider, they must provide written notice of their decision to the provider.

Subsection (1) provides that notice of decision must be in writing and must:

- state the period for which the exemption is in force; and
- state the conditions that apply to the exemption.

Subsection (2) provides that if the System Governor refuses to grant an exemption from subsection 175(1) of the Act to a registered provider in relation to a residential care home, the System Governor must give the provider notice in writing of the decision, including:

- the reasons for the decision; and
- the date of the decision; and

- a statement of the registered provider's right to review of the decision.

The decision is reviewable under Item 5 of the table at section 557-5 of these Rules.

Subdivision C—Revocation of exemptions

Subdivision C deals with the circumstances in which an exemption from the 24/7 registered nurse requirement in section 175 of the Act can be revoked.

Section 175-45 – Revocation on request

Section 175-45 provides for revocation on request.

Subsection (1) provides that the System Governor must revoke a registered provider's exemption from subsection 175(1) of the Act in relation to a residential care home if the registered provider requests the revocation in writing.

Subsection (2) provides that the System Governor must give the registered provider notice in writing of the date that the exemption ceases to have effect, which may be the date of the notice or a later date.

This section allows for situations where a provider may want an exemption to be revoked as they have been able to employ sufficient staff to meet the 24/7 registered nurse responsibility.

Section 175-50 – Revocation on other grounds

Section 175-50 provides for matters relating to the revocation of an exemption by the System Governor, including the grounds upon which they may revoke an exemption from the 24/7 registered nurse responsibility.

Grounds for revocation

Subsection (1) provides that the System Governor may revoke a registered provider's exemption from subsection 175(1) of the Act in relation to a residential care home if:

- the System Governor is satisfied the registered provider has breached a condition of the exemption; or
- the System Governor is not satisfied that the clinical care needs of the individuals in the home:
 - are being met; or
 - will be met during the period the exemption would otherwise be in force; or
- the registration of the registered provider has been varied by the Commissioner under paragraph 123(1)(a) of the Act to vary a condition to which the registration is subject to under section 143 of the Act; or
- the registration of the registered provider has been varied by the Commissioner under paragraph 123(1)(b) of the Act; or
- the System Governor becomes aware there are more than 30 operational beds in the home.

Submissions by registered provider

Subsections 175-50 (2), (3) and (4) provide for certain steps the System Governor must take before deciding to revoke a provider's exemption from the 24/7 registered nurse responsibility in relation to a home.

The System Governor must first notify the provider in writing that the System Governor is considering revoking the exemption (subsection 175-50(2)). The notice must then set out matters (subsection 175-50(3)) that include the reasons why the System Governor is considering revoking the exemption, and invite the approved provider to make written submissions in response within either:

- 14 days after receiving the notice; or
- a shorter period as specified in the notice.

The System Governor is required to consider any submissions provided by the approved provider in response to the notice in making their decision on whether to revoke the exemption (subsection 175-50(4)).

The above steps afford procedural fairness to approved providers as it will ensure they are formally made aware of the possibility that their exemption will be revoked, gives them a reasonable opportunity to respond, and requires the System Governor to consider any response they may make in response to the notice.

Section 175-55 – Notice of decision

Section 175-55 provides that where the System Governor decides to revoke an exemption from the 24/7 registered nurse requirement, they must give the approved provider written notice of their decision, and that the notice must include:

- the reasons for the decision; and
- the date that the exemption ceases to have effect, which may be the date of the decision or a later date; and
- a statement of the provider's right to review of the decision.

The decision is reviewable under Item 6 of the table at section 557-5 of these Rules.

Division 2—Delivery of direct care

Subdivision A—Delivery of direct care –mainstream providers

Subdivision A addresses Recommendation 86 of Royal Commission, which recommended, amongst other matters, that, from 1 July 2024, the Government should require providers of residential care to meet a minimum staff time quality and safety standard, including that the minimum staff time standard should require providers to engage registered nurses, enrolled nurses and personal care workers for at least 215 minutes per individual per day for the average individual, with at least 44 minutes of that time provided by a registered nurse. The Government subsequently accepted Recommendation 86, with an implementation date of 1 October 2024 for the 215 minutes of direct care requirement (previously legislated under the old Act and the *Quality of Care Principles 2014* made under that Act).

Recommendation 86 of the Final Report also recommended that the minimum staff time standard should be linked to the equivalent of what under the Act will be the base rate of person-

centred subsidy (section 229 of the Act), which links subsidy to residential care classification levels, so that providers with a higher-than-average proportion of high needs individuals be required to engage additional staff, and vice versa. The method to calculate the responsibility places relative weights (through varying direct care per individual per day ‘amounts’) on individuals’ classification levels under section 81 of the Act.

Subdivision A also continues to implement a decision of Government that, from 1 October 2024, up to a capped number of minutes of direct care delivered by direct care staff members who are enrolled nurses may be counted toward meeting a provider’s responsibility to deliver registered nurse care minutes in a quarter of a financial year at a home. This provides flexibility for providers to use their nurse workforce more efficiently, recognising the important role enrolled nurses play amid ongoing shortages of registered nurses in residential care.

Section 176-5 – Kinds of providers to which the obligation applies, and requirements

Section 176-5 provides that, for the purposes of section 176 of the Act, this section applies to a registered provider registered in the provider registration category residential care, and that this subdivision sets out the requirements for delivering direct care.

Section 176-10 – Application of this Subdivision

Section 176-10 provides that the requirements of this subdivision do not apply in respect to the delivery of funded aged care services provided under any of the following specialist aged care programs:

- TCP
- MPSP
- NATSIFACP

This is appropriate as the requirements in Subdivision A are limited to mainstream providers (that is, not providers of the specialist aged care programs TCP, MPSP and NATSIFACP). Separate direct care requirements that apply to NATSIFACP providers are provided for in Subdivision B, below.

Section 176-15 – Care minutes that must be provided

Section 176-15 provides for the responsibilities of a registered provider registered in the provider registration category residential care to deliver direct care in relation to a quarter of a financial year.

Subsection (1) provides that this section applies if the provider is delivering funded aged care services in an approved residential care home in a quarter.

For clarity, the responsibilities are to deliver at least an average amount of direct care (including an average amount of direct care to be delivered by registered nurses). The responsibilities are not that an approved provider must provide a particular individual at least an amount of direct care on any day, or during any quarter or other period.

Requirement—care minutes delivered by direct care staff members

Subsection (2) provides that the provider must ensure that the average number of care minutes delivered in the home by direct care staff members of the provider per counted mainstream individual per day is at least the required combined staff average number of care minutes per individual per day calculated under subsection 176-20(1) in respect of the approved residential care home for the quarter.

The note to this subsection clarifies that direct care staff members of the provider include registered nurse staff members of the provider, with reference to the definition of direct care staff member in section 7 of the Act. This is intended to make clear that registered nurses are counted as directed care staff members for the purposes of the care minutes responsibilities.

Requirement—care minutes delivered by registered nurse staff members

Subsection (3) provides that the provider must ensure that the average number of care minutes delivered in the home by registered nurse staff members of the provider per counted mainstream individual per day is at least 90% of the required registered nurse average number of care minutes per individual per day worked out under subsection 176-20(2) in respect of the home for the quarter.

Responsibility—care minutes delivered by registered nurse staff members and enrolled nurse staff members

Subsection (4) provides that the registered provider must ensure that the average number of care minutes delivered in the home by registered nurse staff members and enrolled nurse staff members of the provider per counted mainstream individual per day is at least the required registered nurse average number of care minutes per individual per day worked out under subsection 176-20(2) in respect of the home for the quarter.

Subsection 176-20(2) provides for the method to work out the required registered nurse average amount of direct care per individual per day in respect of the home for a quarter.

The combined effect of subsections 176-15(2), (3) and (4) is that up to 10% of the calculated required registered nurse average amount of direct care per mainstream individual per day for a home for a quarter can be provided by enrolled nurse staff members, to provide flexibility for providers to use all their nurse workforce more efficiently, recognising the important role enrolled nurses play amid ongoing shortages of registered nurses in residential care.

Counted individuals

Subsection (5) provides that an individual receiving funded aged care services in a home on a day is a counted mainstream individual on the day unless:

- the individual receives the funded aged care services through a specialist aged care program referred to in section 176-10; or
- the individual is on extended hospital leave, and the day is on or after the 29th day of the individual's leave.

Extended hospital leave is defined in subsection 244(6) of the Act.

The definition of a counted individual is relevant for the calculation of the average amount of direct care provided through the home by direct care staff members of the provider. It is appropriate for the definition to exclude individuals who are on the 29th day or after of a period of extended hospital leave, as it is unreasonable to expect the provider to continue to maintain staffing levels in respect of an individual who is absent from the home due to a prolonged hospital stay.

Section 176-20 – Average numbers of care minutes

Section 176-20 provides the method for calculating the required:

- combined staff average amount of direct care per individual per day; and
- registered nurse average amount of direct care per individual per day,

for a registered provider in the provider registration category residential care in relation to a quarter of a financial year in relation to a home for a quarter of a financial year.

Required combined staff average number of care minutes

Subsection 176-20(1) provides that the ***required combined staff average number of care minutes*** per individual per day for a quarter is worked out by:

- starting with the sum of the combined staff daily amounts for all of the days of recognised residential care provided in respect of individuals in the home during the reference period for the quarter; and (“reference period combined staff amount” – see representation below);

divided by

- the total number of days of recognised residential care provided in respect of individuals through the home during the reference period for the quarter; and (“reference period recognised residential days” – see representation below)
- rounding the result of that division to 2 decimal places (rounding up if the third decimal place is 5 or more).

To clarify the operation of this provision, this calculation can also be represented as:

$$= \frac{\text{reference period combined staff amount}}{\text{reference period recognised residential days}} \quad (\text{rounded to 2 decimal places})$$

Required registered nurse average number of care minutes

Subsection 176-20(2) provides that the ***required registered nurse average number of care minutes*** per care individual per day for a quarter is:

- the sum of the registered nurse daily amounts for all of the days of recognised residential care provided in respect of individuals through the home during the reference period for the quarter (“reference period registered nurse amount” – see representation below);

divided by

- the total number of days of recognised residential care provided in respect of individuals through the home during the reference period for the quarter (“reference period recognised residential days” – see representation below).

The resulting number is recorded to 2 decimal places (rounding up if the third decimal places is 5 or more).

This calculated amount can also be represented as:

$$= \frac{\text{reference period registered nurse amount}}{\text{reference period recognised residential days}} \quad (\text{rounded to 2 decimal places})$$

Daily amounts

Subsection 176-20(3) provides identification of the relevant daily amount by reference to following table:

Daily amounts			
	Column 1	Column 2	Column 3
Item	For an individual classified as ...	the combined staff daily amount is ... (minutes)	and the registered nurse daily amount is ... (minutes)
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 an individual are identified by reference to the classification level under section 81 of the Act of the individual on that day.

The individual combined staff daily amount and registered nurse daily amount for each individual provided with care in the reference period are added together to produce the reference period combined staff amount and the reference period registered nurse amount.

Day of recognised residential care

Subsection (4) provides that a ***day of recognised residential care*** is a day funded aged care services are delivered to the individual in the home through the residential care service category are provided to an individual who has a classification under section 81 of the Act in effect in the reference period.

Subsection (5) provides that despite subsection (4), a ***day of recognised residential care*** does not include a day where funded aged care services are delivered through TCP, MPSP or NATSIFACP, or where funded aged care services are provided to an individual classified as Class 0 or Respite Class 0.

The exclusions are appropriate as the responsibilities do not apply to funded aged care services delivered through TCP, MPSP or NATSIFACP, and as individuals with Class 0 or Respite Class 0 classification levels have not yet received a classification assessment and there is not information to assign appropriate daily amounts reflecting these individuals' care needs for the purposes of working out the required amounts of direct care and registered nurse direct care.

Reference period

Subsection (6) provides that the ***reference period*** for a quarter is the period of 3 months beginning on the day that is 4 months before the first day of the quarter.

This subsection provides for the calculation of the direct care responsibilities for a home for a quarter using data from the period shortly before that quarter. This is intended to provide certainty to providers about their responsibilities for the upcoming quarter before it commences, while still reasonably reflecting the care needs of the cohort of individuals who will be present at the home during the quarter. This will allow providers to plan appropriate staffing in advance.

Information to be disregarded for calculations

Subsection (7) provides that the following information is to be disregarded for calculations:

- information about an individual that enters or exits a home during the reference period for the quarter if it is given to the System Governor on or after the calculation day for the quarter, and
- a change to a classification decision for an individual that is made on or after the calculation day for the quarter but takes effect before the calculation day.

The effect of disregarding this information is to ensure that only information that was available to both the department and providers immediately before the calculation day will be used when calculating the required average amounts of direct care. Further, it ensures that the information

used to calculate the required average amounts of direct care is certain and static, regardless of when the calculations are performed.

Calculation if no days of recognised residential care provided during reference period

Subsection (8) provides that if no days of recognised residential care were provided in respect of individuals in an approved residential care home during the reference period for a quarter, the result of the calculations in subsections (1) and (2) in relation to the quarter is taken to be zero minutes per individual per day.

The note to this subsection clarifies that this rule has been provided to avoid an undefined result from being produced from the calculation of required average amounts of direct care from dividing a number by zero.

Subdivision B – Delivery of direct care –NATSIFACP providers

The purpose of this subdivision is to maintain direct care requirements that already apply to NATSIFACP providers that deliver residential care services.

Section 176-25 – Kinds of providers to which the obligation applies, and requirements

Section 176-25 provides that, for the purpose of section 176 of the Act, this section applies to NATSIFACP providers registered in the provider registration category residential care, and that this subdivision sets out the requirements for delivering direct care.

Section 176-30 – Application of this Subdivision

Section 176-30 provides that the requirements of this subdivision do not apply to the following specialist aged care programs:

- TCP; and
- MPSP.

Section 176-35 – Care minutes that must be delivered- NATSIFACP providers

Section 176-35 provides the care minutes that NATSIFACP providers delivering funded aged care services in an approved residential home must deliver to individuals.

Direct care staff of a NATSIFACP provider should deliver an average of at least 215 minutes of direct care per counted NATSIFACP individual per day. This should include:

- an average of at least 39.6 minutes of direct care delivered by registered nurses per counted NATSIFACP individual per day.
- an average of at least 44 minutes of direct care delivered by enrolled nurses and registered nurses per individual per day.

A counted NATSIFACP individual is anyone receiving funded aged services in an approved residential care home on a given day unless:

- the individual is on extended hospital leave
the day is on or after the 29th day of the individual's leave.

Extended hospital leave is defined in subsection 244(6) of the Act.

It is appropriate to exclude individuals who are on the 29th day or after of a period of extended hospital leave, as it is unreasonable to expect the provider to continue to maintain staffing levels in respect of an individual who is absent from the home due to a prolonged hospital stay.

Part 7 – Other obligations—cooperation with other persons

Part 7 prescribes requirements for the purposes of subsection 177(2) of the Act for the Pricing Authority, performing the function mentioned in paragraph 131A(1)(a) of the *National Health Reform Act 2011* (NHR Act) to provide advice to each relevant Commonwealth Minister in relation to aged care pricing or costing matters, to be able to:

- request data or records from a registered provider;
- request access to a responsible person or aged care worker of a registered provider; and
- request access to a residential care home of a registered provider.

Subsection 177(2) of the Act broadly provides that a registered provider must cooperate with and provide all reasonable facilities and assistance (including access to an approved residential care home) to the Pricing Authority in the performance of their activities for the purpose of performing the function set out in paragraph 131A(1)(a) of the NHR Act.

If a registered provider fails to comply with the requirements in 177(2) of the Act, they will be liable to a civil penalty. That civil penalty is 30 penalty units.

Section 177-10 – Giving data or records to the Pricing Authority

Section 177-10 provides for the Pricing Authority to be able to request data or records from a registered provider for the purposes of performing a ***Pricing Authority advice activity***.

Pricing Authority advice activity is defined in section 5-5 definitions as an activity mentioned in paragraph 131A(1)(c) of the NHR Act for the purpose of performing a function mentioned in paragraph 131A(1)(a) of that Act.

The Pricing Authority function in paragraph 131A(1)(a) of the NHR Act is to provide advice to each relevant Commonwealth Minister in relation to one or more aged care pricing or costing matters, including in relation to methods for calculating funding of aged care services such as commonwealth contributions paid under the Act.

The Pricing Authority activity in paragraph 131A(1)(c) of the NHR Act is to:

- to conduct, or arrange for the conduct of, one or more of the following activities for the purpose of performing a function mentioned in paragraph 131A(a) or (b) of the NHR Act:
 - the collection and review of data;
 - costing and other studies;
 - consultations.

Application of this section

Subsection (1) provides that this section applies to every kind of registered provider, subject to subsection (2).

Subsection (2) provides that the requirements outlined in this section do not apply to a registered provider in respect of the delivery of funded aged care services under the specialist aged care programs CHSP and TCP. This means it will apply to the specialist aged care programs MPSP and NATSIFACP.

The government currently provides block grant and subsidy funding to MPSP and NATSIFACP. As part of broader funding and regulatory reforms to the aged care sector, government has requested that the Pricing Authority undertake an assessment of the funding models for these 2 programs over the coming years. The Pricing Authority's analysis will evaluate the most effective future funding arrangements for the services of these programs designed to operate in thin markets. Informed by the Pricing Authority's analysis and advice, government will make a policy decision as to the future funding arrangements for the MPSP and the NATSIFACP.

Requirement to comply with notice

Subsection (3) provides that, for the purposes of subsection 177(2) of the Act it is a requirement that a registered provider must comply with a request made under subsection (4) or (6).

Notice to provide data or records

Subsection (4) provides that the Pricing Authority may request, by written notice given to a registered provider, that the registered provider:

- give the Pricing Authority data or records held by the registered provider, or copies of the data or records, that are necessary for the conduct of a Pricing Authority advice activity mentioned in paragraph 131A(1)(c) of the NHR Act (the collection and review of data; costing and other studies; or consultations); and
- give the data or records in a form and manner specified in the notice; and
- give the data or records before or on the day specified in the notice (the day specified in the notice must be at least 14 days after the day on which the notice is given to the provider, as per subsection (5) below).

This subsection ensures that registered providers have sufficient notice to collate and provide the relevant data or records in the specified form and manner. Providing for the Pricing Authority to specify certain requirements or standards and the manner in which data and records must be provided will ensure, as much as possible, that the provided material is complete and received from providers in a consistent format. This will facilitate the effective and efficient performance of the Pricing Authority's functions

Subsection (5) provides that a written notice given by the Pricing Authority under subsection (4) must:

- set out that the request is for the purposes of the Pricing Authority performing the function mentioned in paragraph 131A(1)(a) of the NHR Act (to provide advice to each relevant Commonwealth Minister in relation to aged care pricing or costing matters); and
- specify the details of the data or records that the registered provider is requested to give; and

- specify a day by which the registered provider must give the data or records, which must be at least 14 days after the day on which the notice is given to the registered provider; and
- set out the effect of subsection 177(4) of the Act, which provides for a civil penalty against a registered provider that fails to comply with subsection 177(2) of the Act, including the requirements outlined in this section.

Request for further data or records

Subsection (6) provides that, if a registered provider responds to a request to provide data or records made under subsection (4) and the Pricing Authority considers that additional data or records are required before the Pricing Authority can comprehensively carry out the function mentioned in paragraph 131A(1)(a) of the NHR Act (to provide advice to each relevant Commonwealth Minister in relation to aged care pricing or costing matters), the Pricing Authority may request, by written notice given to the registered provider, that the registered provider give the Pricing Authority that additional data or records, or copies of that additional data or records.

The intent of subsection (6) is to ensure that, where the data or records given by a registered provider in responding to a request made under subsection (4) are not considered sufficient (for any reason) by the Pricing Authority for the carrying out of the Pricing Authority's functions, the Pricing Authority may make a further request for data or records in relation to the original request made under subsection (4). For example, data or records received that comply with the original request may indicate that additional, supplementary or updated data or records are required. Further, there may be a need to make an additional subsequent request for data or records not previously contemplated.

Section 177-15 – Allowing access by the Pricing Authority to certain persons

Section 177-15 provides for the Pricing Authority to be able to request access to a responsible person or aged care worker of a registered provider where necessary for conduct of a Pricing Authority advice activity.

Application of this section

Subsection (1) provides that this section applies to every kind of registered provider, subject to subsection (2).

Subsection (2) provides that the requirements outlined in this section do not apply to a registered provider in respect of the delivery of funded aged care services under the specialist aged care programs CHSP and TCP. This means it will apply to the specialist aged care programs MPSP and NATISFACP. However, such a registered provider is required to comply with a request from the Pricing Authority in respect of access to a responsible people or aged care worker in respect of those services (if any) that they deliver other than under a specialist aged care program.

Requirement to comply with notice

Subsection (3) provides that, for the purpose of subsection 177(2), it is a requirement that a registered provider must comply with a request made under subsection (4).

Notice to allow access to certain persons

Subsection (4) provides that the Pricing Authority may request, by written notice given to a registered provider, that the registered provider:

- allow and facilitate access by an official of the Pricing Authority to a person referred to in subsection (6) for the purposes of undertaking a Pricing Authority advice activity; and
- make arrangements before or on a day specified in the notice to allow and facilitate the access within a reasonable timeframe (the day specified in the notice must be at least 14 days after the day on which the notice is given to the registered provider, as per subsection (5) below).

Subsection (5) provides that a written notice given by the Pricing Authority under subsection (4) must:

- specify the form of the access, which may be in person, by audio link or by audio-visual link; and
- specify a day by which the registered provider must make arrangements for the access, which must be at least 14 days after the day on which the notice is given to the registered provider; and
- set out the effect of subsection 177(4) of the Act, which provides for a civil penalty against a registered provider that fails to comply with subsection 177(2) of the Act, including the requirements outlined in this section.

Subsections (4) and (5) will ensure that registered providers have sufficient notice to facilitate the required access to the specified person.

Subsection (6) provides that, for the purposes of paragraph (4)(a), the persons to whom the Pricing Authority may request access are the following:

- a specified responsible person of the registered provider;
- any responsible person of the registered provider who is responsible for a specified matter for the registered provider;
- a specified aged care worker of the registered provider;
- any aged care worker of the registered provider who is responsible for a specified matter for the registered provider.

The difference between a “specified person” and “any person” of either the responsible person or aged care worker is intended to capture both particular individuals and those occupying particular positions and functions.

For example, access may be required to the CEO of the registered provider or the Head of Nursing Services at the approved residential aged care home. However, in other circumstances access may be required to a specific individual, for example a particular aged care worker who was working on a particular day.

Section 177-20 Allowing access by the Pricing Authority to residential care homes

Section 177-20 provides for the Pricing Authority to be able to request access to a residential care home of a registered provider for the purposes of a Pricing Authority advice activity (as defined). This will ensure that the Pricing Authority can, for example, conduct a costing study onsite at an approved residential aged care home by monitoring and recording data on

care time spent between aged care staff and individuals receiving funded aged care services. This will enable the Pricing Authority to prepare and provide advice regarding aged care pricing and costing in accordance with paragraph 131A(1)(a) of the NHR Act.

Application of this section

Subsection (1) provides that this section applies to every kind of registered provider, subject to subsection (2).

Subsection (2) provides that the requirements outlined in this section do not apply to a registered provider in respect of the delivery of funded aged care services under the specialist aged care programs CHSP and TCP. This means it will apply to the specialist aged care programs MPSP and NATISFACP. However, such a registered provider is required to comply with a request from the Pricing Authority in respect of access to an approved residential aged care home in respect of those services (if any) that they deliver other than under a specialist aged care program.

Requirement to comply with notice

Subsection (3) provides that, for the purposes of subsection 177(2), it is a requirement that a registered provider must comply with a request made under subsection (4).

Notice to allow access to residential care homes

Subsection (4) provides that the Pricing Authority may request, by written notice given to a registered provider, that the registered provider:

- allow and facilitate access by an official of the Pricing Authority to a residential care home of the provider for the purposes of undertaking a Pricing Authority advice activity; and
- do so on a day specified in the notice.

Subsection (5) provides that a written notice given by the Pricing authority under subsection (4) must:

- specify a day on which the access must be facilitated, which must be at least 14 days after the day on which the notice is given to the registered provider; and
- set out the effect of subsection 177(4) of the Act, which provides for a civil penalty against a registered provider that fails to comply with subsection 177(2) of the Act, including the requirements outlined in this section.

Subsections (4) and (5) will ensure that registered providers have sufficient notice that the Pricing Authority intends to access their approved residential care home. It also ensures that the registered provider is aware of liability to civil penalty if they fail to facilitate the requested access.

Subsection (6) provides that, for the purposes of subsection 177(2) of the Act, it is a requirement that reasonable facilities and assistance provided by the registered provider to whom a notice has been given under subsection (4) must include, but is not limited to:

- providing a site orientation to the official of the Pricing Authority undertaking the Pricing Authority advice activity to which the notice relates, including guidance on how to safely navigate the residential care home; and

- providing information in relation to the Pricing Authority advice activity to aged care workers of the registered provider, individuals to whom the registered provider delivers funded aged care services and supporters of the individuals to whom the registered provider delivers funded aged care services; and
- providing the Pricing Authority official with access to aged care workers of the registered provider who are at the residential care home; and
- providing the Pricing Authority official with access to individuals to whom the registered provider delivers funded aged care services who have consented to the access; and
- providing the Pricing Authority official with access to all areas of the residential care home, excluding rooms and part rooms of individuals who have not consented to the access and private bathroom facilities; and
- providing the Pricing Authority official with facilities (including a suitable workspace, common bathroom facilities, administrative equipment, etc) for the purpose of undertaking the Pricing Authority advice activity; and
- providing the Pricing Authority official with access to records held by the registered provider; and
- providing the Pricing Authority official with instructions about how to access records held by the registered provider; and
- allowing the Pricing Authority official to make copies of those records.

It is important to note that only individuals who have provided consent to access by the Pricing Authority are those to whom the registered provider must facilitate access.

Registered providers are not required to provide access to an individual who has not given consent, or who has withdrawn consent. Individuals and their guardians can withdraw their consent at any time prior to, or during, the Pricing Authority advice activities at the approved residential aged care home.

Consent by an individual for the Pricing Authority to have access must be given by either the individual themselves (including where communicated by their supporter) or their guardian (where the individual lacks capacity to give consent).

Chapter 6—Obligations of operators of aged care digital platforms

The obligations imposed on operators of aged care digital platforms under this Chapter are intended to ensure that digital technologies used in the aged care system operate in a safe, transparent and accountable manner. As digital platforms increasingly facilitate connection between registered providers or individuals and aged care workers, it is critical that operators meet appropriate standards to manage complaints and reportable incidents as well as reporting these issues to the Commissioner. These obligations provide clarity about the requirements of aged care digital platform operators, strengthen safeguards for older people engaging with digital services, and promote confidence in the use of digital tools across the aged care sector.

Part 1—Introduction

Section 187-1 – Simplified outline of this Chapter

Section 187-1 provides a simplified outline of this chapter. It states that this chapter requires operators of aged care digital platforms to check and display certain information about entities that represent via the platforms that they can deliver a service in the Commonwealth aged care system.

It also states that this Chapter imposes additional obligations on constitutional corporations that are operators of aged care digital platforms in relation to:

- Notifying the Commission about the operation of the aged care digital platforms; and
- The management of complaints and reportable incidents; and
- Reporting and record-keeping.

Part 2—Obligations

Section 188-1 – Duty of operators of aged care digital platforms

Section 188-1 provides that for the purposes of subparagraph 188(1)(b)(vi) of the Act, the information that the operator of an aged care digital platform must check and display in relation to an entity that represents via the platform that the entity can deliver a service in the Commonwealth aged care system is the following:

- for an entity that is an aged care worker of a registered provider, the operator of an aged care digital platform must check and display that the entity complies with any applicable worker screening requirements prescribed by rules made under paragraph 152(1)(b) of the Act that apply to the entity, and
- for an entity that seeks to deliver services in the Commonwealth aged care system, the operator of an aged care digital platform must check and display that the entity holds any credentials or qualifications that are stated on the platform in relation to the entity. This paragraph complements the above paragraph by extending the operator's duty to verify the evidence of claimed credentials and qualifications. These include micro-credentials and certified skill-sets enhancing entity capability. Platform users will be able to rely on claims made and will also be advised of the operator's verification processes.

This section further requires that operator of an aged care digital platform must display general information about the processes undertaken by the operator to check an entity's credentials or qualifications.

Aged care digital platforms are often used as tools for registered providers or individuals receiving funded aged care services to source an aged care worker. As registered providers must, under section 152 of the Act, comply with worker screening requirements, this requirement facilitates the engagement of workers via the platform by preventing inaccurate or unverified claims of screening from being displayed.

Improved worker screening requirements combined with operator verification of relevant evidence will provide robust assurance for all platform users. Prior checks undertaken by registered providers may form evidence considered by operators for the purposes of

verification. If a digital platform operator is unable to check that an individual meets the requirements, they may not display information on screening.

This requirement does not replace the obligation on registered providers to check that those they are engaging meet worker screening requirements. A registered provider must still be satisfied that they are meeting their regulatory requirements.

Note that an aged care worker will include an independent contractor who, in certain situations, may also be a registered provider (as outlined in subsection 11(4) of the Act).

Section 189-1 – Notifying Commissioner of operation of aged care digital platforms

Section 189-1 provides for notifying the Commissioner of the operation of aged care digital platforms.

Period within which notice must be given

Subsection (1) provides that for the purposes of paragraph 189(1)(a) of the Act, a notice given by an entity that is both a constitutional corporation and the operator of an aged care digital platform must be given:

- not later than 14 days after the first day on which the platform displays a representation by another entity that the other entity can deliver a service in the Commonwealth aged care system; or
- if the entity becomes the operator of the platform after the end of the 14-day period referred to above, not later than 14 days after the entity becomes the operator of the platform.

The note below paragraph 189-1(1)(b) outlines that this paragraph is to ensure that the provision covers a situation in which the operator of a platform changes.

Content of notice

Subsection (2) provides that the notice must include the following information:

- the name of the aged care digital platform;
- details of the operator, including a key contact person;
- if the operator has an ABN—the ABN;
- the date on which the operator started to operate the aged care digital platform;
- details of the service types that the operator intends to facilitate;
- details of relationships between the operator and registered providers in their corporate structures.

The requirement to notify the Aged Care Quality and Safety Commission of the details of the service types that the operator intends to deliver allows the Commissioner to understand the range of care services impacted by digital platform intermediaries. This assists in forming a

view as to what services, and for what types of individuals or cohorts, the digital platform setting may create risks to safe and quality care.

The requirement to notify the Aged Care and Quality Safety Commission of details of relationships between the operator and registered providers in their corporate structures provides transparency and allows the Commissioner to monitor for conflicts of interest. This ensures that there is no question of the responsibility of a registered provider through the use of a digital platform in their corporate structure, especially in relation to requirements that support the delivery of safe and quality funded aged care.

Section 189-5 – Managing complaints

Section 189-5 provides requirements for managing complaints.

Purpose for which requirements are prescribed

Subsection (1) provides that for the purposes of paragraph 189(1)(b) of the Act, this section prescribes the requirements for managing complaints under a complaints management system implemented by an entity that is both a constitutional corporation and the operator of an aged care digital platform, being complaints about entities that represent that they can deliver, or have delivered, funded aged care services via the platform.

The note under subsection (1) outlines that, under subsection 189(3) of the Act, the requirements prescribed by this section may only be for the purpose of ensuring that systems implemented by operators support compliance by registered providers with certain obligations. Accordingly, when the words managing or management of complaints about registered providers is used in relation to platform operators, it means taking only those steps detailed below to receive and then refer complaints received to the relevant registered provider, so the provider can, in turn, fulfil their requirements in relation to complaint-handling.

Note also that paragraph 189(1)(d) of the Act requires that the aged care digital platform display a summary and explanation of the complaints management system.

General requirements relating to management of receipt etc. of complaints

Subsection (2) provides that in managing complaints, the operator of the digital platform must:

- ensure that each complaint received is recorded, and referred to the registered provider, in accordance with procedures that give effect to the requirements of subsections (3) and (4) below; and
- collect data relating to complaints for the purposes of meeting any applicable reporting requirements; and
- protect the security and confidentiality of information relating to each complaint received; and
- ensure that complaints can be made by any person and can be made anonymously and can be withdrawn; and

- not impose a fee or charge (however described) for receiving a complaint or for dealing with a complaint.

Specific requirements relating to management of receipt and referral of complaints

Subsection (3) provides that in managing complaints, the operator of the aged care digital platform must:

- acknowledge each complaint in writing within 3 days of receipt; and
- refer each complaint in writing to the registered provider to which the complaint relates no more than 7 days after receipt, if referral is appropriate; and
- ensure that information about the nature of each complaint, and contact details of the person making the complaint (if practicable), is provided to the registered provider to which the complaint relates, to the extent that the information is reasonably necessary to address the complaint; and
- if a complaint that has been referred to a registered provider is withdrawn after the referral—notify the registered provider of the withdrawal no more than 2 days after the complaint is withdrawn.

Other requirements relating to management of complaints

Subsection (4) provides that in managing complaints, the operator of an aged care digital platform must ensure:

- that the operator does not refer a complaint, or give information about a complaint, to a registered provider without the informed consent of the person making the complaint (or their authorised supporter or advocate); and
- that the operator provides support and assistance to a person making a complaint (or making an enquiry that may form a complaint), for example, by facilitating access to translation services; and
- that the operator provides information that complaints may be made directly to the registered provider to which the complaint relates; and
- that the operator undertakes reviews as required, and at least annually, to ensure the complaints management system meets the requirements of this section.

An example of operator support to a person (or their representatives) lodging a complaint via a digital platform would be the provision of information about independent aged care advocacy services.

Section 189-10 – Managing reportable incidents

Section 189-10 provides for the management of reportable incidents.

Purpose for which requirements are prescribed

Subsection (1) provides that for the purposes of paragraph 189(1)(c) of the Act, requirements for an incident management system implemented by an entity that is both a constitutional corporation and the operator of an aged care digital platform. The section applies to reportable incidents received by the platform operator involving entities that represent that they can deliver funded aged care services via the platform.

Reportable incidents are the most serious issues arising for an (applicable) operator to facilitate a response to, and in turn, for a registered provider to report on to the Aged Care Quality and Safety Commission under section 165A of the Act. These rules provide clarity in this process.

The note under subsection (1) outlines that, under subsection 189(3) of the Act, the requirements prescribed by this section may only be for the purpose of ensuring that systems implemented by operators support compliance by registered providers with certain obligations. Accordingly, where the words ‘managing’, or ‘management of’, reportable incidents are used in relation to platform operators, it means taking only those steps detailed below to receive and then refer complaints received to the relevant registered provider, so the provider can fulfil their obligations in relation to reportable incident reporting.

An operator receiving information about incidents involving entities that represent that they can deliver funded aged care services via the platform, that do not fall within the reportable incident definition in section 16 of the Act, should draw upon their internal, standard operating procedures to facilitate referral to, and handling by, registered providers.

Paragraph 189(1)(d) of the Act requires that the aged care digital platform must display a summary and explanation of the reportable incidents management system.

General requirements relating to management of reportable incidents

Subsection (2) provides that in managing reportable incidents, the operator of the aged care digital platform must:

- ensure that if a reportable incident is reported, it is recorded, and referral to the registered provider to which the reportable incident relates is facilitated, in accordance with procedures that give effect to the requirements of subsections (3) and (4) below; and
- collect data relating to each reportable incident that is reported, for the purposes of meeting reporting requirements; and
- protect the security and confidentiality of information relating to reportable incidents; and
- ensure that any person may report a reportable incident; and
- not impose a fee or charge (however described) for reporting of reportable incidents or supporting registered providers in responding to such incidents.

Specific requirements relating to management of reportable incidents

Subsection (3) provides that in managing reportable incidents, the operator of an aged care digital platform must:

- acknowledge each report of a reportable incident in writing; and
- refer a report of a reportable incident in writing to the registered provider to which the incident relates no more than 24 hours after receipt of the report; and
- ensure that each referral of a reportable incident covers the following (if known) in order to support the registered provider in meeting their obligations in relation to the reporting of reportable incidents:
 - the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected by the reportable incident;
 - to the extent known—the consequences of that harm;
 - the time and date when the reportable incident was identified;
 - the name and contact details of the person recording the details of the reportable incident;
 - whether or not the reportable incident was reported to the police;
 - to the extent known—the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;
 - to the extent known—the names and contact details of the persons directly involved in the reportable incident;
 - to the extent known—the names and contact details of any witnesses to the reportable incident.

Other requirements relating to management of reportable incidents

Subsection (4) provides for other requirements relating to management of reportable incidents. In managing reportable incidents, the operator must ensure:

- that the operator provides support and assistance to a person wishing to report a reportable incident (or making an enquiry that may relate to reporting such an incident), for example, by facilitating access to translation services; and
- that the operator provides advice to entities that represent that they can deliver funded aged care services via the platform on how to report a reportable incident; and
- that the operator provides information that reportable incidents may be reported directly to the registered provider to which the incident relates; and
- that the operator undertakes reviews as required, and at least annually, to ensure the incident management system meets the requirements of this section; and

- that the operator has regard to the requirements of registered providers in relation to reporting reportable incidents, and gives them information in a manner that facilitates compliance with those obligations; and
- that the operator provides training to staff in identifying and taking responsibility for referring reportable incidents including, but not limited to, referring them to registered providers or emergency services if required.

An example of operator support to a person making an enquiry about reporting an incident via a digital platform would be the provision of information about independent aged care advocacy services.

A requirement for reporter consent in relation to reportable incidents facilitated by digital platforms is excluded from these operator rules. Section 165A of the Act and rules authorised by that provision establish a mandatory requirement on registered providers to report to the Aged Care Quality and Safety Commissioner where they receive information falling within the definition of reportable incidents. Once such reports are received by a registered provider, they must report them to the Commissioner irrespective of the reporter's consent. The exclusion of reporter consent in that case is justified given the serious risk to older people in not reporting.

In accordance with subsection 189(3) of the Act, an (applicable) digital platform operator is required to support the registered provider in complying with their requirement in respect of reportable incidents. The mandatory terms of the registered provider's requirement, then, necessarily inform interpretation of the supporting party's obligations (i.e. those of a digital platform operator), and so justifies the exclusion of consent in the digital platform rules. Accordingly, the exclusion of reporter consent here better protects older people and supports fulfillment of requirements for reporting reportable incidents to the Commissioner

The note at the end of the section provides that *reportable incident* is defined in section 16 of the Act.

Section 189-15 – Reporting requirements

Section 189-15 provides for reporting requirements for operators of aged care digital platforms.

Subsection (1) provides that for the purposes of paragraph 189(1)(e) of the Act, this section sets out the prescribed requirements in relation to a notice to be given to the Commissioner by an entity that is both a constitutional corporation and the operator of an aged care digital platform.

Subsection (2) provides that the operator must report the following information for each quarter:

- the number and type of complaints received, referred, or otherwise handled during that quarter about registered providers and aged care workers of registered providers;
- the number and type of reportable incidents reported, referred to another person or body, or otherwise handled, during that quarter about registered providers and aged care workers of registered providers;

- the number and details of entities that represented via the platform that the entity could deliver funded aged care services, or individuals to whom funded aged care services were delivered via the platform, that were removed from the platform by the operator during that quarter, and the reasons why they were removed;
 - entities that represent via a platform that the entity could deliver funded aged care services;
 - individuals to whom funded aged care services were delivered via the platform;
- the aggregate number of aged care workers of registered providers, registered providers and other entities seeking to deliver funded aged care services via the platform that were on the platform during that quarter;
- if available, the aggregate number of individuals to whom funded aged care services were delivered via the platform during that quarter.

Subsection (3) provides that for the purposes of paragraphs (2)(a) and (b), the report must deal separately with each registered provider and each aged care worker of a registered provider, about whom a complaint or a report of a reportable incident was received, referred or otherwise handled during the quarter concerned.

Subsection (4) provides that for the purposes of paragraph (2)(c), the report must deal separately with each entity, and each individual, removed from the platform by the operator during the quarter concerned.

Section 189-18 – Reporting changes to the Commissioner

Section 189-18 provides that for the purposes of paragraph 189(1)(e) of the Act, if:

- an entity that is both a constitutional corporation and the operator of an aged care digital platform has given a notice to the Commissioner under paragraph 189(1)(a) of the Act in accordance with subsection 189-1(1) of this instrument; and
- there is a change in the information included in the notice;

the entity must report the change to the Commissioner not later than 14 days after the change.

Notification of these changes supports the Aged Care Quality and Safety Commission's ongoing monitoring of operators' activities in the aged care setting. This includes the types of services they are facilitating, and any risks to provision of safe and quality care arising from conduct on the platform and/or relationships between operators and registered providers in their corporate structures.

Section 189-20 – Keeping and retaining records, etc.

Section 189-20 provides for the keeping and retaining of records.

Subsection (1) provides that for the purposes of paragraph 189(1)(g) of the Act, requirements in relation to the records to be kept and retained by an entity that is both a constitutional corporation and the operator of an aged care digital platform.

Subsection (2) provides that the operator must keep and retain the following records for each complaint made and each report of a reportable incident received:

- the complaint made, or the report of the reportable incident, and any information relating to the complaint or report, as the case requires;
- how the complaint or report was managed through the operator's systems;
- details of when the complaint or report was referred to the relevant registered provider;
- the date of acknowledgement of receipt by the relevant registered provider.

Subsection (3) provides that the operator must keep and retain records of the following entities that represent via the platform that they can deliver a funded aged care service:

- aged care workers of registered providers;
- registered providers and their associated providers.

Subsection (4) provides that the operator must keep and retain records of:

- the funded aged care services delivered to an individual; and
- the aged care workers and the registered providers responsible for the delivery of those services.

This requirement applies to the extent information appears on the platform and is accessible by the operator.

Subsection (5) provides that the operator must keep and retain records of the following that the operator removed from the platform, and the reasons why:

- the names and numbers of aged care workers of registered providers;
- registered providers and associated providers of registered providers;
- individuals to whom funded aged care services were delivered via the platform.

Gathering this information on platform removals identifies parties and numbers that may present a risk to the delivery of aged care services. Having regard to subsection 189-15(3) above, records must deal separately with each entity, and each individual, removed from the platform by the operator during the quarter concerned.

Subsection (6) provides that the operator must keep and retain records of the details of requests for corrections to information held on the platform, and the operator's responses to those requests. In all cases where precise requests for corrections are made and the operator

decides to correct or not correct the information, a record ought to be made and kept of the decision-making.

Subsection (7) provides that the operator must ensure that procedures are in place requiring that all records that must be kept and retained by the operator are retained for at least 7 years.

Section 189-25 – Disclosing information included in records, etc.

Section 189-25 provides for the disclosure of information included in records.

Subsection (1) provides that for the purposes of paragraph 189(1)(g) of the Act, the information that is to be disclosed by an entity that is both a constitutional corporation and the operator of an aged care digital platform is prescribed in this section.

Subsection (2) provides that, if the operator has records about an individual to whom funded aged care services are being or have been delivered, the operator must provide that information on request in a timely manner:

- to the individual; and
- with the individual's informed consent—to their supporters or advocates, or to a registered provider.

This authorised access to information enables supporters to exercise the functions for which they have registered, and for advocates to support an individual in their aged care-related decision-making and actions. For a registered provider it enables timely access to information that may be relevant to the delivery of care; for example, clarification of an individual's past preferences expressed on a platform document that may be relevant to delivery of subsequent care by the provider.

Section 189-30 – Correcting records, etc.

Section 189-30 provides for the correcting of records.

Subsection (1) provides that for the purposes of paragraph 189(1)(g) of the Act, this section applies to records that are kept and retained, as prescribed by section 189-20 of the Rules, by an entity that is both a constitutional corporation and the operator of an aged care platform.

Subsection (2) provides that another entity may request, in writing or orally, that the operator make a correction to information relating to the other entity that is included in the operator's records.

Subsection (3) provides that, if the operator is satisfied that information included in its records is inaccurate, incomplete, out of date, irrelevant or misleading, the operator must take reasonable steps to correct the information.

An operator may receive requests for correction to information held on the platform that it is unable to action; for example, certain branding, advertising content or service descriptions by registered providers beyond the operator's requirements under section 189 of the Act.

Chapter 7 – Funding of aged care services – Commonwealth contributions

Part 1 – Introduction

Section 190-5 – Simplified outline of this chapter

This provision provides a simplified outline of Chapter 7 of the rules. It clarifies that this chapter provides for matters relating to Commonwealth contributions for funded aged care services under Part 2 of Chapter 4 of the Act, and that:

- Division 1 of Part 2 relates to person-centred subsidy for subsidy for home support;
- Division 2 of Part 2 relates to provider-based subsidy for subsidy for home support;
- Part 3 relates to subsidy for assistive technology;
- Part 4 relates to subsidy for home modifications;
- Part 5 relates to the fee reduction supplement for the service groups home support, assistive technology and home modifications;
- Part 6 relates to unspent Commonwealth portions and home care accounts;
- Division 1 of Part 7 relates to person-centred subsidy for subsidy for residential care;
- Division 2 of Part 7 relates to provider-based subsidy for subsidy for residential care;
- Part 8 relates to the compensation payment reduction for the service groups home support, assistive technology, home modifications and residential care;
- Part 9 relates to subsidy for certain specialist aged care programs;
- Part 10 relates to subsidy claims for payments; and
- Part 11 sets out the Grantee Code of Conduct

Section 582(1) of the Act provides that the System Governor may, in writing, arrange for the use, under the System Governor's oversight, of computer programs to take administrative action that must be taken by the System Governor under this Act. This includes administrative actions under Parts 2 to 5 of Chapter 4 of the Act as provided for by subparagraph 582(2A)(e) of the Act. The rules in Chapter 7 are made for the purposes of sections 190 to 268 in Part 2 of the Act and include administrative actions that may be automated.

Part 2 – Subsidy for home support

Division 1 – Person centred subsidy

Subdivision AA – Eligibility

Section 191-5 – Ineligible funded aged care services

This provision supports Part 2, Division 1, Subdivision A of the Act. Subsection 191(2) of the Act provides requirements that must be met for a registered provider to be eligible for person-centred subsidy for home support under section 191 of the Act. Paragraph 191(2)(f) of the Act provides the requirement that the funded aged care service is not prescribed by the rules.

Section 191-5 prescribes the funded aged care service home support care management for the purposes of paragraph 191(2)(f) of the Act *for an individual who*;

- has an access approval in effect for the classification type ongoing for the service group home support; or

- has the classification level SAH restorative care pathway in effect for the classification type short-term for the service group home support.

This means that a registered provider is not eligible to claim person-centred subsidy for *those classification types*.

Subdivision A – Available ongoing home support account balance

Section 193-5 – Quarterly rollover credit

This section provides that, for the purposes of subsection 193(4) of the Act, the rollover amount for the ongoing home support account balance is either the higher of:

- a capped amount of \$1,000, or
- 10% of the base individual amount plus any supplements multiplied by the number of days in the quarter.

Section 193-15 – Circumstances for no credits

This section, for the purposes of subsection 193(9) of the Act, outlines specific circumstances in which a credit to an individual's notional ongoing home support account is not to be made, even though it would otherwise be required under subsection 193(3), (4), (5) or (6) of the Act.

These circumstances are outlined below:

- after the end of a quarter in which an ongoing funded aged care service was delivered to the individual through the service group home support, at least 4 consecutive quarters have passed in which an ongoing funded aged care service was not delivered to the individual through the service group home support;
- after a registered provider provided the System Governor and the Commissioner with a cessation notification in relation to the individual:
 - at least 4 consecutive quarters have passed; and
 - a registered provider has not provided a start notification to the System Governor and the Commissioner in relation to the individual about starting the delivery of funded aged care services to the individual for the classification type ongoing through the service group residential care;
- after the start day included in a start notification given by a registered provider to the System Governor and the Commissioner about starting the delivery of funded aged care services to the individual for the classification type ongoing through the service group residential care;
- the individual has died.

Support at Home participants receiving ongoing services will have the flexibility to stop receiving Support at Home services for various reasons. Paragraph (a) provides that no credits will be made to the notional ongoing home support account after four consecutive quarters have passed from the quarter when the last service was delivered. During the four consecutive quarters, the notional ongoing home support account will continue to be credited.

Other circumstances where no further credits will be made are expressed in paragraph (b). No credits are made where after the provider has provided a cessation notification to the System

Governor and the Commission in relation to the individual, more than at least four consecutive quarters have passed since the quarter where an individual ceased receiving services from a Support at Home provider, and the individual did not commence ongoing services in residential care.

Paragraph (c) provides no credits are made where the Support at Home participant started receiving ongoing services in residential care, and paragraph (d) provides no credits are made where the individual has died.

The intent of the section is to prevent the accumulation of unused funds where services have not been delivered for an extended period, where a cessation notification has been given without a subsequent start notification, where ongoing residential care has commenced or where the individual has died.

Section 193-20 – Circumstances for ceasing of account

This provision provides that, for the purposes of subsection 193(10) of the Act, an individual's notional ongoing home support account ceases where:

- more than 60 days have passed since the individual died;
- and any longer period determined by the System Governor under paragraph 251(3)(b) of the Act for a claim for person-centred subsidy that is payable to a registered provider under section 251 of the Act for the delivery of a funded aged care service to the individual has ended.

Subdivision B – Base individual amounts

Section 194-5 – Classification type ongoing

This provision supports Part 2, Division 1, Subdivision A of the Act and provides, for the purposes of section 194 of the Act, for the base amounts for individuals for the classification type ongoing for the service group home support.

Non-transitional classification levels

Subsection (2) provides a table which sets out the base individual amounts for individuals who have classification levels that are not transitional classification levels. These amounts are subsection to subsection (2A).

Item 1 of the table provides that the base individual amount for an individual that has the classification level SAH level 1 is \$26.46.

Item 2 of the table provides that the base individual amount for an individual that has the classification level SAH level 2 is \$39.54.

Item 3 of the table provides that the base individual amount for an individual that has the classification level SAH level 3 is \$54.16.

Item 4 of the table provides that the base individual amount for an individual that has the classification level SAH level 4 is \$73.22.

Item 5 of the table provides that the base individual amount for an individual that has the classification level SAH level 5 is \$97.88.

Item 6 of the table provides that the base individual amount for an individual that has the classification level SAH level 6 is \$118.64.

Item 7 of the table provides that the base individual amount for an individual that has the classification level SAH level 7 is \$143.38.

Item 8 of the table provides that the base individual amount for an individual that has the classification level SAH level 8 is \$192.59.

Subsection (2A) provides that if an interim place is in effect for an individual for the classification type ongoing for the service group home support under section 92A of the Act, the base individual amount for the individual is the amount equal to 60% of the amount that applies to the individual under subsection (2).

Transitional classification levels

Subsection (3) provides a table which sets out the base individual amounts for individuals who have transitional classification levels.

Item 1 of the table provides that for an individual that has the classification level HCP class 1 the amount is \$27.09.

Item 2 of the table provides that for an individual that has the classification level HCP class 2 the amount is \$47.64.

Item 3 of the table provides that for an individual that has the classification level HCP class 3 the amount is \$103.70

Item 4 of the table provides that for an individual that has the classification level HCP class 4 the amount is \$157.21.

Section 194-10 – Classification type short-term

This provision supports Part 2, Division 1, Subdivision C of the Act and sets out, for the purposes of section 194 of the Act, the base individual amounts for individuals for the classification type short-term for the service group home support.

Non-transitional classification levels

Subsection (2) provides a table which sets out the base individual amounts for individuals who have classification levels that are not transitional classification levels.

Item 1 provides that for an individual that has the classification level SAH restorative care pathway the base individual amount is \$53.67.

Item 2 provides that for an individual that has the classification level SAH end-of-life pathway the base individual amount is \$298.04.

Transitional classification levels

Subsection (3) provides a table which sets out the base individual amounts for individuals who have transitional classification levels.

Item 1 provides that for an individual that has the classification level STRC class the base individual amount is \$260.97.

Subdivision C—Available short term home support account balance

Section 195-1 – Number of days for initial credit

This provision supports Part 2, Division 1, Subdivision A of the Act. Subsection 195(3) of the Act provides for amount to be credited to the account at the start of the day it is established.

Section 195-1 provides for the period to be prescribed by the rules for the purposes of paragraphs 195(3)(a) and (b) of the Act. For the classification level SAH end-of-life pathway the period prescribed is 84 days. For the classification level SAH restorative care pathway, the period prescribed is 112 days.

The End-of-Life Pathway provides a 12-week budget which can be used for up to 16 weeks. This provides flexibility for the individual, should they live beyond the 12-week mark. The Restorative Care Pathway provides a 16-week budget to maintain or regain function, and to reduce or prevent functional decline.

Section 195-3 – Circumstances, day and amount for other credit

This provision supports Part 2, Division 1, Subdivision A of the Act. Subsection 195(3A) of the Act provides that if circumstances prescribed by the rules apply in relation to an individual, at the start of a day prescribed by the rules the amount prescribed by the rules is credited to the account.

Subsection (1) provides that, for the purposes of subsection 195(3A):

- the amount is an amount equal to the amount credited to the account under subsection 195(3) of the Act; and
- the circumstances are that the System Governor has determined the amount for the individual under subsection (2); and
- the individual has the classification level SAH restorative care pathway in effect for the classification type short-term for the service group home support; and
- the individual has not had that classification level in effect 2 or more times in the 365 days before the start of the current period of effect of that classification level; and
- the day is the day the System Governor determines the amount for the individual under subsection (2).

Subsection (2) provides that the System Governor must determine the amount for the individual at the end of a day if the following requirements are met:

- on or before the day, a registered provider gives the System Governor:
 - a list of funded aged care services (existing services) that are set out in the individual's care and services plan as services that the provider will deliver to the individual through the service group home support in the period of effect of the classification level SAH restorative care pathway for the individual; and
 - a written certificate from a medical practitioner, registered nurse or allied health professional, or an aged care worker of the provider who is a restorative care partner, stating that, to achieve the goals in the plan, the individual needs

- to access funded aged care services in the service types nursing care and allied health and therapy (the additional services) in addition to the existing services; and
 - evidence of the total cost for the delivery of the existing services and the additional services; and
- the total cost for the delivery of the existing services and the additional services exceeds the total of the amounts credited to the individual's notional short term home support account under subsections 195(3) and (4) of the Act in the period of effect of the classification level SAH restorative care pathway for the individual; and
- if the individual also has a classification level in effect for the classification type ongoing for the service group—the total cost for the delivery of the existing services and the additional services exceeds the sum of:
 - the total of the amounts credited to the individual's notional short term home support account under subsections 195(3) and (4) of the Act in the period of effect of the classification level SAH restorative care pathway for the individual; and
 - the total of the amounts credited, or to be credited, to the individual's notional ongoing home support account under section 193 of the Act for the quarters during which the classification level SAH restorative care pathway is in effect for the individual; and
- on the day, the System Governor considers a place for the classification type short term for the service group home support is available in accordance with a determination made under subsection 91(1) of the Act.

Some participants with higher and more complex needs may require additional services to meet their restorative care goals. Eligibility to access an additional unit of funding for the Restorative Care Pathway is provided for in this section. The additional unit of funding is to be used during the initial episode of restorative care, of up to 16 weeks.

Eligibility includes a demonstrated need, through evidence, that the initial unit of funding is insufficient to meet defined restorative outcomes. In practice, this evidence can be the goal plan and individualised budget, with a written statement to indicate that the restorative care goals cannot be met as indicated in these documents.

If the participant is already receiving ongoing Support at Home services, there must also be demonstrated need that the initial unit of funding and any ongoing funding in place, is insufficient to meet defined restorative outcomes. Evidence would provide that adjustments to the ongoing care plan and individualised budget cannot be made to enable the meeting of restorative care goals.

To be considered eligible for the additional units of funding, there must also be units of funding available for the Restorative Care Pathway to be allocated, and the participant must not have already been approved for two units of funding for the Restorative Care Pathway within a 12 month period. This is because a participant can access a maximum of two units of funding within a 12 month period.

Section 195-10 – Circumstances for ceasing of account

This provision supports Part 2, Division 1, Subdivision D of the Act and provides for the circumstances in which an individual's notional short-term home support account ceases for the purposes of subsection 195(7) of the Act.

The circumstances are as follows:

- 60 days have passed since the end of the maximum period of effect for that classification level; and
- any longer period determined by the System Governor under paragraph 251(3)(b) of the Act for a claim for person-centred subsidy that is payable to a registered provider under section 250 of the Act for the delivery of a funded aged care service to the individual has ended.

This section does not apply to the classification type SAH restorative care pathway as an individual may access the restorative care pathway more than once (up to two episodes in 12 months with at least 3 months between each episode, or two units of funding in one episode of up to 16 weeks).

Subdivision D—Primary person-centred supplements

Section 196-5 – Purpose of this Subdivision

This provision supports Part 2, Division 1, Subdivision A of the Act and provides for the following for the purposes of section 196 of the Act:

- primary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group home support; and
- the circumstances in which the supplements will apply to individuals for a day; and
- the amounts of the supplements.

Section 196-10 – Primary person-centred supplements

This provision supports Part 2, Division 1, Subdivision A of the Act and sets out the primary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group home support.

Item 1 of the table prescribes the following primary person-centred supplements for ongoing home support:

- Oxygen supplement (see section 196-15)
- Enteral feeding supplement (see section 196-20)
- Veterans' supplement (see section 196-25)
- Dementia and cognition supplement (see section 196-30)
- Top-up supplement (see section 196-35)

Item 2 of the table prescribes the following primary person-centred supplements for short-term home support:

- Oxygen supplement (see section 196-15)
- Enteral feeding supplement (see section 196-20)
- Veterans' supplement (see section 196-25)

Section 196-12 – Primary person-centred supplements for classification type short term—circumstances for applicability (general)

This provision supports Part 2, Division 1, Subdivision A of the Act and sets out that the primary person-centred supplements for the classification type short-term will apply to an individual for a day only if, on the day, the individual does not have an access approval in effect for the classification type ongoing for the service group home support, as well as the following apply:

- The individual has an access approval in effect for the classification type ongoing for the service group home support;
- A primary person-centred supplement for the classification type ongoing for the service group home support applies to the individual;
- The individual has the classification level SAH end-of-life pathway in effect for the classification type short-term for the service group home support.

The primary person-centred supplements for the classification type short-term and classification level SAH end-of-life pathway will apply to an individual for a day, even if the individual has an access approval in effect for the classification type ongoing for the service group home support and the primary person-centred supplements for the classification type ongoing for the home support group have been applied for that day.

Primary person-centred supplements are applicable to an individual in both classification type ongoing and classification level End-of-Life concurrently. This is to ensure supplements are applied to the individual's End-of-Life budget while access to their ongoing classification budget is on pause. However, individuals cannot access their ongoing funding at the same time as their End-of-Life funding. This section ensures that supplements are applied to an individual's End-of-Life account and can also be applied to their ongoing account. This is not duplication of supplements as the individual can only access one account at a time.

Where an individual is accessing both ongoing Support at Home services and the Restorative Care Pathway, there can be no duplication of primary person-centred supplements.

Section 196-15 – Oxygen supplement—circumstances for applicability and amount

This provision supports Part 2, Division 1, Subdivision A of the Act and sets out circumstances for the applicability and amount of oxygen supplement.

Subsection (1) provides that the oxygen supplement will apply to an individual for a day if:

- on the day, the individual's classification level for a classification type for the service group home support is other than STRC class; and
- on the day, the care and services plan for the individual:
 - covers the delivery of a funded aged care service in the service type nursing care consumables to the individual; and
 - Includes providing oxygen to the individual using materials and equipment hired, temporarily obtained or owned by the provider; and
- a medical practitioner or a nurse practitioner has certified, in writing, that the individual has a continual need for the provision of oxygen, other than on a short-term or episodic basis.

The amount of oxygen supplement for a day is \$14.66 and is subject to change.

Section 196-20 – Enteral feeding supplement – circumstances for applicability and amount

This provision supports Part 2, Division 1, Subdivision A of the Act and provides for circumstances for applicability and the amount of enteral feeding supplement.

Subsection (1) provides that the circumstances under which enteral feeding supplement will apply to an individual for a day are as follows:

- on the day, the individual's classification level for a classification type for the service group home support is other than STRC class; and
- on the day, the care and services plan for the individual:
 - covers the delivery of the funded aged care service nutrition supports to the individual; and
 - includes supplying enteral supplementary dietary products to the individual; and
- a medical practitioner has certified, in writing, that the individual has a medical need for enteral feeding, other than for intermittent or supplementary enteral feeding given in addition to oral feeding.

Subsection (2) provides that the amounts of enteral feeding supplement for a day is \$23.25 for bolus feeding and \$26.11 for non-bolus feeding, however these amounts are subject to change.

Section 196-25 – Veterans' supplement—circumstances for applicability and amount

This provision supports Part 2, Division 1, Subdivision A of the Act and provides for circumstances in which an individual is eligible for the veteran's supplement and the amount of supplement.

Subsection (1) provides that the circumstances under which an individual is eligible for the veteran's supplement are as follows:

- on the day, the individual's classification level for a classification type for the service group home support is other than STRC class; and
- the individual is a veteran with an accepted mental health condition; and
- the individual has, before, on or after that day, authorised either or both of the following to disclose to a registered provider that the individual is a veteran with an accepted mental health condition:
 - the Secretary of the Department administered by the Minister administering the Veterans' Entitlements Act;
 - the Secretary of the Department administered by the Minister administering the *Human Services (Centrelink) Act 1997*.

Subsection (2) prescribes the amount of the veterans' supplement for a day for an individual with the classification type ongoing for the service group home support is the amount that is 11.5% of the sum of the base individual amount for the individual's classification level for the day plus, for an individual covered by subsection 203(3) of the Act, the base provider amount for a registered provider in relation to the individual, rounded up to the nearest cent.

Subsection (3) prescribes that the amount of the veterans' supplement for a day for an individual for the classification type short term for the service group home support, the amount is 11.5% of the base individual amount for the individual's classification level for the classification type short-term for the service group home support for the day.

Section 196-30 – Dementia and cognition supplement—circumstances for applicability and amount

This provision supports Part 2, Division 1, Subdivision A of the Act and provides for circumstances in an individual is eligible for the dementia and cognition supplement and the amount of supplement.

Subsection (1) provides that the circumstances under which an individual is eligible for the dementia and cognition supplement are as follows that on the day, the individual has a transitional classification and immediately before the transition time, the individual was eligible for a dementia and cognition supplement under section 83 of the *Subsidy Principles 2014*.

The amount of dementia and cognition supplement is for a day for an individual is the amount that is 11.5% of the sum of the base individual amount for the individual's classification level for the classification type ongoing for the service group home support for the day and, for an individual covered by subsection 203(3) of the Act—the base provider amount for a registered provider in relation to the individual, rounded up to the nearest cent.

This section ensures that individuals receiving the dementia and cognition supplement on 31 October 2025 retain this supplement (and have it applied in their notional ongoing home support account) after 1 November 2025.

Section 196-35 – Top up supplement—circumstances for applicability and amount

This provision supports Part 2, Division 1, Subdivision A of the Act and provides for circumstances in which an individual is eligible for the top-up supplement and the amount of the supplement.

Subsection (1) provides that top-up supplement will apply to an individual for a day if:

- on the day, the individual has a transitional classification; and
- immediately before the transition time, top-up supplement applied to the individual under section 67M of the Aged Care (Transitional Provisions) Principles 2014.

The amount of top up supplement is \$3.45 and is subject to change

Division 2 – Provider based subsidy

Subdivision A – Eligibility

Section 201-5 – Eligible funded aged care services

This provision supports Part 2, Division 1, Subdivision C of the Act. Paragraph 201(c) of the Act provides requirements that must be met for a registered provider to be eligible for provider-based subsidy for home support under section 201 of the Act.

This provision prescribes the funded aged care service home support care management for the purposes of paragraph 201(c) of the Act. This means that a registered provider can claim provider-based subsidy for care management.

Subdivision B—Available service delivery branch account balance

This subdivision relates to the management of a provider's service delivery branch account, which holds care management funding for participants with SAH ongoing classifications.

Section 203-10 – Amount to be credited in first and second quarters of active operation—number of days for calculation

This provision supports Part 2, Division 1, Subdivision C of the Act and prescribes the number of days for calculation. This provision prescribes that the number of days is:

- for an individual whose start notification is given in the first quarter of operation in the first financial year - the number of days remaining in the first quarter of operation (including the day on which the notification is given); or
- for an individual whose start notification is given in the second quarter of operation in the first financial year, the number of days remaining in the second quarter of operation (including the day on which the notification is given).

New service delivery branch accounts (that is, in operation for two quarters or less) will receive credits on a pro-rata basis for participants joining mid-quarter, rather than having credits made based on the case-mix of participants within a service delivery branch on the last day of the previous quarter (as described in 203(5) of the Act). This is in recognition that they will not have or unlikely to have enough participants within their service delivery branch for this approach. From the third quarter a service delivery branch is established, 203(5) in the Act will apply to calculate credits.

Section 203-11 – Time before which registered provider must give start notification

This provision supports Part 2, Division 1, Subdivision B of the Act. For the purposes of paragraph 203(5)(a) of the Act, section 203-11 prescribes 10.00pm (by legal time in the Australian Capital Territory) on the last day in the quarter immediately before the relevant quarter as the time before which the registered provider must give the start notification.

Section 203-12 – Amount to be credited for provider-based supplement starting to apply – number of days for calculation

This provision supports Part 2, Division 2, Subdivision B of the Act. For the purposes of subsection 203(7) of the Act, section 203-12 prescribes the number of days remaining in the quarter after the day the provider-based supplement starts applying to the provider in relation to the individual as the number of days for calculation for the amount to be credited for provider-based supplement starting to apply.

Section 203-15 – Rollover credits

This provision supports Part 2, Division 1, Subdivision B of the Act and prescribes, for the purposes of subsection 203(8) of the Act, the circumstances and amount of rollover credit for the available service delivery branch account balance.

Subsection (2) provides that the rollover credit applies in the following circumstances for the account for the financial year (the *relevant financial year*):

- the previous financial year was the first financial year referred to in that subsection of the Act; and
- the account for the financial year was established between 1 January and 30 June in that year.

Subsection (3) prescribes the amount for the circumstances mentioned in subsection (2). The amount is the available balance of the account for the first financial year immediately before the time at which the account for the relevant financial year is required to be credited in accordance with that subsection of the Act.

Subsection (4) provides that the circumstance that subsection (2) of this section does not apply in relation to the account for a financial year (the relevant financial year) is also prescribed.

Subsection (5) provides that the amount prescribed for the circumstance mentioned in subsection (4) is the lesser of:

- The available balance of the account for the previous financial year immediately before the time at which the account for the relevant financial year is required to be credited in accordance with that subsection of the Act; or
- The sum of the following amounts:
 - the amount that was credited to the account for the final quarter of the previous financial year in accordance with subsection 203(4) of the Act;
 - the amount of any credit made to that account in that quarter in accordance with subsection 203(6) of the Act;
 - the amount of any credit made to that account in that quarter in accordance with subsection 203(7) of the Act.

Care management needs are not linear and flex up or down over any given time. This section enables rollover of funds in recognition of this. A cap on the amount that can be rolled over between financial years intends to prevent large amounts of unused credits from accumulating, while still providing flexibility into subsequent financial years.

Section 203-25 – Circumstances for ceasing of account

This provision provides that a notional service delivery account for a registered provider in relation to a service delivery branch of the provider ceases in the following circumstances:

- the registered provider has reported to the System Governor, under subsection 166(1) of the Act, that the provider intends to close a service delivery branch of the provider, and the branch has subsequently closed following the report to the System Governor;
- both of the following apply:
 - the service delivery branch is a merging service delivery branch; and
 - under subsection 263A-5(3) of the rules, the available balance of the notional service delivery account of the registered provider in relation to the merging service delivery branch is credited to the notional service delivery account for the registered provider in relation to a continuing service delivery branch.

Once a service delivery branch has closed under subsection 166(1) of the Act, the service delivery branch account which holds its respective care management funding should also be closed. This is because no participants will be assigned to it, and therefore no credits can be made.

When a service delivery branch is merged into a continuing service delivery branch under section 263A of the Act, its notional service delivery branch account ceases only after its available balance has been transferred to the continuing branch's account. This ensures that the account ceases only after the successful crediting of funds under 263A-5(3) of the rules and prevents premature closure of service delivery branch account before all funding is accounted for during the merger process.

Subdivision C—Base provider amount

Section 204-5 – Classification type ongoing

This provision sets out the base provider amount for a registered provider in relation to an individual covered by subsection 203(5) of the Act for individuals for the classification type ongoing for the service group home support for the purposes of section 204 of the Act.

Non-transitional classification levels

Subsection (2) provides a table which sets out the base provider amounts in relation to individuals who have classification levels that are not transitional classification levels:

- Item 1 provides that for an individual that has the classification level SAH level 1 the amount is \$2.94
- Item 2 provides that for an individual that has the classification level SAH level 2 the amount is \$4.39
- Item 3 provides that for an individual that has the classification level SAH level 3 the amount is \$6.02
- Item 4 provides that for an individual that has the classification level SAH level 4 the amount is \$8.14
- Item 5 provides that for an individual that has the classification level SAH level 5 the amount is \$10.88
- Item 6 provides that for an individual that has the classification level SAH level 6 the amount is \$13.18
- Item 7 provides that for an individual that has the classification level SAH level 7 the amount is \$15.93
- Item 8 provides that for an individual that has the classification level SAH level 8 the amount is \$21.40.

These amounts are subject to change.

Subsection (2A) provides for the base provider amount for an individual who has an interim place in effect for the classification type ongoing for the service group home support. The amount is 60% of the amount that applies in relation to the individual under subsection (2).

Transitional classification levels

Subsection (3) provides a table which sets out the base provider amounts in relation to individuals who have transitional classification levels:

- Item 1 provides that for an individual that has the classification level HCP class 1 the amount is \$3.01
- Item 2 provides that for an individual that has the classification level HCP class 2 the amount is \$5.29
- Item 3 provides that for an individual that has the classification level HCP class 3 the amount is \$11.52
- Item 4 provides that for an individual that has the classification level HCP class 4 the amount is \$17.47

These amounts are subject to change.

Subdivision D – Provider-based supplements

Section 205-5 – Care management supplement

This section prescribes the care management supplement for the purposes of subsection 205(1) of the Act.

Section 205-10 – Care management supplement—applicability

This section prescribes that, for the purposes of paragraph 205(2)(a) of the Act, the circumstances in which the care management supplement will apply to a service delivery branch of a registered provider in relation to an individual on a day are:

- the individual is an Aboriginal or Torres Strait Islander person; or
- the individual is homeless or at risk of homelessness; or
- the individual is a care leaver, that is, an individual who has spent time in institutional care or out of home care (such as orphanages and foster care), and includes an individual who is a Forgotten Australian, a former child migrant or a member of the Stolen Generations; or
- the individual is referred to the provider by the care finder program funded by the Department; or
- veterans' supplement applies to the individual under section 196-25 of the rules.

Paragraph (b) provides that if subparagraphs (a)(i), (ii), (iii), or (iv) the System Governor must also have been notified of the fact through an aged care needs assessment for the individual or in a notice from the registered provider in the approved form.

Paragraph (c) provides that if subparagraph (a)(v) applies to the individual, the System Governor must have been notified of that fact by the Department administered by the Minister administering the Veterans' Entitlements Act.

The care management supplement is available to providers in recognition that participants meeting the circumstances in this section may require more intensive care management support. The supplement is pooled at the service delivery branch account to enable further flexibility and contribute to the overall available funding which a provider can claim against. This supports a provider to deliver flexible and responsive care management that meets the

often varied and changing needs of their participants. Applicability of the supplement occurs from when the System Governor is notified and credited according to section 203 of the Act.

Section 205-15 – Care management supplement—amount

This section provides the amount of care management supplement an individual can receive. The amount of care management supplement in relation to an individual for a day is \$3.95.

This is the amount worked out by dividing the yearly supplement allocation (12 hours per year multiplied by an hourly rate of \$120.00) by 365 days (the number of days in a year).

The rate at which the care management supplement is calculated at reflects pricing data from similar programs and pricing studies conducted for the Support at Home program.

Part 3 – Subsidy for assistive technology

Division 1 – Eligibility

Section 209-5 – Excluded classification levels

This section prescribes, for the purposes of subparagraph 209(2)(d)(ii) of the Act, the classification level AT CHSP. This means that a registered provider is not eligible for person-centred subsidy for a funded aged care service delivered by the provider to an individual through the service group assistive technology on a day if the individual has the classification level AT CHSP.

Division 2 – Available assistive technology account balance

Section 211-5 – Account period for classification type ongoing

This section provides for the account period for classification type-ongoing and supports subsection 211(1) of the Act.

If an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type ongoing for the service group assistive technology, the account period for the account is the period beginning on the entry day and ending at the earlier of the following:

- the end of the day the individual dies;
- the end of the maximum period of effect for the classification level.

Section 211-10 – Account period for classification type short term

This section outlines the account period when an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type short-term for the service group assistive technology for the purposes of subsection 211(1) of the Act.

The period is:

- 12 months beginning on the entry day for the individual; or
- if an individual has been diagnosed with a condition by a medical practitioner in writing as part of the prescribed list in subsection (2):

- the period of 24 months beginning on the entry day for the individual; or
- if a registered provider notifies the System Governor, in accordance with subsection (3), that a longer account period is needed for the individual – the period of 48 months beginning on the entry day for the individual.

The list in subsection (2) applies to an individual if a medical practitioner has certified, in writing, that the individual has been diagnosed with any of the following conditions:

- Cerebral palsy;
- Epilepsy;
- Huntington’s disease;
- Motor neurone disease;
- Multiple sclerosis;
- Parkinson’s disease;
- Polio;
- Spinal cord injury;
- Spinal muscular atrophy;
- Stroke;
- Other acquired brain injury;
- Muscular dystrophy or muscular atrophy.

Subsection (3) provides that for the purposes of subparagraph (1)(b)(ii) of the rules, a registered provider may notify the System Governor that a longer account period is needed for an individual. In this case, the notification must be made both in the approved form and before the end of 24 months beginning on the entry day for the individual. This extension may be used where it is necessary to do so to ensure that the individual’s care needs are met.

Section 211-15 – Day and amount for credit to account for classification type ongoing

This section provides that if an individual’s notional assistive technology account is established because an entry day for the individual occurs for the classification type ongoing for the service group assistive technology:

- the day is each anniversary of the day the account is established; and
- the amount is the tier amount for the individual.

Section 211-20 – Day and amount for credit to account for classification type short-term for classification level AT High

This section prescribes conditions surrounding the day and amount credited to an individual’s account for the classification short-term for the service group assistive technology, and the individual has the classification level AT High.

Subsection (1) provides that if an individual’s assistive technology account is established because an entry day for the individual occurs for the classification type short-term for the service group assistive technology, and the individual has the classification level AT High:

- the day is the day a determination of an amount under subsection (5) is made for the individual; and
- the amount is the amount determined for the individual.

Subsection (2) provides that a registered provider can apply to the System Governor for an amount of money for an individual receiving funded aged care services. This application has to meet certain requirements which are as follows:

Subsection (3) provides that the application must be in the approved form and be made before the end of 12 months beginning on the entry day for the individual.

Subsection (4) provides that the System Governor needs to consider an application and decide whether or not to determine an amount to the individual under subsection (5).

Subsection (5) provides that the System Governor may determine an amount for the individual if:

- the registered provider has provided written evidence of:
 - the individual's need for one or more items; and
 - the cost of each of those items; and
- the total cost of the items exceeds the sum of the amount credited to the individual's account under subsections 211(3) and (5) of the Act; and
- the amount is the amount by which the total cost of the items exceeds the sum of the amounts credited to the individual's account.

The registered provider should also consider the individual's need for prescription and wraparound activities. Where these services are required and contribute to the total costs exceeding the amounts credited to the individual's account, The provider may also provide written evidence of the need for and cost of these services in their application for consideration by the System Governor.

Subsection (6) provides that the System Governor needs to give written notice to the registered provider of the decision within 28 days after the application was made. Subsection (7) provides that a notice of the decision needs to include both the reasons for the decision, and how the registered provider may apply for reconsideration of the decision.

Section 211-25 – Day and amount for credit to account for classification type short-term—credit due to change in classification coming into effect

This section prescribes, for the purposes of subsection 211(4A) of the Act, that if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type short-term for the service group assistive technology, and subsection (2) applies, the day is the day mentioned in subsection (3) and the amount is the amount mentioned in subsection (4).

Subsection (2) prescribes that the subsection applies if the System Governor makes a decision establishing a different classification level in the classification type for the individual on a day that is after the entry day for the individual, and the tier amount (the ***new tier amount***) for the individual for the classification type for the service group is higher as a result of the decision coming into effect.

Subsection (3) prescribes that the day is the day the different classification level comes into effect, and subsection (4) prescribes that the amount is the difference between the new tier amount and the total of the amounts debited from the account while the previous classification level was in effect.

Division 3 – Tier amounts

Section 212-5 – Classification type ongoing

This section sets out the tier amount for an individual for an account period for the classification type ongoing for the service group assistive technology for the purposes of section 212 of the Act. For individuals that have the classification level assistance dogs the amount is \$2,000 per annum.

Section 212-10 – Classification type short-term

This section sets out the tier amount for an individual for an account period for the classification type short-term for the service group assistive technology for the purposes of section 212 of the Act.

For an individual that has the classification level AT low the amount is \$500.

For an individual that has the classification level AT medium the amount is \$2,000.

For an individual that has the classification level AT high the amount is \$15,000 (or more with evidence). For an individual that has the classification level AT transitional the amount is \$0. This tier applies to the transitioning home care cohort and enables the use of any unspent Commonwealth portions and home care accounts for assistive technology.

Division 4 – Primary person-centred supplements

Section 213-5 – Rural and remote supplement

This section sets out the rural and remote supplement amount for an individual for a day for a classification type for the service group assistive technology for the purposes of section 213 of the Act.

The circumstances in which rural and remote supplement will apply to the individual are that the individual resides at a location in the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7.

The amount of supplement an individual will receive is the amount that is 50% of the tier amount for the individual for the account period for the classification type for the service group assistive technology, rounded to the nearest cent.

Part 4 – Subsidy for home modifications

Division 1 – Eligibility

Section 218-5 – Excluded classification levels

This section prescribes for the purposes of subparagraph 218(2)(d)(ii) the classification level HM CHSP. This means that a registered provider is not eligible for person-centred subsidy for a funded aged care service delivered by the registered provider to an individual through the service group home modifications if the individual has the classification level HM CHSP.

Division 2 – Available home modifications account balance

Section 220-5 – Account period for classification type short-term

This section prescribes the account period for classification type short term as follows:

Subsection (1) provides that if an individual's notional home modifications account is established because an entry day for the individual occurs for the classification type short-term for the service group home modifications, the account period for the account is:

- the period of 12 months beginning on the entry day for the individual; or
- if the individual has the classification level HM High for that service type, and a registered provider has notified the System Governor, in accordance with subsection (2), that a longer period is needed for the individual— the period of 24 months beginning on the entry day for the individual.

Subsection (2) provides that, for the purposes of paragraph (1)(b) a registered provider may notify the System Governor that a longer account period is needed for an individual. The notification must be both in the approved form and be made before the end of 12 months beginning on the entry day for the individual. This extension may be used where home modifications have been scheduled for delivery, and are in progress, but will not be delivered before the end of 12 months beginning on the entry day for the individual.

Division 3 – Tier amounts

Section 221-5 – Classification type short term

This section sets out the tier amount for an individual for an account period for the classification type short-term for the service group home modifications for the purposes of section 221 of the Act.

For an individual that has the classification level HM Transitional the amount is \$0. This tier applies to the transitioning home care cohort and enables the use of their unspent Commonwealth portions and home care accounts for home modifications.

For an individual that has the classification level HM Low the amount is \$500.

For an individual that has the classification level HM Medium the amount is \$2,000.

For an individual that has the classification level HM High the amount is based on the following:

- if it is the first occasion that a notional home modifications account is established for the individual with that classification level—\$15,000; and
- if it is not the first occasion that a notional home modifications account is established for the individual with that classification level—\$15,000 reduced by the total of any amounts debited to the individual's previous notional home modifications accounts when the individual had that classification level.

Division 4 – Primary person-centred supplements

Section 222-5 – Rural and remote supplement

This section prescribes the rural and remote supplement an individual for a day for a classification type for the service group home modifications.

The circumstances in which rural and remote supplement will apply to the individual are that the individual resides at a location in the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7.

The amount of rural and remote supplement is the amount that is 50% of the tier amount for the individual for the account period for the classification type for the service group home modifications, rounded to the nearest cent. These amounts are approximate and subject to change.

Part 5 – Fee reduction supplement for home support, assistive technology and home modifications

Section 197-1 – Purpose of this part

This section provides that for the purposes of subsections 197(2), 214(2) and 223(2) of the Act, this Part provides for the circumstances in which the fee reduction supplement will apply to an individual for a day and the amount of the fee reduction supplement.

Note 1 clarifies that the fee reduction supplement is a secondary person-centred supplement for an individual for a day for a classification type for the service groups home support, assistive technology and home modifications (see paragraphs 197(1)(a), 214(1)(a) and 223(1)(a) of the Act).

Note 2 clarifies that the amount of the fee reduction supplement for a day for an individual reduces individual contribution for the delivery of a funded aged care service to the individual on the day in accordance with Step 4 in the method statement in subsection 273(2) of the Act.

Section 197-5 – Fee reduction supplement – circumstances for applicability, amount and reduction of contributions – home or community fee reduction supplement determinations (financial hardship)

Circumstances for applicability of fee reduction supplement

Subsection (1) prescribes that the circumstances in which the fee reduction supplement will apply to an individual for a day in a fortnight are that:

- on the day, either an individual contribution rate determination is in effect for the individual or the individual does not have means not disclosed status; and
- on the day, the value of the individual's assets, worked out in accordance with Division 1 of Part 3.12 of the Social Security Act and reduced by the value of any unrealisable assets, is not more than 1.5 times the sum of the annual amount of the following:
 - maximum basic rate under point 1064-B1 of Module B of Pension Rate Calculator A that applies to a person who is not a member of a couple;

- the pension supplement amount under point 1064-BA3 of Module BA of Pension Rate Calculator A that applies to a person who is not a member of a couple;
- the energy supplement amount under point 1064-C3 of Module C of Pension Rate Calculator A that applies to a person who is not a member of a couple; and
- on the day, the individual has not gifted more than \$10,000 in the current financial year or in any of the previous 4 financial years; and
- on the day, the individual has not gifted more than \$30,000 in the period comprising the current financial year and the previous 4 financial years; and
- on the day, a home or community fee reduction supplement determination is in effect for the individual; and
- the individual's fortnightly individual contribution cap for the fortnight is equal to or less than the individual's fortnightly base individual amount for the fortnight.

Amount of fee reduction supplement

Subsection (2) prescribes that the amount of fee reduction supplement for a day in a fortnight for an individual to whom the supplement applies under subsection (1) is:

- if, on the day, the total of the unreduced individual contributions for the delivery of funded aged care services to the individual on the day and the preceding days in the fortnight does not exceed the individual's fortnightly individual contribution cap for the fortnight—zero; or
- if, on the day, the total of the unreduced individual contributions for the delivery of funded aged care services to the individual on the day and the preceding days in the fortnight exceeds the individual's fortnightly individual contribution cap for the fortnight—the amount by which that total exceeds that cap; or
- if the day is after the day mentioned in the dot point above, the amount of the total of the unreduced individual contributions for the delivery of funded aged care services to the individual on the day.

Section 197-8 – Applications for home or community fee reduction supplement determinations

Subsection (1) provides that an individual may apply to the System Governor for a home or community fee reduction supplement for the individual. Subsection (2) provides that the application must be in the approved form.

The Note to subsection (2) clarifies that for penalties for knowingly providing false or misleading information or documents in applications, see section 591 of the Act and Part 7.4 of the *Criminal Code*.

Subsection (3) provides that if the individual has made an application (an ***existing application***), the individual must not make a further application for a home or community fee reduction supplement determination for the individual in the decision-making period (within the meaning of subsection 588(5) of the Act) for the existing application.

Subsection (4) provides that if a home or community fee reduction supplement determination (an *existing determination*) is made for an individual, the individual must not make an application for another determination within 90 days from the day the existing determination was made.

Subsection (5) provides that if the home or community fee reduction supplement determination is revoked, the individual must not make an application for a further determination within 28 days from the day the revocation takes effect.

Section 197-10 – Home or community fee reduction supplement determinations

Subsection (1) requires the System Governor to determine the following matters within 28 days of receiving an application for home or community fee reduction supplement.

For a particular fortnight, the System Governor must determine:

- The individual's fortnightly total income amount, total essential expenses and remaining income amount; and
- The day the determination takes effect; and
- The period for which the determination takes effect.

The note under subsection (1) refers to section 588 of the Act which allows the System Governor to request further information, and provides for the consequence of not giving any requested further information in the requested time, and the extension of the decision making period if requested information is given in the requested time.

Subsection (2) provides that for the purposes of determining the day the determination takes effect in paragraph 197-10(1)(b):

- unless paragraph (b) applies—the System Governor must determine that the determination takes effect on the day the application was made; or
- the System Governor must determine that the determination takes effect on a day that is earlier than the day the application was made, if:
 - the individual's application includes a request for the determination to take effect on an earlier day because the individual was experiencing financial hardship on and after the earlier day, and evidence of that financial hardship; and
 - the System Governor is satisfied that the individual was experiencing financial hardship on and after the earlier day.

The note under subsection (1) refers to section 588 of the Act which allows the System Governor to request further information, and provides for the consequence of not giving any requested further information in the requested time, and the extension of the decision making period if requested information is given in the requested time.

Essential expenses

Subsection (3) provides a non-exhaustive list of expenses that the System Governor may determine to be essential expenses in relation to an individual. These include:

- Food costs;
- Costs relating to the individual's home, including:

- rent or mortgage repayments;
- home maintenance, including repair and replacement costs;
- home insurance;
- rates;
- water, sewage, gas and electricity costs;
- telephone and internet costs;
- Any of the following that are not already covered by other government schemes or programs or by private health insurance;
 - medical expenses, including expenses incurred under the direction of a registered health practitioner or allied health professional;
 - dental care;
 - prescription glasses (one pair per year) or contact lenses;
 - artificial limbs, eyes or hearing aids;
 - wheelchair and mobility aids;
 - transport costs to attend medical appointments;
- Ambulance cover;
- Private health insurance;
- Transport related costs (other than transport costs to attend medical appointments), including public transport costs, vehicle registration, vehicle repairs and vehicle insurance;
- If the individual is paying a funeral plan on a periodic basis—the funeral plan.

However, the essential expenses listed above do not include amounts that are spent by another person, who is authorised to act on the individual's behalf, other than for the benefit of the individual.

Subsection (4) provides that the individual's ***fortnightly total income amount*** for a fortnight is worked out by working out the individual's total assessable income using section 323 of the Act and dividing that amount by 26.

Subsection (5) provides that the individual's ***fortnightly total essential expenses*** is the amount that is the individual's total essential expenses, worked out on a fortnightly basis.

Subsection (6) provides that the individual's ***fortnightly remaining income amount*** for a fortnight is worked out by reducing (but not below zero) the individual's fortnightly total income amount for the fortnight by the individual's fortnightly total essential expenses for the fortnight.

Subsection (7) provides that the individual's ***fortnightly individual contribution cap*** for a fortnight is the amount equal to the difference between:

- the fee reduction supplement fortnightly threshold amount for the fortnight; and
- the fortnightly remaining income amount determined in the home or community fee reduction supplement determination that is in effect for the individual on the first day of the fortnight.

Subsection (8) provides that the individual's ***fortnightly base individual amount*** for a fortnight is the amount obtained by rounding down to the nearest cent the amount worked out

by adding together the individual's fortnight base home support individual amount for the fortnight and the individual's fortnightly base AT-HM individual amount for the fortnight.

Subsection (9) provides that the individual's *fortnight base home support individual amount* for a fortnight is the amount obtained by rounding down to the nearest cent the amount worked out by multiplying the following:

- the base individual amount for the individual, on the first day of the fortnight, for:
 - if the individual has a classification level in effect only for the classification type ongoing for the service group home support—that classification level; or
 - if the individual has a classification level in effect only for the classification type short term for the service group home support—that classification level; or
 - if the individual has classification levels in effect for the classification types ongoing and short term for the service group home support—the classification level in effect for the classification type ongoing;
- 14;
- the individual contribution rate for the individual, on the first day of the fortnight, for the means testing category everyday living.

Subsection (10) provides that the individual's *fortnightly base AT-HM individual amount* for a fortnight is the amount obtained by rounding down to the nearest cent the amount worked out by multiplying the following:

- the tier amount for the individual:
 - if the individual has a classification level in effect only for the classification type ongoing for the service group home modifications—that classification level; or
 - if the individual has a classification level in effect only for the classification type ongoing or short-term for the service group assistive technology—that classification level;
 - if the individual has both a tier amount for the service group assistive technology and a tier amount for the service group home modifications—the sum of those tier amounts;
- 1/365;
- the individual contribution rate for the individual, on the first day of the fortnight, for the means testing category independence.

Section 197-15 – Notice of home or community fee reduction supplement determinations

Subsection (1) provides that the System Governor must give written notice of the home or community fee reduction supplement determination to the individual and to the registered provider delivering funded aged care services to the individual. The System Governor must do this within 14 days after making the determination.

Subsection (2) sets out the requirements for the notice. The notice must include:

- each of the matters determined in the determination; and
- the reasons for the following decisions:
 - the determination of the individual's fortnightly total income amount;
 - the determination of the individual's fortnightly total essential expenses;

- the day the determination takes effect;
- the period for which the determination is in effect; and
- how the individual may apply for reconsideration of those decisions; and
- a statement of the effect of section 197-20 of the rules which provides for varying or revoking the home or community fee reduction supplement determination.

Section 197-20 – Varying or revoking home or community fee reduction supplement determinations—general

Subsection (1) provides that the System Governor may vary or revoke a home or community fee reduction supplement determination for an individual in the following circumstances:

- if the System Governor has been notified of the occurrence of an event or a change in the individual's circumstances under Subdivision E of Division 1 of Part 2 of Chapter 10 of this instrument; or
- if an individual contribution rate determination for the individual is made, varied or revoked; or
- if the individual has means not disclosed status under section 314A of the Act; or
- on the System Governor's own initiative (see section 197-30 of the rules).

Subsection (2) provides that the home or community fee reduction supplement determination may be varied or revoked if the System Governor is satisfied that the determination is incorrect.

Effect of decision

Subsection (3) provides that if a home or community fee reduction supplement determination is varied or revoked, the variation or revocation takes effect on the day specified by the System Governor in the notice under section 197-35 of the rules.

Subsection (4) provides that the day specified may be before the day the notice is given but must not be earlier than the day the circumstances that are the reason for the variation or revocation occurred.

Section 197-25 – Varying or revoking home or community fee reduction supplement determinations—on notification of event or change in circumstances

Subsection (1) provides that this section applies if the System Governor has been notified of the occurrence of an event or a change in an individual's circumstances under Subdivision E of Division 1 of Part 2 of Chapter 10 of the Rules.

Subsection (2) provides that the System Governor must decide whether to vary or revoke the home or community fee reduction supplement determination in effect for the individual. The System Governor must make a decision within 28 days from being notified of the event or change in individual's circumstances.

Subsection (3) provides that the System Governor may request the individual to give the System Governor further information to assist the System Governor to decide whether to vary or revoke the home or community fee reduction supplement. The request must be by written notice. The individual must give the further information within the period specified in the

notice. The period must not be less than 28 days after giving the notice. The note to this section confirms that the individual is not obliged to give the information.

Subsection (4) provides that the individual can request an extension and the System Governor may extend the specified period.

Section 197-30 – Varying or revoking home or community fee reduction supplement determinations – on the System Governor’s initiative

Notice before variation or revocation

Subsection (1) provides that before the System Governor varies or revokes a home or community fee reduction supplement determination on the System Governor’s own initiative, the System Governor must give the individual written notice that the System Governor is considering varying or revoking the determination.

Subsection (2) sets out the requirements for the notice. The notice must:

- set out the reasons why the System Governor is considering varying or revoking the determination, and what the effect of the variation or revocation would be; and
- invite the individual to make a submission, in writing, to the System Governor in relation to the matter within the period specified in the notice (which must not be less than 28 days after giving the notice); and
- inform the individual that the System Governor may decide to vary or revoke the determination:
 - if no submission is made within the specified period; or
 - after considering any submission made by the individual within the specified period.

Request for further information

Subsection (3) provides that the System Governor may also request in the notice that the individual give the System Governor the information specified in the notice, within the period specified in the notice, to assist the System Governor to decide whether to vary or revoke the determination. The note clarifies that the individual does not have to give the information.

Subsection (4) provides that if the individual makes a submission, the System Governor may, by written notice, request the individual to give the System Governor further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to vary or revoke the determination.

The notes under subsection (4) clarify that the System Governor may request further information regardless of whether the information was given under subsection (3), and that the individual is not obliged to give the information.

Subsection (5) provides that the provides that the individual can request an extension and the System Governor may extend the specified period for submitting further information under subsections (3) or (4).

Deciding whether to vary or revoke fee reduction supplement determination

Subsection (6) provides that the System Governor must consider any submission made or and any further information given. The System Governor must also make a decision whether to vary or revoke the determination within the following timeframes:

- If no submission is made—within 28 days of the end of the period specified in the original notice under paragraph 197-25(2)(b) of the rules (including that period as extended by the System Governor (if applicable); or
- The later of either the following:
 - If a submission is made and no further information is requested—within 28 days of the day the submission is made; and
 - If a submission is made and further information is requested by the System Governor—within 28 days of the day the individual gives the System Governor the further information.

Section 197-35 – Notice of decision to vary or revoke home or community fee reduction supplement determination

Notice requirements

Subsection (1) provides that the System Governor must give an individual written notice of a decision under subsection 197-20(1) to vary or revoke a home or community fee reduction supplement determination for the individual within 14 days after making the decision.

Subsection (2) sets out the requirements for the notice. The notice must:

- state that the individual is required to notify the System Governor of any events or changes in the individual's circumstances in accordance with Subdivision E of Division 1 of Part 2 of Chapter 10 of the Rules; and
- if the decision is to vary the home or community fee reduction supplement determination:
 - include details of the variation (including specifying the amounts determined to be the individual's fortnightly total income amount and fortnightly total essential expenses); and
 - specify the day the variation takes effect (see subsection 197-20(4)); and
- if the decision is to revoke the home or community fee reduction supplement determination:
 - explain the consequences of the revocation of the determination; and
 - specify the day the determination ceases to be in force (see subsection 197-20(4)); and
- set out the reasons for the following decisions:
 - varying or revoking the determination under subsection 197-20(1);
 - the day the variation or revocation takes effect under subsection 197-20(4);and
- state how the individual may apply for reconsideration of the decision under subsection 197-20(1).

Copies to registered provider

Subsection (3) provides that the System Governor must give the registered provider delivering funded aged care services to the individual a copy of the notice to vary or revoke the home or community fee reduction supplement determination for the individual.

Part 6 – Unspent Commonwealth portions and home care accounts

Section 226A-5 – Day for reduction of portion – provider elects to return available balance

Subsection 226A(6) of the Act provides that if a registered provider elects to return unspent funds, the unspent Commonwealth portion is reduced at the start of the day prescribed by the rules by the amount of that balance at the start of the day.

Section 226A-5 of the rules prescribes that the day is the day the provider made the election.

Section 226A-10 – Day for reduction of portion – individual transfers between provider service delivery branches

Subsection 226A(7) of the Act provides that if a registered provider returns the available balance of an unspent Commonwealth portion for the individual to the Commonwealth, the portion is reduced at the start of a day prescribed by the rules, by the amount of that balance at the start of that day.

This section prescribes that the day is the day the provider could make a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

Section 226A-15 – Day for reduction of portion – provider ceases to deliver services

Subsection 226A(8) of the Act provides that if a registered provider returns the available balance of an unspent Commonwealth portion for the individual to the commonwealth, the portion is reduced, at the start of a day prescribed by the rules by the amount of that balance at the start of that day.

This section prescribes that the day is the day after the last day on which the registered provider could make a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

The note under this section clarifies that for the period in which a registered provider may make a claim for person-centred subsidy that is payable to the provider, see subsection 251(3) of the Act.

Section 226B-5 – Day for reduction of portion – provider ceases to deliver services

Subsection 226B(1) of the Act provides that a registered provider may, by written notice given to the System Governor and in accordance with the rules, elect to return the available balance of an unspent Commonwealth portion for an individual to the Commonwealth.

This section provides that the notice must be given through the information technology system relating to aged care payments operated by Services Australia.

Section 226B-10 – Period within which available balance must be returned – provider election

Paragraph 226B(4)(a) of the Act provides that the provider must return the available balance of the unspent Commonwealth portion for the individual to the Commonwealth within the period prescribed by the rules after the day the notice of the decision is given to the System Governor. This section provides that the period is 1 day.

Section 226C-5 – Period within which available balance must be returned—individual transfers between provider service delivery branches

Subparagraph 226C(2)(b)(i) of the Act provides that a provider must return the available balance of the unspent Commonwealth portion for the individual to the Commonwealth within the period prescribed by the rules after cessation.

This section provides that the period is:

- Starting after the day after section 226C of the Act begins to apply in relation to the registered provider and the individual (when the individual transfers); and
- Ending at the end of the day after the last day on which the registered provider could make a claim under section 251 of the Act.

This period is intended to allow any outstanding claims to be finalised before the balance must be returned.

The Note to this section clarifies that, for the period in which a registered provider may make a claim for person-centred subsidy that is payable to the provider, see subsection 251(3) of the Act.

Section 226D-5 – Period within which available balance must be returned – provider ceases to deliver services

Subparagraph 226D(2)(b)(i) provides that the provider must return the available balance of the unspent Commonwealth portion for the individual to the Commonwealth within the period prescribed by the rules starting on the day after the cessation. Section 226D-5 provides the period is the claim period under 251 of the Act.

Section 226E-5 – Day for credit of account—provider elects to return available balance

Subsection 226E(4) provides that if a registered provider elects to return the available balance of an unspent Commonwealth portion for the individual to the Commonwealth because the provider elects to return the available balance, the account is credited, at the start of a day prescribed by the rules (which may be a day before the day the election is made), by the amount of that balance at the start of that day. Section 226E-5 prescribes the day is the day the provider made the election.

Section 226E-10 – Day for credit of account—individual transfers between provider service delivery branches

Subsection 226E(5) of the Act provides that if a registered provider returns the available balance of an unspent Commonwealth portion for the individual to the Commonwealth because the individual transfers between the provider's service delivery branches, the account

is credited, at the start of a day prescribed by the rules, by the amount of that balance at the start of that day. Section 226E-10 prescribes the day is the day the provider next makes a claim under section 251 of the Act for person-centred subsidy for the delivery of a funded aged care service to the individual.

Section 226E-15 – Day for credit of account—provider ceases to deliver services

Subsection 226E(6) of the Act provides that if a registered provider returns the available balance of an unspent Commonwealth portion for the individual to the Commonwealth because the provider ceases to deliver services, the account is credited, at the start of a day prescribed by the rules, by the amount of that balance at the start of that day.

Section 226E-15 prescribes prescribed day is the day after the last day on which the registered provider could make a claim under section 251 of the Act for person centred subsidy for the delivery of a funded aged care service to the individual.

The note under section 226E-15 clarifies that for the period in which a registered provider may make a claim for person centred subsidy that is payable to the provider, see subsection 251(3) of the Act.

Section 226E-20 – Home care account—circumstances in which account is reduced to zero

Subsection 226E(8) of the Act provides that if circumstances prescribed by the rules apply to the individual on a day, the account is reduced to zero on that day.

This section prescribes that the circumstances are that:

- both of the following apply:
 - the individual is deceased;
 - the period in which a registered provider could make a claim under section 251 of the Act for person centred subsidy for the delivery of a funded aged care service to the individual has ended; or
- both of the following apply:
 - the individual is over 115 years old; and
 - the period in which a registered provider could make a claim under section 251 of the Act, for person centred subsidy for the delivery of a funded aged care service to the individual through a service group other than residential care, has ended.

The note under this section clarifies that for the period in which a registered provider may make a claim for person centred subsidy that is payable to the provider, see subsection 251(3) of the Act.

Section 226E-25 – Home care account—circumstances in which account ceases

Subsection 226E(9) provides that the account ceases in the circumstances prescribed by the rules. This section provides that the circumstances are:

- the available balance of the account is reduced to zero; and
- no registered provider holds an unspent Commonwealth portion for the individual under section 226A of the Act; and

- no person is required to pay the Commonwealth the Commonwealth portion of an unspent home care amount (within the meaning of the old Act) of the individual.

Part 7 – Subsidy for residential care

Division 1A – Classes of individuals to which Division 4 of Part 2 of Chapter 4 of the Act does not apply

Section 227A-5 – Classes of individuals

Section 227A of the Act provides that Division 4 of Part 2 Chapter 4 of the Act (which provides for subsidy for residential care) does not apply in relation to an individual accessing ongoing funded aged care service group residential care if the individual is in a class of individuals prescribed by the rules. The rules prescribe that the classes of individuals are:

- the pre-2014 residential contribution class
- the post-2014 residential contribution class

Division 1—Person centred subsidy

Subdivision A—Base rates

Section 229-5 – Base rates—classification type ongoing

Section 229-5 provides for the base rate for an individual for the classification type ongoing for the service group residential care for a day.

Section 229-5 continues implementation of the Australian National Aged Care Classification (AN-ACC) funding model that has operated in full since October 2022 and that includes linking calculation of a variable amount of residential care subsidy to the classification level of an individual receiving ongoing residential care (see section 80-35 of these Rules).

General – classification level Class 0

Subsection (2) provides for the base rate of person-centred subsidy for individuals with the classification level Class 0. If neither subsections (4) nor (5) (which provide for extended hospital leave) apply to the individual, and the classification level for the individual is Class 0, the base rate is the amount worked out by multiplying the national efficient price by:

- if the funded aged care services delivered to the individual are in the form of palliative care—the National Weighted Activity Unit (NWAU) specified for the classification level Class 1 in the table in subsection (3); or
- otherwise—the NWAU specified for the classification level Class 8 in the table in subsection (3).

The effect of subsection (2) is that for an individual with classification level Class 0, which results when the individual has not yet received an ongoing residential care classification assessment (see subsection 80-35(1) of these Rules), and who is not admitted to receive palliative care, the base rate of person-centred subsidy paid is equivalent to the amount if the individual had a Class 8 classification (see Item 8 of subsection 81-35(1)). This ensures all individuals who have not yet been classified on the basis of an ongoing residential

classification assessment receive an amount of subsidy that is equal to the average subsidy for individuals who have a classification on the basis of such an assessment.

The effect of subsection (2) is also to alternatively provide that if an individual has been admitted for palliative care with classification level Class 0 the rate of subsidy which is paid is equivalent to the subsidy amount if the individual had a Class 1 classification level (see Item 1 of subsection 81-35(1)). This ensures subsidy is paid at the Class 1 classification level, which applies when an individual enters an approved residential care home to receive palliative care, during the interim period until an assessment has evidenced Class 1 applies.

Subsection (2) replicates the substance of section 64ZC of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

General – classification levels Class 1 to Class 13 *General – classification levels Class 1 to Class 13*

Subsection (3) provides for the base rates for individuals with the classification levels Class 1 to Class 13. If neither subsection (4) nor (5) (which provide for extended hospital leave) apply to the individual, and the classification level for the individual is specified in the table in subsection (3), the base rate is the amount worked out by multiplying the national efficient price by the National Weighted Activity Unit (NWAU) specified for the classification level.

Item 1 of the table provides that if the classification level for the individual is Class 1 the NWAU is 0.73.

Item 2 of the table provides that if the classification level for the individual is Class 2 the NWAU is 0.21.

Item 3 of the table provides that if the classification level for the individual is Class 3 the NWAU is 0.40.

Item 4 of the table provides that if the classification level for the individual is Class 4 the NWAU is 0.29.

Item 5 of the table provides that if the classification level for the individual is Class 5 the NWAU is 0.43.

Item 6 of the table provides that if the classification level for the individual is Class 6 the NWAU is 0.39.

Item 7 of the table provides that if the classification level for the individual is Class 7 the NWAU is 0.54.

Item 8 of the table provides that if the classification level for the individual is Class 8 the NWAU is 0.60.

Item 9 of the table provides that if the classification level for the individual is Class 9 the NWAU is 0.53.

Item 10 of the table provides that if the classification level for the individual is Class 10 the NWAU is 0.59.

Item 11 of the table provides that if the classification level for the individual is Class 11 the NWAU is 0.68.

Item 12 of the table provides that if the classification level for the individual is Class 12 the NWAU is 0.66.

Item 13 of the table provides that if the classification level for the individual is Class 13 the NWAU is 0.73.

The base rate of person-centred subsidy reflects a core feature of the Australian National Aged Care (AN-ACC) funding model that has operated in full since October 2022, that subsidy varies with the specific characteristics of individuals receiving funded aged care services. The varying amounts are consistent with the prior research that led to the AN-ACC funding model (the University of Wollongong's *Resource Utilisation and Classification Study*, available on the department's website) that found a need for different amounts of subsidy in different circumstances to meet the care needs of individuals.

The different amounts for different classes of individuals are based on the averaged actual costs of providing residential care to individuals in the different classes. Since 2023 the NWAUs per classification level have reflected Government's consideration of annual changes in relevant care costs as advised by 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*.

Subsection (3) replicates the substance of section 64K of the Aged Care (Subsidy, Fees and Payments) Determination 2014.

Individual on extended hospital leave and day on or after 29th day of leave

Subsection (4) provides that if the individual is on extended hospital leave on the day, and the day is on or after the 29th day of the individual's leave, the base rate is nil.

Subsection (5) provides that if the individual is on extended hospital leave on the day, the base rate is nil for the day if:

- at the transition time, the individual is on extended hospital leave and the sum of the following periods (the combined period) is 29 days or more:
 - the period immediately before the transition time during which the individual was on extended hospital leave (within the meaning of the old Act);
 - the period beginning at the transition time during which the individual is on extended hospital leave; and
- the day is on or after the 29th day in the combined period.

The effect of subsections (4) and (5) is that during an extended period in which an individual is on leave in the care of a hospital the amount of residential person-centred subsidy is reduced to nil. However, the base provider amount of provider-based subsidy continues (see section 238-5 below), reflecting that while the variable costs of caring for the individual are reduced due to their absence in hospital there are fixed costs for maintaining a bed in the approved residential care home for the individual to return to at the conclusion of their episode of hospital care.

Subsections (4) and (5) replicate the substance of the classification amount of residential care basic subsidy previously provided for in subsection 64ZB(2) of the Aged Care (Subsidy, Fees and Payments) Determination 2014.

Section 229-10 – Base rates – classification type short-term

Section 229-10 provides the base rate for an individual for the classification type short term for the service group residential care for a day is the amount worked out by multiplying the national efficient price by the NWAU specified for the classification level for the individual in the table provided by section 229-10.

Item 1 of the table provides that if the classification level of the individual is Respite Class 0 the NWAU is 0.574.

Item 2 of the table provides that if the classification level of the individual is Respite Class 1 the NWAU is 0.405.

Item 3 of the table provides that if the classification level of the individual is Respite Class 2 the NWAU is 0.574.

Item 4 of the table provides that if the classification level of the individual is Respite Class 3 the NWAU is 0.714.

The note under the table at section 229-10 provides that for the maximum period of effect for a classification level for the classification type short term for the service group residential care see section 80-60 of the rules.

The base rate of person-centred subsidy reflects a core feature of the Australian National Aged Care (AN-ACC) funding model that has operated in full since October 2022, that subsidy varies with the specific characteristics of individuals receiving funded aged care services. The varying amounts are consistent with the prior research that led to the AN-ACC funding model (the University of Wollongong's *Resource Utilisation and Classification Study*, available on the department's website) that found a need for different amounts of subsidy in different circumstances to meet the care needs of individuals.

The different amounts for different classes of individuals are based on the averaged actual costs of providing residential respite care to individuals in the different classes. Since 2023 the NWAUs per classification level have reflected Government's consideration of annual changes in relevant costs as advised by 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*.

Section 229-10 replicates the substance of the classification amount of residential care basic subsidy previously provided for in section 64L of the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Subdivision B – Primary person-centred supplements

Section 230-3 – Purpose of this Subdivision

This section provides for section 230 of the Act and states that **Section 230-3 provides for the following in relation to primary person-centred supplements:**

other primary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group residential care; and

the circumstances in which the accommodation supplement, oxygen supplement and enteral feeding supplement will apply to individuals for a day; and

the amounts of the supplements.

The note under subsection 230-3 clarifies that the accommodation supplement and the hotelling supplement are primary person-centred supplements for the classification types ongoing and short-term for the service group residential care (see paragraph 230(1)(a) of the Act).

Section 230-4 – Other primary person-centred supplements

Section 230-4 prescribes other primary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group residential care.

Item 1 of the table provides that for an individual for a day for the following classification type ongoing for the service group residential care, the supplements prescribed are oxygen supplement and enteral feeding supplement.

Item 2 of the table provides that **for an individual for a day for the classification short-term for the service group residential care, the supplements prescribed are oxygen supplement and enteral feeding supplement.**

Section 230-5 – Hotelling supplement – amount

Subsection 230(2) of the Act provides that the rules may prescribe, for each primary person-centred supplement, the circumstances in which the supplement will apply and the amount of supplement.

Section 230-5 prescribes the amount of hotelling supplement as \$22.15, which applies for an individual for a day for the classification types ongoing and short term for the service group residential care (see paragraph 230-3(a) of these Rules).

Government policy is to index the amount of the hotelling supplement each year on 20 March and 20 September, to take account of general movements in costs, and as needed to adjust the amount for other changes in relevant costs as advised by 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*.

The amount of the hotelling supplement, together with other funding sources, is intended to sufficiently cover the costs of providing the residential everyday living ('hotel') services set out in section 8-145 of these Rules to individuals receiving funded aged care services for the classification types ongoing and ongoing and short-term for the service group residential care, excluding care delivered through specialist aged care programs. This also assists with the costs of employing staff for such services, which include catering, cleaning and gardening.

With respect to other funding sources, in addition to the hotelling supplement, providers receive a basic daily fee (see subsections 277(2) and (4) of the Act) which is also intended to go towards meeting the costs of providing hotel services.

The hotelling supplement aims to clearly identify the part of Commonwealth contributions paid to providers of residential care that relate to the provision of everyday living ('hotel') services, to differentiate between the provisions of these services with the provision of the residential accommodation services set out in section 8-140 of these Rules, and the residential non-clinical care and clinical care and residential clinical care services set out in sections 8-150 and 8-155 of these Rules.

A dedicated hotelling supplement also communicates the Government's expectation that the base rate of person-centred subsidy (see section 229 of the Act) and the base rate of provider-based subsidy (see section 238 of the Act) is intended to meet the costs of delivering the residential non-clinical ('personal') care services and residential clinical care services set out in sections 8-150 and 8-155 of these Rules. This includes the costs of employing and paying the wages of aged care staff to deliver that care and, in contrast to the hotelling supplement, is not intended to subsidise the costs of everyday living ('hotel') services (or of accommodation-related services for which providers may receive a separate Commonwealth contribution through the accommodation supplement (see Part 4 of Chapter 4 of the Act and section 230-10 of these Rules).

Section 230-5 replicates the substance of the hotelling supplement previously provided for in section 64ZT of the Aged Care (Subsidy, Fees and Payments) Determination 2014.

Section 230-10 – Accommodation supplement – circumstances for applicability and amount

Circumstances for applicability

Section 230-10- prescribes the circumstances for applicability for the accommodation supplement and the amount of supplement.

Subsection (1) provides that the circumstances in which accommodation supplement will apply to an individual for a day are that:

- either or both of the following apply:
 - the individual is a low means individual;
 - the fee reduction supplement applies to the individual for the day; and
- the funded aged care services delivered to the individual on the day are ongoing funded aged care services; and
- the individual is not charged, for the day, an extra service fee for or in connection with the services; and
- concessional resident supplement does not apply to the individual for the day.

Amount – general

Subsection (2) provides that the amount of accommodation supplement for the individual for the day is:

- if, for the payment period in which the day occurs, the low means resident percentage for the approved residential care home in which funded aged care services are delivered to the individual is 40% or more—the building status amount for the individual for the day; or
- otherwise—the amount worked out by reducing the building status amount for the individual for the day by 25%.

Nil amount for individuals with daily means tested amount of at least the amount under subsection (2)

Subsection (3) provides that if the daily means tested amount for the individual for the day is equal to, or more than, the amount of the accommodation supplement that would, apart from this subsection, apply under subsection (2) for the individual for the day, then the amount of the accommodation supplement for the individual for the day is nil.

Reduced amount for individuals with daily means tested amount greater than zero but less than the amount under subsection (2)

Subsection (4) provides that if the daily means tested amount for the individual for the day (the **first amount**) is greater than zero but less than the amount of the accommodation supplement (the **second amount**) that would, apart from this subsection, apply under subsection (2) for the individual for the day, then the amount of the accommodation supplement for the individual for the day is the amount equal to the difference between:

- the first amount; and
- the second amount.

Section 230-11 – Oxygen supplement – circumstances for applicability and amount

Circumstances for applicability

Section 230-11 prescribes the circumstances in which an oxygen supplement will apply to an individual and the amount of supplement.

The section provides for continuation of the oxygen supplement, which supports individuals receiving residential care who have a medical need for continual oxygen therapy. Individuals who have a long-term medical need for continuous oxygen are eligible for this supplement. The supplement is not payable for an emergency or for short-term illnesses, such as bronchitis.

Subsection (1) provides that an oxygen supplement will apply to an individual for a day if:

- on the day, the care and services plan for the individual:
 - covers the delivery of the funded aged care service nursing to the individual; and
 - includes providing oxygen to the individual using materials and equipment hired, temporarily obtained or owned by the provider; and
- a medical practitioner or a nurse practitioner has certified, in writing, that the individual has a continual need for the provision of oxygen, other than on a short term or episodic basis.

Subsection (2) provides amount of oxygen supplement is \$14.45

Section 230-11 replicates, in a less complex form, the substance of the oxygen supplement previously provided for in sections 24 to 27 of the repealed *Subsidy Principles 2014* and in section 64ZJ of the repealed *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Section 230-12 – Enteral feeding supplement—circumstances for applicability and amount

Section 230-12 prescribes the circumstances in which the enteral feeding supplement will apply to an individual and the amount of supplement.

The section provides for continuation of the enteral feeding supplement, which supports individuals receiving residential care who have a medical need for enteral feeding. Enteral feeding is where a resident gets nutrients through a tube in their nose, stomach or small intestine. The supplement is not payable for dietary formulas that are taken orally, used as food supplements, or administered in addition to food by mouth.

Subsection (1) provides that the circumstances in which enteral feeding supplement will apply to an individual for a day are that:

- on the day, the care and services plan for the individual:
 - covers the delivery of the funded aged care service meals and refreshments to the individual; and
 - includes supplying enteral supplementary dietary products to the individual; and
- a medical practitioner has certified, in writing, that the individual has a medical need for enteral feeding, other than for intermittent or supplementary enteral feeding given in addition to oral feeding.

Subsection (2) provides that the amount of enteral feeding supplement is:

- for bolus feeding—\$22.90; and
- for non-bolus feeding—\$25.71.

Section 230-12 replicates, in a less complex form, the substance of the enteral feeding supplement previously provided for in sections 28 to 31 of the repealed *Subsidy Principles 2014* and in section 64ZK of the repealed *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

Subdivision C – Accommodation supplement concepts

Section 230-13 – Meaning of *low means resident percentage* for an approved residential care home for a payment period

Section 230-13 prescribes the meaning of low means resident percentage in the context of an approved residential care home for a payment period.

This section prescribes the formula for the low means resident percentage for an approved residential care home for a payment period as follows:

$$\frac{\text{Low means resident counted days}}{\text{Total counted days}} \times 100$$

Where the following definitions apply:

counted day: a day is a **counted day** in respect of an individual in an approved residential care home if an ongoing funded aged care service is delivered to the individual through the service group residential care in the home on the day and the individual is not charged, for the day, an extra service fee for or in connection with the service.

low means resident counted days means the total number of counted days delivered in respect of low means residents in the home in the payment period.

low means resident means:

- an individual to whom the concessional resident supplement applies (see section 242B-25; or
- a supported individual; or
- a low-means individual.

total means resident counted days means the total number of counted days delivered in respect of low means residents in the home in the payment period.

total counted days means the total number of counted days in respect of individuals in the home in the payment period.

Section 230-15 – Meaning of building status amount for an individual for a day

Section 230-15 prescribes for the meaning of **building status amount** for individuals receiving funded aged care services in an approved residential care home for a day.

Subsection (1) provides that if on the day, each building in which funded aged care services are delivered to individuals in the home meets the privacy and space requirements that apply to the building under this section then the amounts are as follows:

- if the home is a newly built home or a significantly refurbished home—\$70.94; or
- if the home is not a newly built home or a significantly refurbished home—\$46.26

Subsection (1) also provides that if, on the day, each building in which funded aged care services are delivered to individuals in the home does not meet the privacy and space requirements that apply to the building under this section, then the amount is \$38.86.

Privacy and space requirements—post-end-July 1999 buildings

Subsection (2) specifies requirements for a building, or part of a building, for which plans were submitted after July 1999 to a body (including a local government body) responsible for building or development approval in the area where the building is located or proposed, for approval to construct or alter the building, or part of the building.

Subsection (3) provides that for a building to which subsection (2) applies, the privacy and space requirements are that the building must have:

- an average of no more than 1.5 individuals per room; and
- no room that may accommodate more than 2 individuals; and
- no more than 3 individuals per toilet; and
- no more than 4 individuals per shower or bath; and
- toilets, showers and baths distributed across the building to ensure equitable and ready access for all individuals.

For example, if a building has more than one wing, toilets and bathing facilities must not be restricted to one wing, or at a point in a wing where it would be difficult for residents to access them.

If the approved provider (when requested by the System Governor) can demonstrate that, having regard to the culture of those individuals, that it is not appropriate for the requirements regarding average number of persons per room and maximum of 2 individuals per room in paragraph (3)(a) to apply, then that requirement does not apply.

Pre-end-July 1999 buildings

Subsection (5) provides that for a building that had plans submitted or was built before the end of July 1999, the privacy and space requirement are as follows:

- an average of no more than 4 individuals per room (subject to sub-section (6)); and
- no more than 6 individuals per toilet; and
- no more than 7 individuals per shower or bath; and
- toilets, showers and baths distributed across the building to ensure equitable and ready access for all individuals.

For example, if a building has more than one wing, toilets and bathing facilities must not be restricted to one wing, or at a point in a wing where it would be difficult for individuals to access them.

Subsection (6) provides that if the registered provider of the home, (when requested by the System Governor), can demonstrate that it is not, having regard to the culture of those individuals, appropriate for the requirement of an average of no more than 4 individuals per room in paragraph (5)(a) to apply, then that requirement does not apply.

Working out numbers of individuals per toilet and shower

Subsection (7) sets out the calculation for working out the number of individuals per toilet and shower for the purposes of paragraphs (3)(b) and (5)(b). For post-end-July 1999 buildings, where no more than 3 individuals per toilet is mandated, and for pre-end-July 1999 building where no more than 6 individuals per toilet is mandated, the following is to be used in the calculation of the number of toilets and showers required:

- toilets, showers and baths off common areas are to be included; and
- toilets, showers and baths primarily for the use of staff are to be excluded.

Section 230-20 – Meaning of newly built home

Section 230-20 prescribes the meaning of *newly built home*. An approved residential care home is considered a newly built home if meets either of the following criteria:

- each building in which funded aged care services are delivered to individuals in the home was completed on or after 20 April 2012; or
- each building in which funded aged care services are delivered to individuals in the home was converted, on or after 20 April 2012, from one or more buildings that, before that date, were used for a purpose other than delivering funded aged care services care to individuals in an approved residential care home.

An approved residential care home is also considered newly built if the following apply:

- more than one building is used to deliver funded aged care services to individuals in the home; and
- one or more of those buildings was:
 - o completed on or after 20 April 2012; or
 - o converted, on or after 20 April 2012, from one or more buildings that, before that date, were used for a purpose other than delivering funded aged care services to individuals in an approved residential care home; and
- none of those buildings had been used, before 20 April 2012, to deliver funded aged care services to individuals in an approved residential care home.

Section 230-25 – Application for determination—approved residential care homes that have been, or are proposed to be, significantly refurbished

Section 230-25 prescribes the conditions of application for a determination that an approved residential care home has been significantly refurbished.

Subsection (1) provides that if an approved residential care home of a registered provider has been significantly refurbished, the provider may apply, in the approved form, to the System Governor for a determination in relation to the home.

Subsection (2) provides that if it is proposed that an approved residential care home of a registered provider be significantly refurbished, the provider may apply, in the approved form, to the System Governor for a determination in relation to the home.

However, subsection (3) provides that an application must not relate to more than one approved residential care home.

Section 230-30 – Determination for approved residential care homes that have been significantly refurbished

Section 230-30 prescribes rules regarding determinations that an approved residential care home is a significantly refurbished home.

Subsection (1) provides that if the System Governor receives an application in relation to an approved residential care home, the System Governor may determine, in writing, that the home is a significantly refurbished home.

The note under subsection (1) clarifies that the System Governor must not make a determination under this subsection in certain circumstances (see subsection (2) and section 230-40).

Subsection (2) provides that the System Governor must not make a determination unless the System Governor is satisfied of the matters listed under subsection (2). Further, a decision to refuse to make a determination is a reviewable decision under section 557 of the Act.

The System Governor must not make a determination unless the System Governor is satisfied of the following:

- the refurbishment was completed on or after 20 April 2012;
- the alterations, updates, upgrades or other improvements that have been made to the home have resulted in the home being significantly different in form, quality or functionality after the refurbishment;
- a significant proportion of the areas of the home that have been refurbished are areas that are accessible to, and for the use of, individuals to whom funded aged care services are being delivered in the home;
- the refurbishment provides significant benefits to low means residents to whom funded aged care services are being delivered in the home;
- the refurbishment provides significant benefits to low means residents to whom funded aged care services are being delivered in the home;
- the relevant costs of the refurbishment will be capitalised for the purposes of the Australian accounting standards because:
 - o the refurbishment consisted of structural improvements; or
 - o those costs can be depreciated because they relate to fixtures, fittings or anything that can be removed intact;
- the refurbishment:
 - o has resulted in at least 40% of the individuals to whom funded aged care services are being delivered in the home having an individual's room that has been significantly refurbished; or
 - o provides a significant benefit to at least 40% of the individuals to whom funded aged care services are being delivered in the home; or
 - o consisted of an extension to the home involving an increase of at least 25% of the number of individual's rooms in the home;
- the proportion of the total number of individual's rooms in the home that are available after the refurbishment for low means residents is equivalent to, or higher than, the proportion of the total number of individual's rooms in the home that were available before the refurbishment for low means residents;
- the refurbishment cost in relation to the home is at least the minimum monetary spend amount in relation to the home.

The note clarifies that the requirement in paragraph (2)(a) regarding the refurbishment being completed on or after 20 April 2012 is affected by subsection (3).

Subsection (3) provides that when deciding whether to be satisfied that the refurbishment was completed on or after 20 April 2012, the System Governor must take into account the following:

- if the refurbishment consisted solely of the building of a new accommodation wing—the date when the occupancy certificate (or equivalent) was issued for the new wing;
- if the refurbishment did not include the building of a new accommodation wing—the date when all work involved in the refurbishment was completed;
- if the refurbishment consisted of the building of a new accommodation wing and the refurbishment of existing parts of the home—the later of:
 - o the date when the occupancy certificate (or equivalent) was issued for the new wing; and
 - o the date when all work involved in the refurbishment was completed;
 - o Any other matter the System Governor considers to be relevant.

Section 230-35 – Determination for homes that are proposed to be significantly refurbished

Section 230-35 prescribes for requirements for determinations regarding homes that are proposed to be significantly refurbished.

Subsection (1) provides that if the System Governor receives an application in relation to an approved residential care home, the System Governor may determine, in writing, that the home is a significantly refurbished home, subject to the condition that the determination does not take effect unless:

- after the refurbishment is completed, the registered provider of the home gives the System Governor, in the approved form, and includes the required information and;
- the System Governor notifies the registered provider that the System Governor is satisfied, having regard to the information given by the registered provider, that the requirements specified in relation to the refurbished home are met.

The System Governor must not make a determination under this subsection if the relevant requirements are not met and a decision to refuse to make a decision under this section is a reviewable decision under section 557 of the Act.

Subsection (2) provides that the System Governor must not make a determination unless the System Governor is satisfied of the following:

- the proposed refurbishment includes alterations, updates, upgrades or other improvements to the home that will result in the home being significantly different in form, quality or functionality after the refurbishment;
- a significant proportion of the areas of the home that are proposed to be refurbished are areas that are accessible to, and for the use of, individuals to whom funded aged care services will be delivered in the home;
- the proposed refurbishment will provide significant benefits to low means residents to whom funded aged care services will be delivered in the home;
- the relevant costs of the proposed refurbishment will be capitalised for the purposes of the Australian accounting standards because:
 - o the proposed refurbishment will consist of structural improvements; or
 - o those costs will be able to be depreciated because they will relate to fixtures, fittings or anything that can be removed intact;
- the proposed refurbishment:

- o will result in at least 40% of the individuals to whom funded aged care services will be delivered in the home having an individual's room that has been significantly refurbished; or
 - o will provide a significant benefit to at least 40% of the individuals to whom funded aged care services will be delivered in the home; or
 - o will consist of an extension to the home involving an increase of at least 25% of the number of individual's rooms in the home;
- the proportion of the total number of individual's rooms in the home that will be available after the proposed refurbishment for low means residents will be equivalent to, or higher than, the proportion of the total number of individual's rooms in the home that were available before the proposed refurbishment for low means residents;
- the refurbishment cost in relation to the home will be at least the minimum monetary spend amount in relation to the home.

Subsection (3) prescribes the information about the refurbished home that the registered provider must give the System Governor under this section is information showing the following:

- the proposed refurbishment has been completed;
- the alterations, updates, upgrades or other improvements that have been made to the home have resulted in the home being significantly different in form, quality or functionality after the refurbishment;
- a significant proportion of the areas of the home that have been refurbished are areas that are accessible to, and for the use of, individuals to whom funded aged care services are being delivered in the home;
- the refurbishment provides significant benefits to low means residents to whom funded aged care services are being delivered in the home;
- the relevant costs of the refurbishment will be capitalised for the purposes of the Australian accounting standards because:
 - o the refurbishment consisted of structural improvements; or
 - o those costs can be depreciated because they relate to fixtures, fittings or anything that can be removed intact;
- the refurbishment:
 - o has resulted in at least 40% of the individuals to whom funded aged care services are being delivered in the home having an individual's room that has been significantly refurbished; or
 - o provides a significant benefit to at least 40% of the individuals to whom funded aged care services are being delivered in the home; or
 - o consisted of an extension to the home involving an increase of at least 25% of the number of individual's rooms in the home;
- the proportion of the total number of individual's rooms in the home that are available after the refurbishment for low means residents is equivalent to, or higher than, the proportion of the total number of individual's rooms in the home that were available before the refurbishment for low means residents;
- the refurbishment cost in relation to the home is at least the minimum monetary spend amount in relation to the home.

Subsection (4) provides that if the System Governor needs further information to decide whether to be satisfied in relation to the refurbished home, the System Governor may give the registered provider a notice requesting the registered provider to give the further information within 28 days after receiving the notice.

Subsection (5) provides that the System Governor must, within 28 days after receiving information from the registered provider in relation to the refurbished home do the following:

- decide whether, having regard to the information, the System Governor is satisfied in relation to the refurbished home; and
- notify the registered provider, in writing, of the System Governor's decision

A decision that the System Governor is not satisfied in relation to the refurbished home is a reviewable decision under section 557 of the Act.

Subsection (6) provides that if the System Governor requests further information, the 28-day period referred to above does not include the period beginning on the day the request was made and ending on the day the information was received.

Subsection (7) provides that if the System Governor is satisfied in relation to the refurbished home, the notice given in relation to the refurbished home, the notice given under paragraph (5)(b) must specify the date on which the determination by the System Governor is to take effect.

Section 230-40 – Circumstances in which System Governor must not make determinations

Section 230-40 prescribes that the System Governor must not make a determination in relation to an approved residential care home if the refurbishment of the home consisted, or the proposed refurbishment of the home will consist, only of:

- routine repairs; or
- maintenance of premises (such as painting, plumbing, electrical work or gardening); or
- replacement of furniture; or
- fire safety improvements.

Section 230-45 – Notification of System Governor's decision

Section 230-45 prescribes that the System Governor must notify, in writing, the applicant for a determination of the System Governor's decision on whether to make the determination.

Subsection (2) provides that if the decision relates to an application in relation to an approved residential care home that has been significantly refurbished; and the decision is to make the determination, then the notice must state the day on which the determination takes effect.

However, subsection (3) provides that if the decision relates to an application in relation to an approved residential care home that is proposed to be significantly refurbished; and the decision is to make the determination, then the notice must include a statement setting out the **conditions regarding refurbished and significantly refurbished homes (listed above).**

Section 230-50 – Day of effect of determination

Section 230-50 prescribes that a determination in relation to an approved residential care home that has been significantly refurbished takes effect on the day the application has been received.

Subsection (2) provides that a determination relating to an approved residential care home that is proposed to be significantly refurbished takes effect on the day the System Governor receives the information about the refurbished home.

Subdivision D—Secondary person-centred supplements

Section 231-5 – Purpose of this Subdivision

For the purposes of section 231 of the Aged Care Act (2024), section 231-5 prescribes for the following:

- Other secondary person-centred supplements for an individual for a day for the classification types ongoing and short-term for the service group residential care
- The circumstances in which secondary person-centred supplements will apply to individuals for a day
- the amounts of the supplements
- that the fee reduction supplement reduces certain fees, payments and contributions, and the method for those reductions

The note under **section 231-5 clarifies that the fee reduction supplement is a secondary person-centred supplement for the classification types ongoing and short-term for the service group residential care (see paragraph 231(1)(a) of the Act).**

Section 231-10 – Other secondary person-centred supplements

Section 231-10 sets out other secondary person-centred supplements for an individual or a day for the classification types ongoing and short-term for the service group residential care.

Item 1 of the table provides that for an individual for a day for the classification type ongoing for the service group residential care the supplements are the following:

- initial entry adjustment supplement
- veterans' supplement

Item 2 of the table provides that for an individual for a day for the classification type short-term for the service group residential care the supplements are the following:

- respite supplement
- veterans' supplement

Section 231-15 – Fee reduction supplement—circumstances for applicability, amount and reduction of fees and contributions—residential care fee reduction supplement determinations (financial hardship)

Circumstances for applicability of fee reduction supplement

Section 231-15 prescribes for the circumstances for applicability in relation to the fee reduction supplements and the amount of supplement.

Subsection (1) provides that the circumstances in which the fee reduction supplement will apply to an individual for a day are as follows.

- An income determination is in effect for the individual for the day; and
- An asset determination is in effect for the individual for the day; and
- On the day, the individual does not have means not disclosed status.

In addition, an individual is eligible for the fee reduction supplement if the value of the individual's assets, worked out in accordance with section 330 of the Act and reduced by the value of any unrealisable assets of the individual, is not more than 1.5 times the sum of the annual amount of the following:

- the maximum basic rate under point 1064-B1 of Module B of Pension Rate Calculator A that applies to a person who is not a member of a couple
- the pension supplement amount under point 1064-BA3 of Module BA of Pension Rate Calculator A that applies to a person who is not a member of a couple
- the energy supplement amount under point 1064-C3 of Module C of Pension Rate Calculator A that applies to a person who is not a member of a couple

Further, the individual must not have gifted more than \$10,000 in the current financial year or in any of the previous 4 financial years and the individual has not gifted more than \$30,000 in the period comprising the current financial year and the previous 4 financial years.

Finally, on the day, a residential care fee reduction supplement determination must be in effect for the individual. The individual's daily remaining income amount for the day, as determined in the residential care fee reduction supplement determination, is less than the fee reduction supplement daily threshold amount for the day.

Amount of fee reduction supplement

Subsection (2) provides that the amount of the fee reduction supplement for an individual to whom the supplement applies for the day is the amount equal to the difference between:

- the fee reduction supplement daily threshold amount for the day; and
- the individual's daily remaining income amount for the day, as determined in the residential care fee reduction supplement determination that is in effect for the individual on the day.

Fee reduction supplement reduces unreduced daily amount of the resident contribution

Subsection (3) provides that the amount of the fee reduction supplement for a day for the individual reduces the amounts worked out under each of Steps 1, 3 and 4 of the method statement in subsection 277(1) of the Act in accordance with section 231-25.

Section 231-16 – Applications for residential care fee reduction supplement determinations

This section provides that an individual may apply to the System Governor for a residential care fee reduction supplement determination for the individual. The application must be in the approved form.

The note under section 231-16 clarifies that there are penalties for knowingly providing false or misleading information or documents in applications, see section 591 of the Act and Part 7.4 of the Criminal Code.

Section 231-17 – Residential care fee reduction supplement determinations

Subsection (1) provides that the System Governor must, within 28 days from receiving an application in accordance with section 231-16, determine:

- the following for a particular day:
 - the individual's daily total essential expenses;
 - the individual's daily remaining income amount;
 - the individual's unreduced daily amount of the resident contribution;
 - the individual's reduced daily amount of the resident contribution; and
- the day the determination takes effect; and
- the period for which the determination is in effect.

The note under subsection (1) refers to section 588 of the Act (which allows the System Governor to request further information, and provides for the consequence of not giving any requested further information in the requested time, and the extension of the decision making period if requested information is given in the requested time).

Subsection (2) provides that for the purposes of determining the day the determination takes effect:

- unless paragraph (b) applies—the System Governor must determine that the determination takes effect on the day the application was made; or
- the System Governor must determine that the determination takes effect on a day that is earlier than the day the application was made, if:
 - the individual's application includes a request for the determination to take effect on an earlier day because the individual was experiencing financial hardship on and after the earlier day, and evidence of that financial hardship; and
 - the System Governor is satisfied that the individual was experiencing financial hardship on and after the earlier day.

Essential expenses

Subsection (3) provides a non-exhaustive list of expenses that the System Governor may determine to be essential expenses in relation to an individual. These include:

- unreduced daily amounts of the resident contribution, and other fees and contributions payable by the individual under Division 2 of Part 3 of Chapter 4 of the Act, other than the higher everyday living fee under section 284 of the Act;
- accommodation payment or accommodation contribution;
- if the individual's partner (if any) or a dependent child of the individual lives at the individual's principal home—rent or mortgage payments for the principal home;
- any of the following that are not already covered by other government schemes or programs or by private health insurance:
 - medical expenses, including expenses incurred under the direction of a registered health practitioner or allied health professional;

- dental care;
- prescription glasses (one pair per year) or contact lenses;
- wheelchair and mobility aids;
- transport costs to attend medical appointments;
- ambulance cover;
- private health insurance;
- if the individual is paying a funeral plan on a periodic basis—the funeral plan;

However, essential expenses do not include amounts that are spent by another person, who is authorised to act on the individual's behalf, other than for the benefit of the individual.

Subsection (4) provides that the individual's daily total essential expenses is the amount that is the individual's total essential expenses, worked out on a per day basis.

Subsection (5) provides that the individual's daily remaining income amount for a day is worked out by subtracting the individual's daily total essential expenses for the day from the individual's total assessable income, as determined in the income determination that is in effect for the individual (worked out on a per day basis) on the day.

Subsection (6) provides that the individual's unreduced daily amount of the resident contribution for a day is the amount that would be the amount of the maximum daily amount of the resident contribution payable by the individual for the day if subsection 277(4) of the Act were disregarded. Section 277(4) of the Act sets out how which fees and contributions the fee reduction supplement reduces and in what order. Disregarding the application of this subsection is how the rules achieve the unreduced daily amount of resident contribution.

Subsection (7) provides that the individual's reduced daily amount of the resident contribution for a day is the amount of the maximum daily amount of the resident contribution payable by the individual for the day after applying subsection 277(4) of the Act. Subsection 277(4) of the Act applies the fee reduction supplement to the individual's fees or contributions.

Section 231-18 – Notice of residential care fee reduction supplement determinations

Subsection (1) provides that the System Governor must, within 14 days after making a residential care fee reduction supplement determination for an individual, give written notice of the determination to the individual.

Subsection (2) provides the requirements for the notice. The notice must include:

- each of the matters determined in the determination; and
- the reasons for the following decisions:
 - the determination of the individual's daily total essential expenses;
 - the day the determination takes effect;
 - the period for which the determination is in effect; and
- how the individual may apply for reconsideration of those decisions; and
- a statement of the effect of section 231-19.

Section 231-19 – Varying or revoking residential care fee reduction supplement determinations – general

Subsection (1) provides that the System Governor may vary or revoke a residential care fee reduction supplement determination for an individual:

- if the System Governor has been notified of the occurrence of an event or a change in the individual's circumstances under Subdivision D of Division 2 of Part 5 of Chapter 4 of the Act (see also sections 336-5 and 337-5 of this instrument); or
- if an income determination or asset determination in relation to the individual is made, varied or revoked; or
- if the individual has means not disclosed status under section 320 of the Act; or
- on the System Governor's own initiative (see section 231-21 of this instrument).

Subsection (2) provides that the residential care fee reduction supplement determination may be varied or revoked if the System Governor is satisfied that the determination is incorrect.

Effect of decision

Subsection (3) provides that if a residential care fee reduction supplement determination is varied or revoked, the variation or revocation takes effect on the day specified by the System Governor in the notice under section 231-22.

Subsection (4) provides that the day specified may be before the day the notice is given but must not be earlier than the day the circumstances that are the reason for the variation or revocation occurred.

Section 231-20 – Varying or revoking residential care fee reduction supplement determinations—on notification of event or change in circumstances

Section 231-20 provides for the variation or revocation of the residential care fee reduction supplement determination if the System Governor has been notified of the occurrence of an event or change in the individual's circumstances under Subdivision D of Division 2 of Part 5 of Chapter 4 of the Act.

Subsection (2) provides that the System Governor must decide, within 28 days from the day the notification is made, whether to vary or revoke the residential care fee reduction supplement determination in effect for the individual.

Subsection (3) provides that the System Governor may, by written notice, request the individual to give the System Governor further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to vary or revoke the residential care fee reduction supplement determination. The individual is not obliged to give the information.

Subsection (4) provides that the System Governor may, at the request of the individual, extend the specified period.

Section 231-21 – Varying or revoking residential care fee reduction supplement determinations—on System Governor’s initiative

Notice before variation or revocation

Subsection (1) provides that before the System Governor varies or revokes a residential care fee reduction supplement determination on the System Governor’s own initiative, the System Governor must give the individual written notice that the System Governor is considering varying or revoking the determination.

Subsection (2) provides the requirements for the notice. The notice must:

- set out the reasons why the System Governor is considering varying or revoking the determination, and what the effect of the variation or revocation would be; and
- invite the individual to make a submission, in writing, to the System Governor in relation to the matter within the period specified in the notice (which must not be less than 28 days after giving the notice); and
- inform the individual that the System Governor may decide to vary or revoke the determination:
 - if no submission is made within the specified period; or
 - after considering any submission made by the individual within the specified period.

Request for further information

Subsection (3) provides that the System Governor may also request, in the notice given under subsection (1), that the individual give the System Governor the information specified in the notice, within the period specified in the notice for the purposes of paragraph (2)(b), to assist the System Governor to decide whether to vary or revoke the determination. The individual is not obliged to give the information.

Subsection (4) provides that if the individual makes a submission in accordance with the invitation under paragraph (2)(b), the System Governor may, by written notice, request the individual to give the System Governor further information, within the period specified in the notice (which must not be less than 28 days after giving the notice), to assist the System Governor to decide whether to vary or revoke the determination.

The notes under subsection (4) clarify that The System Governor may request further information under this subsection regardless of whether information was requested or given under subsection (3). The individual is also not obliged to give the information.

Subsection (5) provides that the System Governor may, at the request of the individual, extend the period specified for paragraph (2)(b) or subsection (4).

Deciding whether to vary or revoke fee reduction supplement determination

Subsection (6) provides that the System Governor must consider any submission made in accordance with the invitation under paragraph (2)(b) and any further information given in accordance with a request under subsections (3) or (4).

If no submission is made, the System Governor must also decide whether to vary or revoke the determination within 28 days from the end of the period specified in the notice (including that period as extended (if applicable) under subsection (5)).

If a submission is made and no further information is requested, the System Governor must decide whether to vary or revoke the determination within 28 days from the day the submission is made.

If a submission is made and further information is requested, the System Governor must decide whether to vary or revoke the determination within 28 days from the day the individual gives the System Governor the further information.

Section 231-22 – Notice of decision to vary or revoke residential care fee reduction supplement determination

Notice requirements

Subsection (1) provides that the System Governor must give an individual written notice of a decision under subsection 231-19(1) to vary or revoke a residential care fee reduction supplement determination for the individual within 14 days after making the decision.

Subsection (2) provides the requirements of the notice. The notice must:

- state that the individual is required to notify the System Governor of any events or changes in the individual's circumstances in accordance with Subdivision D of Division 2 of Part 5 of Chapter 4 of the Act; and
- if the decision is to vary the residential care fee reduction supplement determination:
 - include details of the variation (including specifying the amounts determined to be the individual's fortnightly total income amount and fortnightly total essential expenses); and
 - specify the day the variation takes effect (see subsection 231-19(3)); and
- if the decision is to revoke the residential care fee reduction supplement determination:
 - explain the consequences of the revocation of the determination; and
 - specify the day the determination ceases to be in force (see subsection 231-19(3)); and
- set out the reasons for the following decisions:
 - varying or revoking the determination under subsection 231-19(1);
 - day the variation or revocation takes effect under subsection 231-19(3); and
- state how the individual may apply for reconsideration of the decision under subsection 231-19(1).

Section 231-25 – Fee reduction supplement – reduction of fees, payments and contributions

Section 231-25 of the Act provides that the fee reduction supplement for the individual reduces (but not below zero) the following contributions for the individual, in the following order:

- basic daily fee;
- hotelling contribution;

- non clinical care contribution;
- if the individual is
 - in the pre-2014 accommodation class – accommodation bond or accommodation charge (as applicable); or
 - otherwise – accommodation payment or accommodation contribution (as applicable)

Section 231-30 – Respite supplement – circumstances for applicability and amount

Section 231-30 prescribes for the circumstances for applicability for the respite supplement and the amount of supplement.

Circumstances for applicability

Subsection (1) provides that the circumstances in which respite supplement will apply to an individual for a day are that, on the day, the funded aged care services delivered to the individual are short-term funded aged care services and a classification level for the classification type short-term for the service group residential care is in effect for the individual.

The amount of respite supplement is the building status amount for the individual for the day.

The effect of section 231-30 is that individuals receiving short-term residential care will, while receiving that care, receive a respite supplement that is equal to the maximum amount of the accommodation supplement (see section 230-10 and related sections of these Rules).

Taken with other elements of how short-term residential care is funded, including through the base rate of person-centred subsidy (see section 229-10) and the base rate of provider based subsidy (see section 238-5), a provider will receive, in net, very similar amounts of subsidy for providing care to an individual receiving short-term residential care as for providing ongoing residential care to an individual with similar personal characteristics. This aligns the funding arrangements for individuals receiving short-term residential care and ongoing residential care with the aim of encouraging providers of residential care to offer both types of care. Section 231-30 replicates the substance of the respite supplement previously provided for in section 64ZI of the Aged Care (Subsidy, Fees and Payments) Determination 2014.

Section 231-35 – Initial entry adjustment supplement – circumstances for applicability and amount

Section 231-35 prescribes the circumstances for applicability for the initial entry adjustment supplement and the amount of supplement.

Circumstances for applicability

Subsection (1) provides the circumstances in which initial entry adjustment supplement will apply to an individual for a day are that it is the individual's start day for the classification type ongoing for the service group residential care.

Amount

Subsection (2) provides that the amount of initial entry adjustment supplement is the amount of the national efficient price multiplied by 5.28. The initial entry adjustment supplement recognises the temporary additional costs of settling a new individual into ongoing residential care at an approved residential care home and provides for a one-off payment for the entry of a new resident into non-respite residential care calculated at 5.28 times the current national efficient price. Section 231-35 replicates the substance of the initial entry adjustment supplement previously provided for in section 64ZS of the Aged Care (Subsidy, Fees and Payments) Determination 2014.

Section 231-50 – Veterans’ supplement – circumstances for applicability and amount

Section 231-50 prescribes the circumstances for the applicability of the veteran’ supplement and the amount of supplement.

The section continues availability of a veterans’ supplement for residential care to providers who provide residential care for veterans with service-related mental health conditions. The supplement is designed to ensure a veteran’s mental health condition does not act as a barrier to accessing appropriate care.

Circumstances for applicability

The circumstances in which veterans’ supplement will apply to an individual for a day are that:

- The individual is a veteran with an accepted mental health condition
- the individual has, before, on or after that day, authorised either or both of the following to disclose to a registered provider that the individual is a veteran with an accepted mental health condition
 - o the Secretary of the Department administered by the Minister administering the Veterans’ Entitlements Act
 - o the Secretary of the Department administered by the Minister administering the *Human Services (Centrelink) Act 1997*.

The effect is that the supplement is applicable to any veteran who is receiving Commonwealth-subsidised residential care through an approved provider who has an accepted mental health condition related to their service. There is no need for eligible veterans to apply or undergo an assessment for the supplement to be paid. War widow(er)s and dependants are not eligible for the supplement.

For clarity, for the supplement to be applicable a veteran or their nominated representative must have consented to certain information being disclosed to Services Australia and their provider of residential care.

Amount

The amount of veteran’s supplement is \$8.18.

Section 238-5 replicates the substance of section 68 of the repealed ***Subsidy Principles 2014*** and section 64ZR of the repealed ***Aged Care (Subsidy, Fees and Payments) Determination 2014***.

Division 2—Provider-based subsidy

Subdivision A—Base provider amount

Subdivision A deals with base provider amount for an individual receiving funded aged care services as ongoing or short-term residential care for a day. The base provider amount is an amount of subsidy that is determined by the specific characteristics of the approved residential care home where the individual receives care.

The base provider amount is a core feature of the Australian National Aged Care Classification (AN-ACC) funding model, which has operated in full operation since October 2022. Similar to the base amount of person-centred subsidy (see sections 229-5 and 229-10), the base provider amount varies depending on the specific characteristics of approved residential care homes, reflecting research that different amounts of subsidy are needed to meet the costs of delivering that meets the care needs of individuals.

Characteristics of approved residential care homes that result in different subsidy rates include geographic location, number of operational beds (see subsection 238-5(2)) and whether a home has specialised homeless status or specialised ATSI status (see section 243 of the Act and related sections in these Rules).

Section 238-5 – Base provider amount

This section specifies that the base provider amount for an individual for a day is the amount worked out in accordance with what is specified in column 2 of the relevant item in a table, provided that:

- the individual is provided with residential care funded aged care services on a day through an approved residential care home; and
- on the day, the home also meets the requirements set out in column 1 of an item of the table.

Item 1 of the table provides that for a registered provider delivering funded aged care services in an approved residential care home which has specialised Aboriginal or Torres Strait Islander status and, is located in the 2023 MM category known as MM 7, the amount is the amount worked out using the formula in subsection (2) if it were assumed that the National Weighted Activity Unit (NWAU) were 1.80.

Item 2 of the table provides that for a registered provider delivering funded aged care services in an approved residential care home which has specialised Aboriginal or Torres Strait Islander status and is located in the 2023 MM category known as MM 6, the amount is the amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.78.

Item 3 of the table provides that for a registered provider delivering funded aged care services in an approved residential care home that:

- does not have specialised status;
- is located in the 2023 Modified Monash (MM) category MM 6 or MM 7;
- the number of operational beds in respect of the home is less than 30;

the amount is the amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.68.

Item 4 of the table provides that for a registered provider delivering funded aged care services in an approved residential care home that:

- does not have specialised status
- is located in the 2023 MM category MM 6 or MM 7;
- the number of operational beds in respect of the home is 30 or more;

the amount is sum of the following amounts:

- the amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.68 and that the number of operational beds were 29;
- the amount worked out using the formula in subsection (2) if it were assumed that the NWAU were 0.52 and that the number of operational beds were reduced by 29.

Item 5 of the table provides that for a registered provider delivering funded aged care services in an approved residential care home that:

- does not have specialised status; and
- is located in the 2023 MM category MM 4 or MM 5;

The amount is the amount worked out by multiplying the national efficient prices by the NWAU of 0.58.

Item 6 provides that for a registered provider delivering funded aged care services in an approved residential care home that has specialised homeless status, the amount is the amount worked out by multiplying the national efficient price by the NWAU of 0.92.

Item 7 provides that for a registered provider delivering funded aged care services in an approved residential care home that does not have specialised status and is located in the 2023 MM category MM 2 or MM 3, the amount is the amount worked out by multiplying the national efficient price by the NWAU of 0.53.

Item 8 provides that for a registered provider delivering funded aged care services in an approved residential care home that does not have specialised status and is located in the 2023 MM Category MM 1, the amount is the amount worked out by multiplying the national efficient price by the NWAU of 0.50 for a day before 1 April 2026 and 0.387 NWAU for a day on or after 1 April 2026.

With respect to item 8, the net effect of this amendment and the introduction from 1 April 2026 of a *care minutes supplement* with a maximum value of 0.113 NWAU will be that from 1 April 2026 an approved provider of non-specialised approved residential care home in a metropolitan area will continue to receive funding of 0.5 multiplied by the national efficient price per individual per day if fully meeting their care minutes responsibilities at the home (see also sections 239-30 and 239-35).

The overall effect is that for those approved residential care homes that meet the requirements of items 5 to 8 of the table in subsection 238-5(1) the base provider amount per individual per day is the amount worked out by multiplying the national efficient price by the relevant NWAU.

Subsection 238-5(2) specifies that for those approved residential care homes with a 2023 MM 6 (remote) or 2023 MM 7 (very remote) street address (that is, that meet the

requirements in items 1 to 4 of the table in subsection 238-5(1)), the base provider amount is calculated through the following formula:

$$\text{National efficient price} \times \text{NWAU} \times \left(\frac{\text{Operational beds}}{\text{Occupied beds}} \right)$$

Operational beds and occupied beds are defined in section 5-5 definitions of these Rules.

The effect is that a registered provider of such an approved residential care homes effectively receives subsidy that varies with the national efficient price, NWAU and the number of “operational beds” at the home – whether or not those “operational beds” are occupied by an individual (subject, however, to otherwise meeting the general requirements to be eligible for subsidy).

For each day, this funding is then split out across the individuals in such an approved residential care home who attract subsidy by dividing the amount by the number of “occupied beds” to create a per-individual subsidy amount.

The overall effect is to exclude from the count of operational beds those beds through which a provider cannot offer subsidised care to individuals. This ensures that the base provider amount is only paid in respect of the beds for which the provider has the actual potential to provide care.

This section replicates the substance of the service amount of residential care basic subsidy previously provided for in section 64M of the repealed Aged Care (Subsidy, Fees and Payments) Determination 2014.

Subdivision B – Provider based supplements

Section 239-1 – Purpose of this Subdivision

This section provides that, for the purpose of section 239 of the Act, this Subdivision prescribes:

- provider based supplements for an individual for the classification types ongoing and short term for the service group residential care for a day; and
- the circumstances in which the supplements will apply in relation to individuals; and
- the amounts of the supplements.

Section 239-5 – Provider-based supplements

This section prescribes the registered nurse supplement and the care minutes supplement are prescribed for the classification types ongoing and short-term for the service group residential care.

Section 239-10 – Registered nurse supplement—applicability

This section prescribes the circumstances in which registered nurse supplement will apply in relation to an individual for a day are that funded aged care services are delivered to the individual in a qualifying residential care home for the payment period **in which the day occurs**.

The registered nurse supplement aims to support providers of residential care to provide registered nurse care to individuals. This will assist providers in meeting their obligation under subsection 175(2) of the Act to ensure that, at all times, there is at least one registered nurse (within the meaning of the *Health Insurance Act 1973*) on site, and on duty, at each approved residential care home through which the provider provides residential care (the 24/7 RN obligation).

The registered nurse supplement recognises that meeting the 24/7 RN obligation may be more difficult for a provider who is operating an approved residential care home that, on average, has few individuals receiving care and so receives small amounts of subsidy that can be used to employ sufficient registered nurses to meet the 24/7 RN obligation.

Section 239-15 – Meaning of qualifying residential care home

Section 239-15 prescribes for the meaning of *qualifying residential care home*.

Subsection (1) provides that an approved residential care home is a *qualifying residential care home* for a payment period if it is a group A residential care home for the payment period or a group B residential care home for the payment period.

Subsection (2) provides that an approved residential care home is a *group A residential care home* for a payment period if all of the following criteria are met:

- an exemption from the 24/7 RN obligation in relation to the home is not in force at any time during the period;
- a report in relation to the home and the period has been submitted in accordance with section 166-855 of the rules;
- the total number of days of eligible residential funded aged care services delivered in respect of individuals at the approved residential care home during the period, divided by the number of days in the period, is no more than 50;
- the total number of hours, on days during the period on which funded aged care services were delivered at the home, that a registered nurse was not on site and on duty at the home is no more than the number of such days in the period multiplied by 3.

For the purposes of paragraph (2)(a) of the rules, evidence that may be relied on to determine whether an exemption from the 24/7 RN obligation is in force in relation to an approved residential care home of an approved provider includes:

- whether the System Governor has granted an exemption from the 24/7 RN obligation under section 175-25 of the rules; and
- whether the System Governor has revoked a provider's exemption from the 24/7 RN obligation under section 175-45 or 175-50 of the rules.

For the purposes of paragraph (2)(b) of the rules, the specified report is in relation to registered nurses at approved residential care homes in accordance with section 166-855 of this instrument.

For the purposes of paragraph (2)(c), days of eligible residential funded aged care services delivered in respect of individuals at the home is determined in accordance with section 239-20, and the total number of days of eligible residential care provided in respect of individual at the home during the period, divided by the number of days in the period, must be no more than 50.

The criteria in paragraph (2)(c) is consistent with the Government's intention to provide providers with additional funding support for the provision of registered nurse care at approved residential care homes through which residential care is, on average, provided to a small number of individuals and so where the costs per individual of achieving 24/7 RN coverage are subsequently higher.

The policy intention of these criteria is that, on average, over the days during a payment period on which residential care was provided at the home, at least 21 hours a day of registered nurse coverage is provided. In determining whether a home meets the criteria in paragraph (2)(d), the evidence that may be relied upon includes data in the report referenced in section 166-855 of the rules that is included in, or is required to be included in, the report as required.

Subsection (3) provides that an approved residential care home is a ***group B residential care home*** for a payment period if all of the following criteria are met:

- an exemption from the 24/7 RN obligation through subsection 175(1) of the Act in relation to the home is not in force at any time during the period;
- a report in relation to the home and the period has been submitted in accordance with section 166-855 of the rules;
- the total number of days of eligible residential funded aged care services delivered in respect of individuals at the approved residential care home during the period, divided by the number of days in the period, is no more than 30;
- the total number of hours, on days during the period on which funded aged care services were delivered at the home, that a registered nurse was not on site and on duty at the home is more than the number of such days in the period multiplied by 3 and no more than the number of such days in the period multiplied by 12.

For the purposes of paragraph (3)(a), evidence that may be relied on to determine whether an exemption from the 24/7 RN obligation is in force in relation to an approved residential care home of an approved provider includes:

- whether the System Governor has granted an exemption from the 24/7 RN obligation under section 175-25 of the rules; and
- whether the System Governor has revoked a provider's exemption from the 24/7 RN obligation under section 175-45 or 175-50 of the rules.

For the purposes of paragraph (3)(b), the specified report is in relation to registered nurses at approved residential care homes in accordance with section 166-805 of this instrument.

For the purposes of paragraph (3)(c), days of eligible residential funded aged care services delivered in respect of individuals at the home is determined in accordance with section 239-20 of the rules, and the total number of days of eligible residential care provided in respect of individuals at the home during the period, divided by the number of days in the period, must be no more than 30.

The criteria in paragraph (3)(c) is consistent with the Government's intention to provide providers with additional funding support for the provision of registered nurse care at approved residential care homes through which residential care is, on average, provided to a small number of individuals and so where the costs per individual of achieving 24/7 registered nurse coverage are subsequently higher.

The policy intention of these criteria is that, on average, over the days during a payment period on which residential care was provided at the home, at least 12 to less than 21 hours a day of registered nurse coverage is provided. In determining whether a home meets the criteria in paragraph (2)(d), the evidence that may be relied upon includes data in the report referenced in section 166-855 of the rules that is included in, or is required to be included in, the report as required.

Subsection (4) provides that a *day of eligible residential funded aged care services* is delivered in respect of an individual if a registered provider is eligible for provider-based subsidy for an ongoing or short-term funded aged care service delivered by the registered provider to the individual in an approved residential care home on the day.

The effect of distinguishing between group A and group B homes is to create a framework for differently supporting improved registered nurse coverage between homes with few individuals receiving care (group A, on average 50 or fewer individuals per day during a payment period) and very few individuals receiving care (group B, on average 30 or fewer individuals per day during a payment period), who may otherwise seek an exemption altogether from the 24/7 RN obligation.

Group A residential care home and group B residential care home criteria are mutually exclusive, so that an approved residential care home cannot be both at the same time. For example, an approved residential care home with 30 or fewer individuals per day, on average, during a payment period that satisfies all other group A approved residential care home criteria will qualify only as a group A residential care home, not as both a group A residential care home and a group B residential care home.

Section 239-15 replicates the substance of provisions for eligibility for registered nurse supplement previously provided for in sections 70AK, 70AL and 70AM of the Subsidy Principles 2014.

Section 239-20 – Registered nurse supplement—amount

Section 239-20 prescribes for the amount of registered nurse supplement, for the purposes of paragraph 239(2)(b) of the Act.

Subsection (1) provides that the amount is worked out through a formula and is as follows:

$$\frac{\text{Residential care home supplement amount}}{\text{Total residential care home days}}$$

Subsection (1) defines ***residential care home supplement amount*** as the residential care home supplement amount for the payment period, determined under subsections (2) to (9), for the approved residential care home in which funded aged care services are delivered to the individual.

Subsection (1) also defines ***total residential care home days*** as the total number of days of eligible residential funded aged care services delivered in respect of individuals during the payment period in that approved residential care home.

The effect of this section is that the amount of the registered nurse supplement is the same for each day of eligible residential funded aged care services an individual at a given approved residential care home receives at that home during a particular payment period. However, the calculated amount for a day at that home may vary between payment periods as the output of the calculation that produces the amount varies between payment periods. In other words, the supplement amount is the same for each day of a particular payment period in respect of each day of eligible residential care provided at a given residential care service, but the supplement amount may vary between each payment period.

The amount of registered nurse supplement payable in respect of a group A or group B qualifying residential care home for a payment period takes into account certain characteristics of the qualifying home.

The characteristics taken into account include the location of the home (using 2023 Modified Monash Model categories) and the average daily care count of the facility (that is, the average number of individuals receiving care each day at the home during the payment period). This is consistent with the policy intent to vary the amount of subsidy for approved providers for the provision of registered nurse care depending on where the home is located and to how many individuals care is provided, on average, during a payment period.

'Modified Monash Model' and 'MM category' have the same meanings as in section 5-5, Definitions, of this instrument. Modified Monash Model means the 2023 model developed by the Department to categorise areas according to geographical remoteness and population size, as the model existed on 13 April 2025. MM Category means a category for an area provided for by the Modified Monash Model and known as MM 1, MM 2, MM 3, MM 4, MM 5, MM 6 or MM 7.

As a further incentive to providers operating qualifying residential care homes to increase registered nurse coverage, a group B qualifying residential care home with the same average number of individuals per day over a payment period as a group A residential care home will receive a lesser amount of registered nurse supplement than that group A residential care home.

For example, a group B residential care home with a street address in the 2023 Modified Monash (MM) category MM 6 or MM 7 with between 25 to 30 individuals per day over a payment period will receive \$9,033 in registered nurse supplement. A group A residential care home located in the same MM category with the same number of individuals per day over the payment period will receive \$18,065 in registered nurse supplement (see section 239-20).

Residential care home supplement amount – group A residential care homes in 2023 MM category MM 1

Subsection (2) provides the residential care home supplement amount for a payment period, for a group A residential care home located in the 2023 MM category MM 1, are the following amounts for the average daily care count for the home for the period:

- If the average daily care count is less than or equal to 20, the residential care home supplement amount is \$28,786
- If the average daily care count is more than 20 but less than or equal to 25 the residential care home supplement amount is \$25,667
- If the average daily care count is more than 25 but less than or equal to 30 the residential care home supplement amount is \$14,009
- If the average daily care count is more than 30 but less than or equal to 35 the residential care home supplement amount is \$11,370
- If the average daily care count is more than 35 but less than or equal to 40 the residential care home supplement amount is \$8,732,
- If the average daily care count is more than 40 but less than or equal to 45 the residential care home supplement amount is \$6,093
- If the average daily care count is more than 45 but less than or equal to 50 the residential care home supplement amount is \$3,454.

Residential care home supplement amount –group A residential care homes in 2023¹⁹ MM categories MM 2 and MM 3

Subsection (3) provides that the residential care home supplement amount for a payment period, for a group A residential care home located in the 2023 MM category MM 2 or MM 3, are the following amounts for the average daily care count for the home for the period:

- If an individual's average daily care count is less than or equal to 20, the residential care home supplement amount is \$30,536
- If an individual's average daily care count is more than 20 but less than or equal to 25 the residential care home supplement amount is \$27,228
- If an individual's average daily care count is more than 25 but less than or equal to 30 the residential care home supplement amount is \$14,860
- If an individual's average daily care count is more than 30 but less than or equal to 35 the residential care home supplement amount is \$12,062
- If an individual's average daily care count is more than 35 but less than or equal to 40 the residential care home supplement amount is \$9,263
- If an individual's average daily care count is more than 40 but less than or equal to 45 the residential care home supplement amount is \$6,464
- If an individual's average daily care count is more than 45 but less than or equal to 50 the residential care home supplement amount is \$3,664.

Residential care home supplement amount—group A residential care homes in 2023 MM categories MM 4 and MM 5

Subsection (4) provides that for residential care home supplement amount – group A residential care homes in 2023 MM categories MM 4 and MM 5, the residential care home

supplement amount for a payment period, for a group A residential care home located in the 2023 MM category MM 4 or MM 5, are the following amounts for the average daily care count for the home for the period:

- If an individual's average daily care count is less than or equal to 5 the residential care home supplement amount is \$72,840
- If an individual's average daily care count is more than 5 but less than or equal to 10 the residential care home supplement amount is \$61,804
- If an individual's average daily care count is more than 10 but less than or equal to 15 the residential care home supplement amount is \$50,767
- If an individual's average daily care count is more than 15 but less than or equal to 20 the residential care home supplement amount is \$39,731
- If an individual's average daily care count is more than 20 but less than or equal to 25 the residential care home supplement amount is \$27,912
- If an individual's average daily care count is more than 25 but less than or equal to 30 the residential care home supplement amount is \$15,234
- If an individual's average daily care count is more than 30 but less than or equal to 35 the residential care home supplement amount is \$12,364
- If an individual's average daily care count is more than 35 but less than or equal to 40 the residential care home supplement amount is \$9,495
- If an individual's average daily care count is more than 40 but less than or equal to 45 the residential care home supplement amount is \$6,626
- If an individual's average daily care count is more than 45 but less than or equal to 50 the residential care home supplement amount is \$3,756.

Residential care home supplement amount—group A residential care homes in 2023 MM categories MM 6 and MM 7

Subsection (5) provides that for residential care home supplement amount – group A residential care homes in 2023 MM categories MM 6 and MM 7 the residential care home supplement amount for a payment period, for a group A residential care home located in the 2023 MM category MM 6 or MM 7, the amounts are as follows, for the average daily care count for the home for the period:

- If an individual's average daily care count is less than or equal to 5 than the residential care home supplement amount is \$86,378
- If an individual's average daily care count is more than 5 but less than or equal to 10 the residential care home supplement amount is \$73,290
- If an individual's average daily care count is more than 10 but less than or equal to 15 the residential care home supplement amount is \$60,203
- If an individual's average daily care count is more than 15 but less than or equal to 20 the residential care home supplement amount is \$47,115
- If an individual's average daily care count is more than 20 but less than or equal to 25 the residential care home supplement amount is \$33,099
- If an individual's average daily care count is more than 25 but less than or equal to 30 the residential care home supplement amount is \$18,065
- If an individual's average daily care count is more than 30 but less than or equal to 35 the residential care home supplement amount is \$14,663

- If an individual's average daily care count is more than 35 but less than or equal to 40 the residential care home supplement amount is \$11,261
- If an individual's average daily care count is more than 40 but less than or equal to 45 the residential care home supplement amount is \$7,857
- If an individual's average daily care count is more than 45 but less than or equal to 50 the residential care home supplement amount is \$4,455.

Residential care home supplement amount—group B residential care homes in 2023 MM category MM 1

Subsection (6) provides that for residential care home supplement amount – group B residential care homes in 2023 MM category MM 1, the residential care home supplement amount for a payment period, for a group B residential care home located in the 2023 MM category MM 1, is the following amount for the average daily care count for the home for the period:

- If an individual's average daily care count is less than or equal to 20 the residential care home supplement amount is \$14,393
- If an individual's average daily care count is more than 20 but less than or equal to 25 the residential care home supplement amount is \$12,834
- If an individual's average daily care count is more than 25 but less than or equal to 30 the residential care home supplement amount is \$7,005.

Residential care home supplement amount—group B residential care homes in 2023 MM categories MM 2 and MM 3

Subsection (7) provides that for residential care home supplement amount –group B residential care homes in 2023 MM categories MM 2 and MM 3 the residential care home supplement amount for a payment period, for a group B residential care home located in the 2023 MM category MM 2 or MM 3, is the following amount set for the average daily care count for the home for the period:

- If an individual's average daily care count is less than or equal to 20 the residential care home supplement amount is \$15,268
- If an individual's average daily care count is more than 20 but less than or equal to 25 the residential care home supplement amount is \$13,614
- If an individual's average daily care count is more than 25 but less than or equal to 30 the residential care home supplement amount is \$7,431.

Residential care home supplement amount—group B residential care homes in 2023 MM categories 4 and 5

Subsection (8) provides that for residential care home supplement amount –group B residential care homes in 2023 MM categories 4 and 5, the residential care home supplement amount for a payment period, for a group B residential care home located in the 2023 MM category as MM 4 or MM 5, is the following amount for the average daily care count for the home for the period:

- If an individual's average daily care count is less than or equal to 5 the residential care home supplement amount is \$36,421

- If an individual's average daily care count is more than 5 but less than or equal to 10 the residential care home supplement amount is \$30,902
- If an individual's average daily care count is more than 10 but less than or equal to 15 the residential care home supplement amount is \$25,384
- If an individual's average daily care count is more than 15 but less than or equal to 20 the residential care home supplement amount is \$19,866
- If an individual's average daily care count is more than 20 but less than or equal to 25 the residential care home supplement amount is \$13,956
- If an individual's average daily care count is more than 25 but less than or equal to 30 the residential care home supplement amount is \$7,618.

Residential care home supplement amount—group B residential care homes in 2023 MM categories MM 6 and MM 7

Subsection (9) provides that for residential care home supplement amount –group B residential care homes in 2023 MM categories MM 6 and MM 7, the residential care home supplement amount for a payment period, for a group B residential care home located in the 2023 MM category MM 6 or MM 7, is the following amount for the average daily care count for the home for the period:

- If an individual's average daily care count is less than or equal to 10 the residential care home supplement amount is \$43,190
- If an individual's average daily care count is more than 5 but less than or equal to 10 the residential care home supplement amount is \$36,646
- If an individual's average daily care count is more than 10 but less than or equal to 15 the residential care home supplement amount is \$30,102
- If an individual's average daily care count is more than 15 but less than or equal to 20 the residential care home supplement amount is \$23,558
- If an individual's average daily care count is more than 20 but less than or equal to 25 the residential care home supplement amount is \$16,550
- If an individual's average daily care count is more than 25 but less than or equal to 30 the residential care home supplement amount is \$9,033.

Average daily care count

Subsection (1) provides that the average daily care count for a qualifying residential care home for a payment period is the total number of days of eligible residential funded aged care services delivered in respect of individuals at the residential care home during the period, divided by the number of days in the period.

This section replicates the substance of the registered nurse supplement amount previously provided for in section 64ZU of the repealed Aged Care (Subsidy, Fees and Payments) Determination 2014.

Section 239-30 – Care minutes supplement – applicability

Section 239-30 provides that the care minutes supplement applies to individuals who receive funded aged care services on a day at a non-specialised approved residential care home in a metropolitan area (that is, is located in the 2023 MM 1 category)

The care minutes 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 approved residential care homes in metropolitan areas.

The measure does not apply to approved residential care homes with specialised Aboriginal and Torres Strait Islander status or specialised homeless status (see section 243 of the Act) and in regional centres and large rural towns, medium and small rural towns, and remote and very remote communities (that is, located in the 2023 MM 2, 3, 4, 5, 6 or 7 categories).

The change aims to lift compliance by registered providers operating non-specialised approved residential care homes in metropolitan areas with their care minutes obligations (see section 176 of the Act, which continues a responsibility of providers that previously existed under the old Act). Compliance with care minutes responsibilities is particularly low in non-specialised homes 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.

Section 239-35 – Care minutes supplement—amount

Subsection (1) provides that the care minutes supplement amount for an individual for a day before 1 April 2026 is nil.

Subsection (2) provides that the care minutes supplement amount for an individual receiving residential care funded aged care services 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 home where the individual is receiving funding aged care services on the day against:

- the average number of care minutes delivered in the home by direct care staff members of the provider per counted mainstream individual per day for the delivery quarter expressed as a percentage of the required combined staff average number of care minutes per individual per day worked out under subsection 176-20(1) of the rules in respect of the home for the delivery quarter;
- the average number of care minutes delivered in the home by registered nurse staff members and enrolled nurse staff members of the provider per counted mainstream individual per day for the delivery quarter (worked out in accordance with subsection (3) of this section) expressed as a percentage of the required registered nurse average number of care minutes per individual per day worked out under subsection 176-20(2) of the rules in respect of the home for the delivery quarter.

A table provides a matrix for calculating the care minutes supplement.

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 7 of the Act and means an aged care worker of a registered provider is a registered nurse, enrolled nurse, nursing assistant or personal care

worker or a person prescribed by the rules (noting, for clarity, there are currently no such rules to be made through this amending instrument).

Enrolled nurse is defined in section 7 of the Act 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 7 of the Act and has the same meaning as in the *Health Insurance Act 1973*.

National Law is defined in section 7 of the Act and has the same meaning as in the *Health Insurance Act 1973*.

The national efficient price is defined in section 5-5 of the rules.

NWAU is defined in section 5-5 of the rules and means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set.

The matrix is constructed so that if care minutes performance for the delivery quarter is less than 85% of both required amounts of care minutes for that quarter then the 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 care minutes for that quarter 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 non-zero 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 care minutes amounts.

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

Subsection (3) provides that, for the purposes of calculating the care minutes supplement, care minutes delivered through the home by registered nurse staff members and enrolled nurse staff members of the registered provider operating the approved residential care home per counted individual per day for the delivery quarter can include an amount of direct care delivered through the home by enrolled nurse staff members.

This amount cannot exceed 10% of the required registered nurse average amount of care minutes per individual per day calculated under subsection 176-20(2) of these Rules in respect of the home for the delivery quarter. This is consistent with design of the care minutes responsibility, which allows a certain amount of care minutes provided by enrolled nurses to count toward meeting care minutes obligations.

Subsection (4) provides that a rate of 0.113 NWAU (that is, equivalent to the maximum rate of the care minutes supplement as worked out under subsection (3)) applies per individual per day for the remainder of the quarter in which a non-specialised residential care home in a

metropolitan area is first approved (and so commences operations) and for days in the following three quarters. The effect is that the standard, variable rate of care minutes supplement will not apply until a stable history of care minutes performance has been established at the home.

Subsection (5) clarifies that transitional arrangements under the *Aged Care (Consequential and Transitional Provisions) Act 2024* that ensure that former residential care services under the old Act automatically become approved residential care homes under the Act on 1 November 2025 do not trigger the arrangement under subsection (4).

Subsection (6) provides that a rate of 0.113 NWAU (that is, equivalent to the maximum rate of the care minutes supplement as worked out under subsection 239-35(3)) applies per individual per day for the days in the three quarters following a change to which registered provider a residential care home is approved (that is, following ‘transfer’ of the home between registered providers, for example through sale or merger). The effect is that the standard, variable rate of care minutes supplement will not apply until a stable history of care minutes performance has been established at the home under its new management.

Subsection (7) provides that a rate of 0.113 NWAU (that is, equivalent to the maximum rate of the care minutes supplement as worked out under subsection 239-35(3)) applies per individual per day for the remainder of the quarter in which a non-specialised residential care home in a metropolitan area which has been not been operating (through having 0 operational beds for a period, by having all of its total beds ‘offline’ – see definitions in section 5-5 of the rules) recommences operations, and for the days in the following three quarters. The effect is that the standard, variable rate of care minutes supplement will not apply until a stable history of care minutes performance has been re-established at the home following the non-operational period.

Subsection (8) provides, for clarity, that calculated amounts of care minutes supplement are to be rounded to the nearest cent (that is, if 0.5 cents or *above to be rounded up and if less than 0.5 cents to be rounded down*).

Subdivision D – Reduction amounts for provider-based subsidy for ongoing residential care

A note to this subdivision clarifies that, for the compensation payment reduction for provider-based subsidy, see Part 8.

Section 242-5 – Provider based reduction amount—standard base provider amount

Section 242-5 provides the standard base provider amount for the purposes of subsection 242(2) of the Act. The standard base provider amount for a day for an individual is the amount worked out by multiplying the national efficient price by the NWAU of 0.50.

Section 242 of the Act sets out how the provider-based subsidy reduction amount for a registered provider for an individual for a day is to be worked out. The effect of this subsidy reduction being, where an individual has sufficient means to pay a non-clinical care contribution under section 279 of the Act, the provider-based subsidy for a day for the individual will be reduced by an amount corresponding to the amount of the non-clinical care contribution that is payable by the individual. However, in cases where the non-clinical care contribution exceeds the standard base provider amount, the provider-based subsidy reduction amount will be the standard base provider amount.

The effect of the amount prescribed in section 242-5 is that all individuals receiving ongoing residential care will have the same standard base provider amount used in the calculation of the provider-based subsidy reduction amount, regardless of the actual base provider amount of for the individual used in the calculation of provider-based subsidy. This is because the base provider amount links to the characteristics (that is, the location and specialised status) of the approved residential care home where the individual receives care (see section 238-5). Using the same standard base provider amount for all individuals is an equity measure that, in combination with the linked individual contributions provisions under Division 2 of Part 3 of Chapter 4 of the Act and related rules, ultimately ensures different individuals cannot be liable for different maximum contributions toward the cost of their care on the basis of the location and status of the approved residential care home through which they receive care, over which they have no control. If the standard base provider amount equalled the base provider amount for the individual, as opposed to having the same standard base provider amount as prescribed by this section, individuals receiving care in regional, rural and remote areas would pay a higher contribution when compared to an individual with the same means receiving care in a metropolitan area (as the base provider amount is much higher for approved residential care homes in rural and remote areas).

Section 242-5 replicates, in a simplified form, the substance of the adjusted basic subsidy amount previously provided for in sections 64ZF and 64ZG of the repealed Aged Care (Subsidy, Fees and Payments) Determination 2014 (which was used in the calculation of the care subsidy reduction under section 44-21 of the old Act).

Division 3—Subsidy for transitional cohorts

Subdivision A—Method for calculating amount of subsidy

Section 242B-5 – Amount of residential care subsidy—pre-2014 residential contribution class

Section 242B-5 provides the method statement for calculating the amount of residential care subsidy for an individual in the pre-2014 residential contribution class.

To work out the amount of residential care subsidy for an individual in this class, the rules require the individual's base rate (see section 229-5 of the rules) and the provider's base provider amount (see section 238-5 of the rules) to be added together (as if Division 4 of Part 2 of Chapter 4 of the Act applied to the individual).

Then add to that amount the sum of the following amounts for the classification type ongoing for the service group residential care for the day that apply in relation to the individual:

- the accommodation supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-10 of the rules, and that a reference in that section to the fee reduction supplement were a reference to the transitional fee reduction supplement);
- the oxygen supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-11 of the rules);
- the enteral feeding supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-12 of the rules);
- the transitional accommodation supplement (see section 242B-10 of the rules);
- the 2012 basic daily fee supplement (see section 242B-15 of the rules);

- the accommodation charge top-up supplement (see section 242B-20 of the rules);
- the concessional resident supplement (see section 242B-25 of the rules).

Once those amounts are calculated, the rules require that the sum of the income tested fee for the individual for the day (see section 285A-13 of the rules) plus any transitional compensation payment reduction amount that applies to the individual for the day (see section 242B-55 of the rules) is subtracted, but not below zero.

Finally, the amount under the previous step is added to the following amounts for the classification type ongoing for the service group residential care for the day that apply to the individual:

- the hotelling supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-5 of the rules);
- the transitional fee reduction supplement (see section 242B-27 of the rules);
- the initial entry adjustment supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 231-35 of the rules);
- the veterans' supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 231-50 of the rules);
- the pensioner supplement (see section 242B-40 of the rules);
- the registered nurse supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see sections 239-10, 239-15 and 239-20 of the rules);
- the ex-hostel supplement (see section 242B-45 of the rules).

Section 242B-6 – Amount of residential care subsidy—post-2014 residential contribution class

Section 242B-6 provides the method statement for calculating the amount of residential care subsidy for an individual in the post-2014 residential contribution class.

To work out the amount of residential care subsidy for an individual in this class, the rules require the individual's base rate (see section 229-5 of the rules) and the provider's base provider amount (see section 238-5 of the rules) to be added together (as if Division 4 of Part 2 of Chapter 4 of the Act applied to the individual).

Then add to that amount the sum of the following amounts for the classification type ongoing for the service group residential care for the day that apply in relation to the individual:

- the oxygen supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-11 of the rules);
- the enteral feeding supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-12 of the rules);

Once those amounts are calculated, the rules require that the sum of the means tested care fee for the individual for the day (see section 285A-14 of the rules) plus any transitional compensation payment reduction amount that applies to the individual for the day (see sections 242B-50 and 242B-55 of the rules) is subtracted, but not below zero.

Add to that amount the sum of the following amounts for the classification type ongoing for the service group for the day that apply to the individual:

- the hotelling supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-5 of the rules);
- the accommodation supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 230-10 of the rules, and that a reference in that section to the fee reduction supplement were a reference to the transitional fee reduction supplement);
- the transitional accommodation supplement (see section 242B-10 of the rules);
- the initial entry adjustment supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 231-35 of the rules);
- the veterans' supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see section 231-50 of the rules);
- the registered nurse supplement (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual, see sections 239-10, 239-15 and 239-20 of the rules).

Subdivision B—Supplements

Section 242B-10 – Transitional accommodation supplement—circumstances for applicability and amount

Subsection (1) provides that the circumstances in which the transitional accommodation supplement will apply to an individual are that:

- the individual is in the pre 2014 residential contribution class; and
- immediately before the transition time, the individual was eligible for transitional accommodation supplement under section 37 of the Aged Care (Transitional Provisions) Principles 2014.

Subsection (2) provides that the amount of the transitional accommodation supplement is the amount that is the difference between:

- the amount specified in the table included in this subsection for the day on which the individual entered residential care (within the meaning of the old Act); and
- the amount of accommodation supplement that would apply for the individual for the day if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual.

The table under subsection (2) provides the relevant amounts for paragraph (2)(a).

Item 1 provides that if the individual entered residential care after 19 March 2008 and before 20 September 2010, the amount is \$10.57.

Item 2 provides that if the individual entered residential care after 19 September 2010 and before 20 March 2011, the amount is \$7.05.

Item 3 provides that if the individual entered residential care after 19 March 2011 and before 20 September 2011, the amount is \$3.52.

Subsection (3) provides that the amount of transitional accommodation supplement for a day for the individual is nil if the amount worked out under subsection (2) is a negative amount.

Section 242B-15 – 2012 basic daily fee supplement—circumstances for applicability and amount

Subsection (1) provides that the circumstances in which the basic daily fee supplement will apply are that:

- the individual is in the pre 2014 residential contribution class; and
- immediately before the transition time, the individual was eligible for 2012 basic daily fee supplement under section 39 of the Aged Care (Transitional Provisions) Principles 2014; and
- the individual has a classification level for the classification type ongoing for the service group residential care in effect; and
- the provider charged the individual for the day at least 1% less than the transitional basic daily fee that the provider could have charged the individual for that day.

Subsection (2) provides that the amount of the 2012 basic daily fee supplement for a day for an individual is the amount worked out by rounding down to the nearest cent the amount equal to 1% of the basic age pension amount (worked out on a per day basis).

Section 242B-20 – Accommodation charge top-up supplement—circumstances for applicability and amount

Subsection (1) provides circumstances in which accommodation charge top-up supplement will apply to an individual for a day. These are:

- the individual is in the pre-2014 residential contribution class; and
- immediately before the transition time, the individual was eligible for accommodation charge top-up supplement under section 35 of the Aged Care (Transitional Provisions) Principles 2014; and
- the individual has a classification level for the classification type ongoing for the service group residential care in effect.

Subsection (2) provides for the amount of the accommodation charge top-up supplement for a day for an individual. The amount is the difference between:

- the maximum daily amount at which an accommodation charge would accrue under section 57A-6 of the Aged Care (Transitional Provisions) Act 1997 for the entry of the individual to the residential care service (within the meaning of that Act) in question if the individual were not receiving an income support payment (within the meaning of that Act) on the day of entry; and
- the maximum daily amount at which an accommodation charge would accrue under subsection 118(2) of the Aged Care (Transitional Provisions) Principles 2014 for the entry of the individual to the service if the individual were a post-2008 reform resident (within the meaning of the Aged Care (Transitional Provisions) Act 1997) who was receiving an income support payment (within the meaning of that Act) on that day.

Subsection (3) provides that the amount of transitional accommodation supplement for a day for the individual is nil if the amount worked out under subsection (2) is a negative amount.

Section 242B-25 – Concessional resident supplement—circumstances for applicability and amount

Subsection (1) provides that the circumstances in which the accommodation charge top-up supplement will apply are that:

- the individual is in the pre 2014 residential contribution class; and
- immediately before the transition time, the individual was eligible for accommodation charge top up supplement under section 35 of the Aged Care (Transitional Provisions) Principles 2014; and
- the amount of the concessional resident supplement for the day for the individual under section 91B of the Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014 was not nil; and
- the individual has a classification level for the classification type ongoing for the service group residential care in effect.

Subsection (2) provides that the amount of the accommodation charge top up supplement for a day for an individual is the amount that is the difference between:

- the maximum daily amount at which an accommodation charge would accrue under section 57A-6 of the Aged Care (Transitional Provisions) Act 1997 for the entry of the individual to the residential care service (within the meaning of that Act) in question if the individual were not receiving an income support payment (within the meaning of that Act) on the day of entry; and
- the maximum daily amount at which an accommodation charge would accrue under subsection 118(2) of the Aged Care (Transitional Provisions) Principles 2014 for the entry of the individual to the service if the individual were a post reform 2008 resident (within the meaning of the Aged Care (Transitional Provisions) Act 1997) who was receiving an income support payment (within the meaning of that Act) on that day.

Subsection (3) provides the amount of accommodation charge top up supplement for a day for the individual is nil if the amount worked out under subsection (2) is a negative amount.

Section 242B-27 – Transitional fee reduction supplement—circumstances for applicability and amount

Subsection (1) provides that the circumstances in which transitional fee reduction supplement will apply to an individual for a day are that:

- an income determination is in effect for the individual for the day; and
- an asset determination is in effect for the individual for the day; and
- on the day, the individual does not have means not disclosed status; and
- on the day, the value of the individual's assets, worked out in accordance with section 330 of the Act and reduced by the value of any unrealisable assets, is not more than 1.5 times the sum of the annual amount of the following:
 - the maximum basic rate under point 1064 B1 of Module B of Pension Rate Calculator A that applies to a person who is not a member of a couple;

- the pension supplement amount under point 1064 BA3 of Module BA of Pension Rate Calculator A that applies to a person who is not a member of a couple;
- the energy supplement amount under point 1064 C3 of Module C of Pension Rate Calculator A that applies to a person who is not a member of a couple; and
- on the day, the individual has not gifted more than \$10,000 in the current financial year or in any of the previous 4 financial years; and
- on the day, the individual has not gifted more than \$30,000 in the period comprising the current financial year and the previous 4 financial years; and
- on the day, a residential care fee reduction supplement determination is in effect for the individual; and
- the individual's daily remaining income amount for the day, as determined in the residential care fee reduction supplement determination, is less than the fee reduction supplement daily threshold amount for the day.

Subsection (2) provides a different asset calculation for the individual:

- the post-2014 resident contribution class will be worked out using section 330 of the Act.
- the pre-2014 resident contribution class will be worked out using the asset test located in subsection 44(2) of the Aged Care (Transitional Provisions) Principles 2014 and disregards the inclusion of the value of the home outlined in subsection 330(7)

Subsection (3) provides that the amount of the fee reduction supplement for a day for an individual to whom the supplement applies under subsection (1) for the day is equal to the difference between:

- the fee reduction supplement daily threshold amount for the day; and
- the individual's daily remaining income amount for the day, as determined in the residential care fee reduction supplement determination that is in effect for the individual on the day.

Subsection (4) provides that, for the purposes of paragraph (1)(h) and subsection (3), sections 231-16 to 231-22 of the rules apply as though:

- Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual; and
- a reference in those sections to a fee reduction supplement were a reference to a transitional fee reduction supplement.

Subsection (5) provides for an individual in the pre 2014 residential contribution class, the transitional fee reduction supplement for the individual reduces (but not below zero) the following for the individual, in the following order:

- transitional basic daily fee;
- income tested fee;
- daily accommodation bond or daily accommodation charge (as applicable).

Subsection (6) provides that for an individual in the post 2014 residential contribution class, the transitional fee reduction supplement for the individual reduces (but not below zero) the following for the individual, in the following order:

- transitional basic daily fee;
- means tested care fee;
- daily accommodation payment or daily accommodation contribution (as applicable).

Section 242B-40 – Pensioner supplement—circumstances for applicability and amount

Subsections (1) provides that the circumstances in which the pensioner supplement will apply are that:

- the individual is in the pre 2014 residential contribution class; and
- immediately before the transition time, the individual was eligible for concessional resident supplement under section 44 28 of the Aged Care (Transitional Provisions) Act 1997; and
- the individual has a classification level for the classification type ongoing for the service group residential care in effect.

Subsection (2) provides that the amount of the pensioner supplement for a day for an individual is \$10.57.

Section 242B-45 – Ex hostel supplement—circumstances for applicability and amount

Subsection (1) provides that the circumstances in which the ex-hostel supplement will apply to an individual for a day are that:

- the individual is in the pre 2014 residential contribution class; and
- on 30 September 1997, the individual occupied a place in a hostel approved under the *Aged or Disabled Persons Care Act 1954*, as in force at that date; and
- as at immediately before the transition time, the individual had not entered an aged care service (within the meaning of the old Act) that was approved, before 1 October 1997, as a nursing home under the *National Health Act 1953*; and
- the individual has a classification level for the classification type ongoing for the service group residential care in effect; and
- the provider charged the individual for the day at least \$0.80 less than the transitional basic daily fee that the provider could have charged the individual for that day.

Subsection (2) provides that the amount of the ex-hostel supplement for a day for an individual is \$0.80.

Subdivision C—Transitional compensation payment reduction

Section 242B-50 – Transitional compensation payment reduction amount—circumstances for applicability

Subsection (1) provides that a transitional compensation payment reduction for subsidy applies to an individual for a day if:

- the individual is entitled to compensation under a judgment, settlement or reimbursement arrangement (whether the judgment, settlement or reimbursement arrangement occurred before or after the transition time); and
- the compensation takes into account the future costs of delivering funded aged care services (however described) to the individual on that day; and

- the application of transitional compensation payment reductions to the individual for preceding days has not resulted in reductions in subsidy that, in total, exceed or equal the part of the compensation that relates, or is to be treated under subsections (2) or (3) as relating, to future costs of delivering funded aged care services (however described) to the individual.

Subsection (2) provides that if an individual is entitled to compensation under a judgment or settlement that does not take into account the future costs of delivering funded aged care services (however described) to the individual, the System Governor may, in accordance with subsection (4), determine, by notice in writing given to the individual:

- that, for the purposes of this section, the judgment or settlement is to be treated as having taken into account those future costs; and
- the part of the compensation that, for the purposes of this section, is to be treated as relating to those future costs.

Subsection (3) provides that the System Governor may, in accordance with subsection (4), determine, by notice in writing given to the individual, the part of the compensation that, for the purposes of this section, is to be treated as relating to those future costs if:

- an individual is entitled to compensation under a settlement; and
- the settlement takes into account the future costs of delivering funded aged care services (however described) to the individual; and
- the System Governor is satisfied that the settlement does not adequately take into account those future costs;

Subsection (4) provides that in making a determination under subsections (2) or (3), the System Governor must take into account the following matters:

- the amount of the judgment or settlement;
- for a judgment—the components stated in the judgment and the amount stated for each component;
- the proportion of liability apportioned to the individual;
- the amounts spent on delivering funded aged care services (however described) to the individual at the time of the judgment or settlement.

The System Governor may also take into account any other matters the System Governor considers relevant, including:

- the amounts that are likely to be paid to, or withheld by, other government agencies because of the judgment or settlement;
- the amounts spent on care (other than funded aged care services (however described)) at the time of the judgment or settlement;
- the likely future costs of delivering funded aged care services to the individual;
- other costs of care for which the individual is likely to be liable;
- other reasonable amounts, not related to care, that the individual has spent at the time of the judgment or settlement, or is likely to be liable for.

The Note to this subsection confirms that for subparagraph (4)(a)(ii), examples of the components of a judgment include loss of income and costs of future care.

Section 242B-55 – Amount of transitional compensation payment reduction

Subsection (1) provides that the amount of a transitional compensation payment reduction for subsidy for an individual for a day is worked out under subsection (2) if:

- the individual is entitled to compensation under a judgment or settlement; and
- the compensation is not paid in a lump sum; and
- the judgment or settlement states the individual's proportion of liability; and
- subsection (5) does not apply in relation to the individual.

Subsection (2) provides the amount of the transitional compensation payment reduction for subsidy for the individual for the day is that proportion of the sum of the following:

- whichever of the following amounts apply:
 - if the individual is in the pre 2014 residential contribution class—the amount worked out at Step 1 of the method statement in section 242B-5 of the rules (see also subsection (2A));
 - if the individual is in the post 2014 residential contribution class—the amount worked out at Step 1 of the method statement in section 242B-6 of the rules (see also subsection (2A));
- if oxygen supplement applies to the individual for the day—the amount of that supplement for the day;
- if enteral feeding supplement applies to the individual for the day—the amount of that supplement for the individual for the day.

Subsection (2A) provides that, for the purposes of subparagraph (2)(a)(i) or (ii), when working out the provider's base provider amount at paragraph (b) of Step 1 of the method statement in section 242B-5 or section 242B-6 of the rules (as the case requires), assume that item 8 of the table in subsection 238-5(1) of the rules applies to the provider.

Subsection (3) provides that the amount of a transitional compensation payment reduction for subsidy for an individual for a day is worked out under subsection (4) if:

- the individual is entitled to compensation under a judgment or settlement; and
- the compensation is paid in a lump sum; and
- the judgment or settlement states the amount or proportion of the lump sum that relates to future costs of delivering funded aged care services (however described) to the individual; and
- subsection (5) does not apply to the individual.

Subsection (4) provides that the amount of the transitional compensation payment reduction for subsidy for the individual for the day is the lesser of the following:

- the amount, or the amount of the proportion, mentioned in paragraph (3)(c), reduced (but not below zero) by the total of the amounts of transitional compensation payment reduction for subsidy for the individual for preceding days;
- the sum of the following:
 - the amount mentioned in subsection (4A);
 - if oxygen supplement applies to the individual for the day—the amount of that supplement for the day;

- if enteral feeding supplement applies to the individual for the day—the amount of that supplement for the individual for the day.

Subsection (4A) provides that, for the purposes of subparagraph (4)(b)(i), the amount is whichever of the following apply:

- if the individual is in the pre-2014 residential contribution class—the amount worked out at Step 1 of the method statement in section 242B-5 of the rules (see also subsection (4B));
- if the individual is in the post-2014 residential contribution class—the amount worked out at Step 1 of the method statement in section 242B-6 of the rules (see also subsection (4B)).

Subsection (4B) provides that, for purposes of paragraph (4A)(a) or (b), when working out the provider's base provider amount at paragraph (b) of Step 1 of the method statement in section 242B-5 or section 242B-6 of the rules(as the case requires), assume that item 8 of the table in subsection 238-5(1) of the rules applies to the provider.

Subsection (5) provides that this section applies in relation to an individual if the System Governor believes, on reasonable grounds, that:

- an individual is entitled to a transitional compensation payment reduction in accordance with section 242B-50 of the rules; and
- the System Governor does not have sufficient information to work out the transitional compensation payment reduction for the purposes of that section.

Subsection (6) provides that the System Governor may, by notice in writing given to a person, require the person to give information or produce a document that is in the person's custody, or under the person's control, if the System Governor believes on reasonable grounds that the information or document may be relevant to working out of the transitional compensation payment reduction.

Subsection (7) provides requirements for the notice. The notice must specify:

- how the person is to give the information or produce the document; and
- the period within which the person is to give the information or produce the document; and
- the effect of subsection (8) which provides for a transitional compensation payment reduction amount if the information or document requested by the System Governor is not given.

Subsection (8) provides that if the information or document is not given or produced within the specified period, the System Governor may determine the transitional compensation payment reduction amount for the individual for the day, taking into account the following:

- the matter mentioned in subparagraph 242B-50(4)(a)(iv) of the rules;
- any other matters the System Governor considers relevant, including the following (to the extent that the matters are known to the System Governor):
 - the matters mentioned in subparagraphs 242B-50(4)(a)(i) to (iii) of the rules;
 - the matters mentioned in paragraph 242B-50(4)(b) of the rules.

Division 4—Approved residential care homes with specialised status

Subdivision E—Approved residential care homes with specialised status

Section 243-5 – Kinds of specialised status

For the purposes of paragraph 243(5)(a) of the Act, this section provides that the kinds of specialised status are:

- specialised Aboriginal or Torres Strait Islander status;
- specialised homeless status.

This section continues implementation of the Australian National Aged Care Classification (AN-ACC) funding model that has operated in full since October 2022 and that includes linking calculation of subsidy to the specific characteristics of approved residential care homes, reflecting research that different amounts of subsidy are needed to meet the costs of delivering that meets the care needs of individuals.

This ‘fixed’ component is the same for all residents at a residential care service and is higher for services in remote locations and certain specialist services (provided for by sections 243 and 243A of the Act and related rules) in recognition of higher fixed operating costs (see section 238-5 of the rules for detail of subsidy amounts).

Section 243-10 – Specialised Aboriginal or Torres Strait Islander status—criteria

For the purposes of paragraph 243(5)(b) of the Act, this section provides the criteria that the System Governor must consider when deciding whether to determine an approved residential care home has specialised Aboriginal or Torres Strait Islander status

The criteria are as follows:

- whether, on the day before the application under subsection 243(1) of the Act in relation to the home was made:
 - the home was located in the 2023 MM category known as MM 6 or the 2023 MM category known as MM 7; and
 - at least 50% of the individuals to whom funded aged care services were delivered in the home, other than individuals to whom funded aged care services were delivered under a specialist aged care program, were Aboriginal or Torres Strait Islander persons;
- whether the registered provider that delivers funded aged care services in the home, or a responsible person of the provider, has demonstrated experience in providing, or the capacity to provide, specialist Aboriginal or Torres Strait Islander programs;
- whether:
 - the provider is delivering specialist Aboriginal or Torres Strait Islander programs in the home; or
 - the provider has given a written undertaking that the provider will begin delivering specialist Aboriginal or Torres Strait Islander programs in the home within 3 months after the application is made.

These criteria ensure that specialised Aboriginal or Torres Strait Islander status is limited to being awarded to residential care homes at which an appropriately experienced or capable

provider will focus both on providing care for Aboriginal and/or Torres Strait Islander persons and on providing specialised programs that meet those persons' needs.

This section replicates the substance of subsection 64Q(2) of the repealed Aged Care (Subsidy, Fees and Payments) Determination 2014.

Section 243-15 – Specialised homeless status – criteria

For the purposes of paragraph 243(5)(b) of the Act, this section provides for the criteria that the System Governor must consider when deciding whether to determine an approved residential care home has specialised homeless status.

The criteria are the following:

- whether, on the day before the application under subsection 243(1) of the Act in relation to the home was made, at least 50% of the individuals to whom funded aged care services were delivered in the home, other than individuals to whom funded aged care services were delivered under a specialist aged care program, demonstrated complex behavioural needs and social disadvantage associated with their background as a homeless person
- whether the registered provider that delivers funded aged care services in the home, or a responsible person of the provider, has demonstrated experience in providing, or the capacity to provide, specialist homeless programs;
- whether:
 - the provider is delivering specialist homeless programs in the home; or
 - the provider has given a written undertaking that the provider will begin delivering specialist homeless programs in the home within 3 months after the application is made.

These criteria ensure that specialised homeless status is limited to being awarded to residential care homes at which an appropriately experienced or capable provider will focus both on providing care for disadvantaged homeless persons with complex behavioural needs and on providing specialised programs that meet those persons' needs.

Section 243-15 replicates the substance of subsection 64U(2) of the repealed Aged Care (Subsidy, Fees and Payments) Determination 2014.

Section 243-20 – Specialised status—maximum

For the purposes of paragraph 243(5)(c) of the Act, section 243-20 provides that the maximum period of effect of a specialised status is 3 years.

Limiting the maximum period of effect is appropriate as it ensures a provider must periodically reconfirm their intention and ability to meet the criteria to be a specialised residential care home in respect of a particular residential care home.

Part 8 –Reduction amounts—compensation payment reduction for home support, assistive technology, home modifications and residential care

Section 246A-5 –Circumstances in which compensation information known

Subsections 199(1), 216(1), 225(1), 233(1) of the Act provide for the compensation payment reduction for person-centred subsidy for home support, assistive technology, home modifications, and ongoing residential care respectively. Subsection 241(1) of the Act provides for the compensation payment reduction for provider-based subsidy for ongoing residential care.

Subsection (1) provides for the circumstances in which a compensation payment reduction for person-centred subsidy and provider-based subsidy apply to an individual for a day. The circumstances are that:

- The individual is entitled to compensation under a judgment, settlement or reimbursement arrangement (whether these occurred before or after transition time); and
- The compensation takes into account the future costs of delivering funded aged care services (however described) to the individual on that day; and
- The application of compensation payment reductions to the individual for preceding days has not resulted in reductions in subsidy that, in total, exceed or equal the part of the compensation that relates, or is to be treated under subsections (2) or (3) as relating, to future costs of delivering funded aged care services (however described) to the individual.

Subsections (2), (3) and (4) relate to determinations relating to future costs of delivering funded aged care services.

Subsection (2) provides for the situation in which an individual is entitled to compensation under a judgment or settlement that does not take into account the future costs of delivering funded aged care services (however described) to the individual.

In this situation, the System Governor may, in accordance with subsection (4), determine by notice in writing given to the individual:

- That, for the purposes of this section, the judgment or settlement is to be treated as having taken into account those future costs; and
- The part of the compensation that, for the purposes of this section, is to be treated as relating to those future costs.

Subsection (3) provides for the situation in which:

- An individual is entitled to compensation under a settlement; and
- The settlement takes into account the future costs of delivering funded aged care services (however described) to the individual; and
- The System Governor is satisfied that the settlement does not adequately take into account those future costs.

In this situation, the System Governor may, in accordance with subsection (4), determine by notice in writing given to the individual that part of the compensation is to be treated as relating to those future costs for the purposes of this subsection.

Paragraph (4)(a) provides matters which the System Governor must take into account in making a determination under subsections (2) and (3). The matters which the System Governor must take into account are as follows:

- The amount of the judgment or settlement;
- For a judgment – the components stated in the judgment and the amount stated for each component;
- The proportion of liability apportioned to the individual;
- The amounts spent on delivering funded aged care services (however described) to the individual at the time of the judgment or settlement.

Paragraph (4)(b) provides that the System Governor may take into account any other matters the System Governor considers relevant. Matters which may be relevant include:

- The amounts that are likely to be paid to, or withheld by, other government agencies because of the judgment or settlement;
- The amounts spent on care (other than funded aged care services ((however described)) at the time of the judgment or settlement;
- The likely future costs of delivering funded aged care services to the individual;
- Other costs of care for which the individual is likely to be liable;
- Other reasonable amounts, not related to care, that the individual has spent at the time of the judgment or settlement or is likely to be liable for.

The note under subsection (4) explains that for subparagraph (4)(a)(ii), examples of components of a judgment include a loss of income and costs of future care.

Section 246A-10 –Amount for circumstances in which compensation information known

Subsections 199(2), 216(2), 225(2), 233(2) and 241(2) of the Act provide that the amount of compensation payment reduction for person-centred subsidy and provider-based subsidy for the individual for the day is the amount prescribed in the rules.

Section 246A-10 prescribes that amount for the purposes of subsections 199(2), 216(2), 225(2), 233(2) and 241(2) of the Act. Subsection (2) provides that subsections (3) and (4) apply if:

- The individual is entitled to compensation under a judgment or settlement; and
- The compensation is not paid in a lump sum; and
- The judgment or settlement states the individual's portion of liability.

Subsection (3) provides that the amount of compensation payment reduction for person-centred subsidy for the individual for the day is the proportion of the sum of the following:

- The amount of the base rate for the individual for the day;
- If oxygen supplement applies to the individual for the day - the amount of that supplement for the day;
- If enteral feeding supplement applies to the individual for the day - the amount of that supplement for the individual for the day.

Subsection (4) provides that the amount of the compensation payment reduction for provider-based subsidy for the individual for the day is that proportion of the standard base provider amount for the day for the individual.

Subsections (5), (6) and (7) relate to circumstances in which an individual is entitled to lump sum compensation with a stated amount or proportion for aged care costs.

Subsection (5) provides that subsections (6) and (7) apply if:

- The individual is entitled to compensation under a judgment or settlement; and
- The compensation is paid in a lump sum; and
- The judgement or settlement states the amount or proportion of the lump sum that relates to future costs of delivering funded aged care services (however described) to the individual.

Subsection (6) provides that the amount of the compensation payment reduction for person-centred subsidy for the individual for the day is the lesser of the following:

- The amount, or the amount of the proportion, mentioned in paragraph (5)(c), reduced (but not below zero) by the total of the amounts of compensation payment reduction for person-centred subsidy for the individual and compensation payment reduction for provider-based subsidy for the individual for preceding days;
- The sum of the following:
 - The amount of the base rate for the individual for the day;
 - If oxygen supplement applies to the individual for the day - the amount of that supplement for the day;
 - If enteral feeding supplement applies to the individual for the day - the amount of that supplement for the individual for the day.

Subsection (7) provides that the amount of compensation payment reduction for provider-based subsidy for the individual for the day is the lesser of the following:

- The amount, or the amount of the proportion, mentioned in paragraph (5)(c), reduced (but not below zero) by the total of the amounts of compensation payment reduction for person-centred subsidy for the individual and compensation payment reduction for provider-based subsidy for the individual for preceding days;
- The standard base provider amount for the day for the individual.

Section 246A-15 – Circumstances in which compensation information not known

Section 246A-15 provides that if compensation information for an individual is not known, then the circumstances in which a compensation payment reduction for person-centred subsidy and compensation payment reduction for provider-based subsidy apply to an individual for a day are that section 234 of the Act applies in relation to sections 199, 216, 225, 233 or 241 of the Act (as applicable).

Section 234 of the act provides for the System Governor's powers if compensation information is not known. Under subsection 234(2) the System Governor may require a person to give information or a document that may be relevant to the working out of the compensation payment reduction.

Section 246A-20 – Requirements for determining compensation payment reductions for circumstances in which compensation information not known

Subsection 234(4) of the Act provides that if the information or document is not given or produced within the specified period, the System Governor may determine compensation payment reductions for the individual.

Subsection 234(5) of the Act provides that the compensation payment reductions determined under subsection 234(4) of the Act must be determined in accordance with any requirements in the rules.

Section 246A-20 prescribes requirements for the purposes of subsection 234(5) of the Act. The requirements are that:

- The System Governor must take into account the matter mentioned in subparagraph 246A-5(4)(a)(iv) of the rules; and
- The System Governor may take into account any other matters the System Governor considers relevant, including the following (to the extent that the matters are known to the System Governor):
 - The matters mentioned in subparagraphs 246A-5(4)(a)(i) to (iii) of the rules; and
 - The matters mentioned in paragraph 246A-5(4)(b) of the rules.

Part 9 – Subsidy for certain specialist aged care programs

Division 1 – Agreements for delivery of funded aged care services under specialist aged care programs

Section 247-5 – Circumstances that must apply for System Governor to enter into agreements—Multi-Purpose Service Program

Section 247-5 sets out that for the System Governor to enter into an agreement with an entity for the Multi-Purpose Service Program (MPSP), they must be satisfied of the following:

- the entity, once registered as a registered provider, will deliver funded aged care services in an approved residential care home
- the entity will also deliver a health service in the same location as the home
- the home is not located in the 2023 MM category known as MM 1, and
- there has been adequate consultation about the delivery of funded aged care services by the entity as a registered provider.

To enter into an MPSP agreement, taking into account the outcomes of the consultation and the views of the State and Territory where the home is located, the System Governor must also be satisfied that:

- there is a demonstrated need for the delivery of funded aged care services under the MPSP to improve access to those services for individuals in the area surrounding the home, and
- it will be viable to have an arrangement for the integrated delivery of funded aged care services and health services in that area.

Section 247-15 – Requirements for agreements for delivery of funded aged care services – Transition Care Program

Section 247-15 sets out the requirements that an agreement for the delivery of funded aged care services for the Transition Care Program must meet. This supports paragraph 247(1)(b) of the Act.

The requirements are that:

- the agreement must state:
 - the period of the agreement

- the circumstances in which the agreement can be varied or terminated
- any conditions the System Governor considers necessary for the effective delivery of funded aged care services under the Program, that are not conditions of registration (see Part 4 of Chapter 3 of the Act) or conditions of the allocation of a place for the Program (see section 95 of the Act);
- any indemnity or insurance requirements that an entity is required to satisfy to be allocated a place for the Program under section 95 of the Act; and
- the agreement will take effect on the day, and will only take effect if, the arrangement covered by the agreement meets the following requirements:
 - the arrangement is for the delivery of funded aged care services to an individual after the conclusion of a hospital episode, and is targeted towards older people;
 - the funded aged care services delivered to an individual under the arrangement always include the service transition care therapy services;
 - the delivery of services to an individual under the arrangement is time-limited; and
- the agreement will cease to have effect if the arrangement covered by the agreement ceases to meet the requirements referred to above.

Division 2 – Amount of subsidy – Multi-Purpose Service Program

Section 249-5 – Purpose of Division

Section 249-5 provides that the purpose of this Division is to prescribe the amount of subsidy a registered provider is eligible for under section 248 of the Act, where they are delivering funded aged care services under the MPSP in or from an approved residential care home of the provider.

Section 249-10 – Amount of subsidy

Section 249-10 sets out the formula to determine the amount of subsidy a registered provider is eligible for. It also explains how each component of the formula is calculated. In the case of some components, it also references further sections of the rules, which provides more details that form part of the calculation.

Section 249-25 – Aged care wage supplement amount

Section 249-25 outlines the amount to be used when calculating the aged care wage supplement amount for the three specific providers listed in the table in this section, who deliver services under the MPSP.

Other providers are not listed in the table in this section as this supplement is not available to the majority of providers who deliver services under the MPSP, who are State or Territory government providers.

Section 249-30 – Direct care supplement amount

Section 249-30 outlines the amount that is to be used when calculating the direct care supplement amount for a provider who delivers services under the MPSP. As indicated in the table provided, the amount depends on where the provider is located, with more remote providers receiving a higher amount. How much they will receive depends on

their location as categorised under the Modified Monash Model (MMM) 2023, with the exception of one residential care home for which transitional arrangements are in place.

Subsection (2) clarifies that this subsection covers a State or Territory that is participating in the direct care trials currently underway for the MPSP. Subsection (3) explains that participating States and Territories must be listed on the Department's website.

Section 249-35 – Home or community additional amount

Section 249-35 provides for the additional amount for a home or community place for an approved residential care home.

Subsection (1) and (2) provide that the amount that applies depends on whether the provider's approved residential care home is:

- a Category A residential care home, a Category B residential care home or a Category C residential care home; and
- on the day, the ARIA value additional amount for a day for a home or community place for the home is greater than the 2017 MM category additional amount for a day for a home or community place for the home.

If this is the case, the additional amount is the ARIA value additional amount for a day for a home or community place for the home which is prescribed in the subsection (3). If this is not the case, with the exception of one residential care home for which transitional arrangements are in place, the additional amount is the 2023 MM category additional amount for a day for a home or community place for the home, which is prescribed in subsection (4).

Section 249-40 – Residential care place amount

Section 249-40 outlines the amount to be used when calculating the residential care place amount for an approved residential care home of an approved provider. This amount is calculated by adding together:

- the amount specified at paragraph 249-40(a)
- the viability supplement equivalent amount, and
- the amount specified in the table at paragraph 249-40(c) for the region that the home is in.

The viability supplement equivalent amount is determined based on whether the approved residential care home of the approved provider is a Category A residential care home, Category B residential care home, Category C residential care home or Category D residential home. These categories of homes are defined at section 5-5.

The viability supplement equivalent amount for each category of residential care home is then outlined in sections 249-50 to 249-65 (see further below).

Section 249-45 – Respite supplement equivalent amount

Section 249-45 prescribes the respite supplement equivalent amount for an approved residential care home for a day. This is the amount specified in the table provided for the number of residential care places for the home that are in effect on the day.

Section 249-50 –Viability supplement equivalent amount—Category A residential care homes

Section 249-50 prescribes the viability supplement equivalent amount for a Category A residential care home. This is either:

- the amount specified in the table provided for the number of residential care places that are in effect for the home, where the home has a Statistical Local Area Classification listed in the table, or
- where this not applicable, the amount specified at section 249-50 (b).

Section 249-55 –Viability supplement equivalent amount—Category B residential care homes

Section 249-55 prescribes for the viability supplement equivalent amount for a Category B residential care home for a day. This is the amount specified in the table for the score attained by the home on the day under the scoring system set in subsection (2).

Section 249-60 –Viability supplement equivalent amount—Category C residential care homes

Section 249-60 prescribes for the viability supplement equivalent amount for a Category C residential care home for a day. This is the amount specified in the table for the score attained by the home on the day under the scoring system set in subsection (2).

Section 249-65 –Viability supplement equivalent amount—Category D residential care homes

Section 249-65 prescribes for the viability supplement equivalent amount for a Category D residential care homes for a day. This is the amount specified in the table for the score attained by the home on the day under the scoring system set in subsection (2).

Division 3 – Amount of subsidy – Transition Care Program

Section 249-90 –Amount of subsidy

For the purposes of subsection 249(1) of the Act, section 249-90 provides for the amount of subsidy a registered provider is eligible for under section 248 of the Act on a day in relation to funded aged care services delivered to an individual through a service group under the Transition Care Program (TCP) on the day. The amount is \$262.62.

Part 10 –Subsidy claims and payment

Division 1 –Home support, assistive technology and home modifications (other than under specialist aged care programs)

Section 251-5 –Relevant period—assistive technology

Section 251-5 provides that, for the purposes of paragraph 251(2)(d) of the Act, the relevant period for ongoing funded aged care services delivered to an individual through the service group assistive technology is the account period for the notional assistive technology account established for the individual for the delivery of those services.

Section 251-10 – Period within which claim must be given to the System Governor—prescribed events

Paragraph 251(3)(a) of the Act provides that a claim must be given to the System Governor before the end of either a period of 60 days after the end of the relevant period or 60 days after an event prescribed by the rules. For the purposes of subparagraphs 251(3)(a)(ii), section 251-10 provides that the prescribed events are:

- the individual ceases accessing funded aged care services through the service delivery branch; or
- another registered provider provides a start notification to the System Governor and the Commissioner about starting the delivery of funded aged care services to the individual:
 - through the classification type ongoing for the service group residential care; or
 - through the classification type ongoing or short term for the service group home support.

Division 2—Specialist aged care programs

Section 260-5 – Purpose of this Division

For the purposes of subsection 260(2) of the Act, this section set out the purpose of this division as being the prescription of requirements relating to claims for, and payment of, subsidy under subsection 260(1) of the Act.

Section 260-10 – Multi-Purpose Service Program—timing of payments

For the purposes of subsection 260(1) of the Act, section 260-10 prescribes the subsidy payable to a registered provider for a day in a quarter in relation to the delivery of funded aged care services under the Multi-Purpose Service Program (MPSP)

This subsidy is payable by the Commonwealth within 21 days after the start of the subsequent quarter, or on a day in that quarter or a subsequent quarter agreed between the System Governor and the provider.

Section 260-15 – Transition Care Program—claims

For the purposes of subsection 260(1) of the Act, section 260-15 prescribes for requirements for claims under the Transition Care Program.

For the purposes of obtaining payment of subsidy in relation to the delivery by a registered provider of funded aged care services under the TCP, the provider must, as soon as practicable after the end of each calendar month, give to the System Governor a claim, in the approved form, for subsidy that is payable to the provider for the days in that month.

Section 260-20 – Transition Care Program—payments

For the purposes of subsection 260(1) of the Act, section 260-20 provides for subsidy payable to a registered provider in relation to the delivery of funded aged care services under the TCP.

Subsection (2) provides for the timing of payments. For TCP, subsidy payable for a day in a calendar month is payable by the Commonwealth for the month at such times as the System

Governor thinks fit.

Subsection (3) provides that the subsidy payable in relation to funded aged care services delivered through each service delivery branch or approved residential care home of the registered provider is separately payable by the Commonwealth.

Division 3—Transfers and mergers of service delivery branches

Section 263-5 – Purpose of this Subdivision

For the purposes of paragraph 263(1)(a) and subsection 263A(1) of the Act, section 263-5 provides this Division makes provision for, and in relation to:

- the transfer of a service delivery branch of a registered provider to another registered provider; and
- the merger of 2 or more service delivery branches of a registered provider into a single delivery branch of the provider.

Section 263-10 – Application for approval to transfer service delivery branch

Section 263-10 provides for the application for approval to transfer a service delivery branch

Subsection (1) and (2) provides that a registered provider (the ***proposed transferor***) may apply, in the approved form, to the System Governor for approval to transfer a service delivery branch of the proposed transferor to another registered provider (the ***proposed transferee***). The application must be made at least 90 days, or such smaller number of days as is agreed in writing between the System Governor and the registered provider, before the day proposed in the application for the transfer of the service delivery branch.

This subsection ensures that the 90-day notice period provides sufficient time for operational planning, stakeholder communication, and system transitions. The inclusion of a discretionary shorter notice period, where agreed in writing between registered provider and System Governor recognises that urgent or unforeseen circumstances may arise, requiring a more rapid transfer. This flexibility ensures that the System Governor can respond promptly to urgent situations such as provider insolvency or critical service disruptions, while still maintaining oversight and safeguarding participants.

Subsection (3) provides that the System Governor must consider an application and any further information given and make a decision on the application within 28 days of receiving the application.

The note under subsection (3) clarifies the consequence of not giving any further information in the requested time or extended by referring to section 588 of the Act.

Subsection (4) provides that the System Governor must give notice of the System Governor's decision to the proposed transferor and the proposed transferee.

Subsection (5) provides that the notice must be given as soon as practicable after the System Governor makes the decision. If the System Governor decides not to approve the transfer of the service delivery branch, the notice must include the reasons for the decision and how the proposed transferor or the proposed transferee may apply for reconsideration of the decision.

Section 263-15 – Transfer of service delivery branch

Section 263-15 provides for the transfer of service delivery branch. This section applies if the System Governor approves the transfer of a service delivery branch of a registered provider (the *transferor*) to another registered provider (the *transferee*).

Subsection (2) prescribes that the transferor must ensure that, before the day (the *transfer day*) the transfer takes effect, the transferor has given to the System Governor claims under section 251 of the Act for subsidy payable to the transferor under section 250 of the Act for days before the transfer day in relation to funded aged care services delivered through the transferring service delivery branch.

The intent of subsection (2) is to ensure that all subsidy claims made by the transferor under section 251 of the Act are submitted and finalised before the transfer day. This requirement ensures that the financial position of the transferring service delivery branch is fully accounted for, and that all available balances and budgets transferred to the transferee accurately reflect the services delivered and claims made by the transferor.

Subsection (3) also prescribes that, for the purposes of subsection 251(3) of the Act, on the *transfer day*, the notional service delivery branch account for the transferor in relation to the branch (including the available balance of that account) is transferred to the transferee in relation to the branch.

This ensures that, on the transfer day, the notional service delivery branch account, including its available balance, is transferred from the outgoing provider (transferor) to the incoming provider (transferee). The policy intent is to support continuity of care and financial accountability by ensuring that the funds allocated for service delivery at a particular branch remain with that branch, even when the responsible registered provider changes.

Section 263A-5 – Merger of service delivery branches

Subsection (1) provides that section 263A-5 applies in relation to the merger of one or more service delivery branches (a *merging service delivery branch*) of a registered provider into an existing service delivery branch of the provider (the *continuing service delivery branch*).

Subsection (2) provides that the registered provider must ensure before the day (the *merger day*) the merger takes effect, the provider has given to the System Governor claims for subsidy payable to the provider for days before the merger day in relation to funded aged care services delivered through each merging service delivery branch.

This requirement ensures that:

- the remaining balances and budgets associated with the service delivery branches are accurately calculated and finalised, and
- the continuing service delivery branch's account reflects the full scope of services delivered and claims made prior to the merger.

This also supports the transfer of available credits to the continuing branch's account.

Subsection (3) provides that on the merger day, the available balance of the notional service delivery account for the provider in relation to the merging service delivery branch is credited

to the notional service delivery account for the provider in relation to the continuing service delivery branch.

This ensures that all remaining funds associated with the merging branches are consolidated into the continuing service delivery branch's account, enabling the provider to continue delivering services without financial disruption.

Subsection (4) provides that if:

- a merging service delivery branch of a registered provider is merged during a financial year into a continuing service delivery branch of the provider; and
- an amount was credited to the notional service delivery branch account of the merging service delivery branch in the final quarter of that financial year in accordance with any of the following provisions:
 - subsection 203(4) of the Act;
 - subsection 203(6) of the Act;
 - subsection 203(7) of the Act; and
- subsection 203-15(4) of this instrument applies in relation to the notional service delivery branch account (the **relevant account**) of the continuing service delivery branch for the following financial year (the **relevant financial year**);

then the sum of the amounts referred to in paragraph (b) of this section are taken to be added to the amount referred to in paragraph 203-15(5)(b) of this instrument for the relevant account for the relevant financial year.

This is to ensure that if a merger of service delivery branches takes place in the final quarter of a financial year, that the amount credited to the notional service delivery branch account of the continuing service delivery branch is included in the amount of rollover credit of provider-based subsidy into the next financial year.

Part 11 – Grants

Division 1—Power to enter into other arrangements

Section 265-5 – Grants of financial assistance—other purpose

This section provides that, for the purposes of paragraph 265(2)(g) of the Act, it is a prescribed purpose to provide information to support independence, including information about healthy ageing, positive ageing, ageing well and active ageing.

Division 2—Grantee Code of Conduct

Section 268-5 – Purpose of this Part

This section provides that this Part is made for the purposes of subsection 268(1) of the Act, which provides for the **Grantee Code of Conduct** (the Grantee CoC). The Grantee CoC applies to persons or bodies who receive grants under subsection 265(1) of the Act. These grants are for the purposes listed under subsection 265(2) of the Act.

Section 268-10 – Grantee Code of Conduct

Subsection (1) provides that the Grantee CoC applies to persons or bodies who receive money under an arrangement or a grant of financial assistance under subsection 265(1) of the Act.

Subsection (2) provides for the conduct expected of persons or bodies undertaking activities under subsection 265(1) of the Act. Under the Grantee CoC, grantees must:

- undertake the activity in a safe and competent manner, with care and skill;
- promptly take steps to raise and act on concerns about matters that may affect the quality and safety of the activity;
- promptly disclose to the System Governor, and avoid or manage, any actual, perceived or potential conflicts of interest that could affect the proper undertaking of the activity by the grantee, key personnel of the grantee, or a person who is otherwise employed or engaged by the grantee;
- act with integrity, honesty and transparency;
- treat the following individuals with dignity and respect, and without bullying or harassment, including by valuing the individual's diversity:
 - any individual for whom the activity is being undertaken;
 - any family member, carer or supporter of the individual for whom the activity is being undertaken;
 - any individual engaged in, or participating in, the activity;
 - any individual administering the arrangement or grant (whether the individual is an official of the Department or otherwise); and
- not provide false or misleading information when undertaking the activity or in response to a request for information made for the purposes of the Act in relation to the arrangement or grant.

Subsection (3) provides the circumstances in which a grantee breaches the Grantee CoC because of an act, or an omission to perform an act, by another person or body. These circumstances include:

- the other person or body is a member of the key personnel of the grantee, or is otherwise employed or engaged by the grantee;
- the act, or the omission to perform the act, would be a breach of the Grantee CoC if it were done by the grantee;
- the act, or the omission to perform the act, is done while the other person or body is doing any of the following (whether or not during their ordinary working hours):
 - undertaking or participating in an activity for which money may be payable under an arrangement under subsection 265(1) of the Act or that is funded by a grant that has been made to the grantee under that subsection;
 - engaging with an individual or any family member, carer or supporter of the individual in relation to the individual's participation in such an activity;
 - doing anything incidental to any of the matters mentioned in the previous two paragraphs.

Subsection (4) provides that conflict of interest has its ordinary meaning.

Chapter 8 – Funding of aged care services—individual fees and contributions

Part 1 – Introduction

Section 272-5 – Simplified outline of this Chapter

This section sets out a simplified outline of this Chapter which provides for matters relating to individual fees and contributions for funded aged care services under Part 3 of Chapter 4 of the Act.

Compliance with the requirements in this Chapter is a condition of registration under section 151 of the Act.

Division 1 of Part 2 of this Chapter relates to fees and contributions payable in a home or community setting.

Division 2 of Part 2 of this Chapter relates to fees and contributions payable in an approved residential care home.

Division 2A of Part 2 of this Chapter relates to fees and contributions payable in an approved residential care home for transitional cohorts.

Division 3 of Part 2 of this Chapter relates to fees and contributions for specialist aged care programs.

Section 582(1) of the Act provides that the System Governor may, in writing, arrange for the use, under the System Governor's oversight, of computer programs to take administrative action that must be taken by the System Governor under this Act. This includes administrative actions under Parts 2 to 5 of Chapter 4 of the Act as provided for by paragraph 582(2A)(e) of the Act. The rules in Chapter 8 are made for the purposes of sections 272 to 286 in Part 3 of the Act and include administrative actions that may be automated.

Part 2 – Individual fees and contributions

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

Subdivision A—Individual contributions

Section 273-5 – Working out individual contribution for assistive technology or home modifications—prescribed day

This section provides that the day an individual agrees to the delivery of a service is the day for working out the individual contribution for the delivery of a funded aged care service to an individual, as required under paragraph (b) of Step 1 of the method statement in subsection 273(2) of the Act.

Section 273-10 – Working out individual contribution—circumstances and amounts

This section sets out the circumstances and amounts for the purposes of working out the individual contribution for the delivery of a funded aged care service to an individual on a day, as required under paragraph (b) of Step 3 of the method statement in subsection 273(2) of the Act.

Item 1 of the table provides that the amount is the amount of the cost for the delivery of the service in the following circumstances:

- the funded aged care service is any of the following (which involve the sourcing and supply to the individual of included AT HM items and conditionally included AT HM items other than on loan):
 - managing body functions items (non-loan);
 - self-care items (non-loan);
 - mobility items (non-loan);
 - domestic life items (non-loan);
 - communication and information management items (non-loan);
 - home modifications items; and
- the individual has an access approval in effect for, and the service is delivered to the individual through, the classification type ongoing or short term for the service group assistive technology or home modifications

Item 2 of the table provides that the amount is the amount that is 33.3% of the cost for the delivery of the service in the following circumstances:

- the funded aged care service is any of the following (which involve the sourcing and supply to the individual of included AT HM items and conditionally included AT HM items on loan):
 - managing body functions items (loan);
 - self care items (loan);
 - mobility items (loan);
 - domestic life items (loan);
 - communication and information management items (loan); and
- the individual has an access approval in effect for, and the service is delivered to the individual through, the classification type ongoing or short term for the service group assistive technology

Item 3 of the table provides that the amount is the amount that is 66.6% of the cost for the delivery of the service in the following circumstances:

- a classification decision establishing the classification level HM High in a classification type for the service group home modifications is in effect for the individual; and
- the service is delivered to the individual through that classification type for the service group; and
- the individual resides at a street address, or in a suburb or locality, that is in the 2023 MM category known as MM 6 or 7

Item 4 of the table provides that the amount is the amount that is zero of the cost for the delivery of the service in the following circumstances:

- the individual is in the post-2014 home contribution class; and
- immediately before the transition time, there was an income tested care fee for the individual under section 52D-2 of the old Act; and
- the sum of any individual contributions charged to the individual under section 273 of the Act for the delivery of funded aged care services to the individual during the preceding fortnight exceeds the amount worked out by multiplying that incomes tested care fee by 14.

Section 273-15 – Requirements for prices charged for directly sourced services

This section sets out the requirements for prices charged by a registered provider to an individual for the delivery of funded aged care services for the purposes of subsection 273(4) of the Act.

The requirements are that if, in accordance with an arrangement agreed with the registered provider, the individual directly sources the delivery of the funded aged care service at a particular price from an associated provider for the registered provider, the price charged by the registered provider must not exceed 110% of that particular price. In any case, the price charged by the registered provider must not be unreasonable.

The section allows for a cap on overheads to apply in situations in which the registered provider has agreed for the participant to undertake some of the tasks associated with sourcing or coordinating an entity delivering a service. These scenarios commonly fall within what is termed “self-management”. Some common features in these arrangements are when the participant:

- Researches entities (including individual workers) they want to deliver a service
- Liaises with that entity to identify if they meet the participant’s preferences and whether they are suitable to deliver the service
- Negotiates service prices with the entity
- Obtains information from the entity and provides that information to the registered provider to assist with onboarding
- Develops and negotiates a schedule for the entity to deliver the service according to the participant’s preferences

The registered provider retains responsibility for the service and must have an arrangement with the entity to deliver the service. The cap on the overhead the registered provider can charge is to recognise the contribution the participant makes in these scenarios, lessening the administrative work undertaken by the registered provider.

Section 273-20 – When individual contribution is zero—other contributions or fees

This section sets out, for the purposes of paragraph 273(5)(c) of the Act, the contributions and fees for an individual who was approved a recipient of aged care under the old Act. The following contributions and fees are prescribed:

- The means tested care fees (within the meaning of section 52C-3((3) of the old Act) (if any) for the individual under the old Act;
- The income tested care fees (within the meaning of subsection 52D-2(3) of the old Act) (if any) for the individual under the old Act;
- For an individual in the post-2014 home contribution class or the post-2014 residential contribution class—the means tested care fees for the individual.

Subdivision B—Unspent care recipient portions

Section 273A-5 – Unspent care recipient portions

This section provides that, for the purposes of subsection 273A(2) of the Act, this Subdivision prescribes requirements relating to unspent care recipient portions.

Section 273A-10 – Agreement with individual

This section provides that a registered provider that holds an unspent care recipient portion for an individual must, within 70 days after the transition time, agree in writing one of the following with the individual:

- that the provider will return the portion to the individual;
- that the provider will retain the portion and will deal with the portion in accordance with this Subdivision.

Section 273A-15 – If agreement is to return portion

This section provides that if the provider agrees that the provider will return the portion to the individual, the provider must:

- return the portion to the individual within 14 days after the day the agreement is made; or
- if the individual dies on or after the day the agreement is made and before the provider returns the portion to the individual—return the portion to the individual’s estate within 14 days after the provider is shown the probate of the individual’s will or letters of administration of the individual’s estate.

Section 273A-20 – If agreement is to retain portion

This section provides that if the provider agrees to retain the portion and deal with the portion in accordance with this Subdivision, the provider must:

- reduce (but not below zero) the amount of the portion by the individual contributions charged to the individual by the provider under section 273 of the Act; and
- if the provider ceases to deliver funded aged care services to the individual and the balance of the portion is not zero:
 - if the cessation of delivery of services is because the individual dies—pay the balance of the portion to the individual’s estate within 14 days after the provider is shown the probate of the individual’s will or letters of administration of the individual’s estate;
 - otherwise—pay the balance of the portion to the individual within 70 days after the cessation of delivery of services.

The note to this section provides that for obligations relating to providing information about unspent care recipient portions, see sections 149-45 and 155-40 of the rules.

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

Subdivision A—Classes of individuals to which Division 2 of Part 3 of Chapter 4 of the Act does not apply

Section 275A-5 Division 2 of Part 3 of Chapter 4 of Act not to apply to transitional cohorts

This section provides that, for the purposes of section 275A of the Act, the classes of individuals prescribed are individuals in the pre 2014 residential contribution class and individuals in the post 2014 residential contribution class.

Subdivision C—Hotelling contribution and nonclinical care contribution

Section 279-5 – Maximum non-clinical care contribution

This section prescribes \$105.30 for the purposes of subsection 279(3) of the Act.

Section 279-10 – When non-clinical care contribution is zero—number of days

This section prescribes 1,460 days for the purposes of subsection 279(4) of the Act.

Section 279-15 – When non-clinical care contribution is zero—other contributions or fees

This section prescribes, for the purposes of paragraph 279(5)(c) of the Act, for an individual who was approved as a recipient of aged care under the old Act, the following contributions and fees:

- the means tested care fees (within the meaning of subsection 52C-3(3) of the old Act) (if any) for the individual under the old Act;
- the income tested care fees (within the meaning of subsection 52D-2(3) of the old Act) (if any) for the individual under the old Act;
- for an individual in the post-2014 home contribution class or the post-2014 residential contribution class—the means tested care fees (if any) for the individual.

Section 280-5 – Hotelling contribution and non-clinical care contribution taken to be zero in some circumstances—classes of individuals

Paragraph 280(1)(b) of the Act provides that the hotelling contribution and non-clinical care contribution for an individual is taken to be zero for each day on which the individual is included in a class of persons prescribed by the rules.

Section 280-5 prescribes the relevant classes of persons for the purposes of paragraph 280(1)(b) of the Act. The classes are:

- the classes of individuals for whom both the hotelling contribution and non-clinical care contribution are taken to be zero for a day are the following:
 - individuals who cease accessing funded aged care services in an approved residential care home, without starting to access funded aged care services in another approved residential care home, before the registered provider of the home has been informed of the individual's hotelling contribution and non-clinical care contribution;
 - individuals who start accessing funded aged care services in an approved residential care home, but who die before the registered provider of the home has been informed of the individual's hotelling contribution and non-clinical care contribution;
 - individuals whose start day was more than 6 months before the day they are informed of their daily means tested amount;
 - individuals who have one or more dependent children;
 - individuals who are described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war).
- a class of individuals for whom the non-clinical care contribution is taken to be zero where the individual has elected, in the approved form, to cease being a member of the pre-2014 residential contribution class; and

- a class of individuals for whom the non-clinical care contribution is taken to be zero. This applies to individuals who:
 - were continuing home care recipients under the old Act on 12 September 2024; and
 - since that time, have been provided with funded aged care services through the residential care service group.

Section 280-10 – Hotelling contribution and non clinical care contribution taken to be zero in some circumstances—matters to which System Governor must have regard

Section 280-10 prescribes, for the purposes of subsection 280(4) of the Act, the matters to which the System Governor must have regard when deciding whether to make a determination under subsection 280(2) that an individual’s hotelling contribution and non-clinical care contribution are to be taken as zero.

Subsection 280-20(1) lists the matters the System Governor must consider, which include:

- the individual’s total assessable income (as determined under section 322 of the Act) and the value of the individual’s assets (as determined under section 329 of the Act);
- the individual’s financial arrangements;
- the individual’s entitlement to:
 - an income support payment; or
 - income from any other source;
- whether the individual has taken steps to obtain information about their entitlement to income support payments;
- whether the individual:
 - is eligible to make a request under section 1129 of the Social Security Act (relating to financial hardship rules for pensions);
 - is qualified to participate in the pension loans scheme under Division 4 of Part 3.12 of the Social Security Act; or
 - has access to financial assistance from any other source;
- whether any income of the individual is income that the individual does not reasonably have access to;
- whether there is a charge on the individual’s income over which the payment of fees and contributions cannot practically take precedence;
- whether any assets of the individual are unrealisable assets (within the meaning of the Social Security Act);
- whether the individual is in Australia on a temporary basis.

Section 281-5 – Fees for pre-entry period—ongoing residential care—maximum amount of pre-entry fee chargeable

Paragraph 281(4)(a) of the Act provides that the maximum amount of the pre-entry fee that the registered provider may charge the individual for a day in the pre-entry period is the amount prescribed by the rules.

This section prescribes the amount for a day for an individual is the basic daily fee for the individual for the purposes of paragraph 281(4)(a) of the Act.

Subdivision D—Fees for reserving a bed—ongoing residential care

Sections 282-5 – Maximum amount of bed reservation fee chargeable

Subsection 282(3) of the Act prescribes that the maximum amount of the bed reservation fee that the registered provider may charge the individual under this section for the day is the amount worked out in accordance with the rules.

Section 282-5 prescribes that the amount is the sum of the following amounts:

- the maximum daily amount of the resident contribution that would have been payable by the individual for the day;
- the standard base provider amount for a day for the individual.

These amounts are calculated as if the registered provider delivered an ongoing funded aged care service to the individual through that service group in that approved residential care home on the day.

Subdivision E—Fees for delivery of funded aged care services—short-term residential care

Section 283-15 – Booking fee

Subsection (1) provides that, for the purposes of subsection 283(4) of the Act, this section makes provision in relation to the charging of a booking fee by a registered provider for or in connection with the delivery of short term funded aged care services through the service group residential care to an individual for a period (*the respite period*).

Subsection (2) provides that the booking fee must not exceed the lesser of the following:

- the total of the resident respite fees that the provider would charge the individual for or in connection with the services for a period of 7 days;
- 25% of the total of the resident respite fees that the provider will charge the individual for the days in the respite period.

Subsection (3) requires the provider to refund the whole of the booking fee if any of the following events occur:

- the individual does not access the services because the individual enters hospital before the respite period;
- the individual dies before the respite period;
- the individual cancels the booking for the respite period more than 7 days before the start of the respite period.

Subsection (4) requires the provider to refund the part of the booking fee referred to in subsection (5) if, during the lesser of either the first 7 days of the respite period or the first 25% of the respite period (*the booking fee period*), any of the following events occur:

- the individual enters hospital;
- the individual dies;
- the provider requires the individual to leave the approved residential care home in which the services are being delivered.

Subsection (5) provides that for the purposes of subsection (4), the part of the booking fee required to be refunded is the amount equal to the proportion of the booking fee that corresponds to the proportion of the booking fee period that remains after the event occurs.

Subsection (6) provides that the provider must pay a refund required by subsection (3) or (4) if the individual has died. If, within 14 days after the provider becomes aware of the individual's death, the provider is shown the probate of the will of the individual or letters of administration of the estate of the individual, the provider must pay the refund to the individual's estate within 14 days after the day on which the provider was so shown. Alternatively, if this situation does not apply, the provider must pay the refund to a person that the provider is reasonably satisfied that it is appropriate to pay the refund to within 28 days after the provider becomes aware of the individual's death.

Subsection (6) also provides that the provider must pay a refund to the individual within 14 days after the later of the day the event mentioned in subsections (3) or (4) (as applicable occurs) or the day the provider becomes aware of the event.

Subsection (7) provides for conditions when the booking fee (in part or in full) may not be refunded because the cancellation occurred less than 7 days before the respite care commenced, unless the individual enters hospital or dies.

Subdivision F—Fees for higher everyday living

Section 284-1 – Purpose of this Subdivision

Subdivision (F) relates to the Higher Everyday Living Fee (HELFF), which is an optional fee for people who choose to receive higher quality everyday living services in permanent or short term residential aged care.

This section provides that for the purposes of subsections 284(2), (3) and (6) of the Act, Subdivision F prescribes the following

- requirements for entering into HELFF agreements;
- other requirements for HELFF agreements;
- how agreed amounts of HELFF are to be indexed;
- circumstances in which a registered provider must not charge an individual a HELFF;
- circumstances in which a registered provider must not enter into a HELFF agreement with an individual.

Section 284-2 – Kinds of higher everyday living agreements

This section indicates that a HELFF agreement must be either a standing HELFF agreement or an ad hoc HELFF agreement.

Note 1 clarifies that Standing HELFF agreements encompass the services that are planned and agreed in advance. A standing HELFF agreement may contain an agreed amount for:

- a single service that is to be delivered on a single occasion; or
- services that are to be delivered on an ongoing basis; or
- services that are to be delivered for a fixed term.

Note 2 clarifies that Ad hoc HELFF agreements may contain only an agreed amount for a single funded aged care service, or a single additional service, to be delivered on a single occasion (subsection 284-13(1) provides more details). They are restricted to situations where an individual requests a single service which hasn't been planned or agreed in advance.

They can only be entered into immediately before, or at the time, a service is to be delivered. These agreements can be made verbally and cover impromptu purchases such as a coffee at an onsite café. Providers are encouraged to offer services under a standing HELF agreement where possible, including when there is a recognisable pattern of ad-hoc service usage.

Section 284-5 – Entry requirements—all higher everyday living agreements

This section sets out the overarching entry requirements to which all HELF agreements are subject.

Subsection (1) prohibits a registered provider and an individual from entering into a HELF agreement that contains an agreed amount for a funded aged care service unless the agreement requires the provider to deliver the service to the individual at a standard that is higher than the minimum standard the service is required to be delivered at under the Act.

Subsection (2) prohibits a registered provider and an individual from entering into a HELF agreement that contains an agreed amount in connection with a funded aged care service unless the agreement requires the provider to deliver an additional service, that is connected to the funded aged care service, to the individual.

These sections should be read in conjunction with section 284-25 of the rules which specifies further circumstances in which HELF agreements must not be entered into, and section 284-20 of the rules which specifies circumstances in which a HELF must not be charged.

Section 284-6 – Additional entry requirements—standing higher everyday living agreements

This section applies to standing HELF agreements. It sets out additional requirements, supplementary to those prescribed in section 284-5 that must be met before a registered provider and an individual enter into a standing HELF agreement.

Paragraphs (a) and (b) require that the provider gives the individual a list of each service for which the provider charges a HELF.

If a provider charges a HELF for a funded aged care service delivered at a higher standard than required under the Act, the list must include details of the standard at which the provider delivers the service.

If a provider charges a HELF for an additional service delivered in connection with a funded aged care service, the list must include details of the funded aged care service that the additional service is delivered in connection with.

Paragraphs (c) and (d) deal with information a provider must give to the individual in relation to the fee for each service for which the provider charges a HELF. The requirements differ depending on whether the provider offers the option of bundling the charging of HELF fees.

If the provider does not offer the option of bundling, the provider must inform the individual of the fee for each service for which the provider charges a HELF.

If a provider offers the option of bundling HELF fees for, one or more services, the provider must inform the individual of:

- the standalone fee of each service if not purchased as part of a bundle;

- the fee of each service if purchased as a bundle, which may be offered at a discount from the standalone fee.

Paragraph (d) also requires that the provider inform the individual:

- the individual is under no obligation to agree to the bundling of the charging of HELF fees
- that the provider must offer to deliver, and the individual may choose to access, any of those services individually and not as part of a bundle.

The Note clarifies that subsection 284-11 of the rules deals with bundling the charging of higher everyday living fees.

Section 284-7 – Additional entry requirements—ad hoc higher everyday living agreements

This section applies to ad-hoc HELF agreements. It sets out additional requirements, supplementary to those prescribed in section 284-5 that must be met before a registered provider and an individual enter into an ad hoc HELF agreement.

Paragraphs (1)(a) to (d) require that the provider inform the individual of the following:

- if the agreement relates to the delivery of a funded aged care service—the service, the standard at which the provider delivers the service, and the HELF for the service;
- if the agreement relates to an additional service connected to a funded aged care service—the additional service, the funded aged care service that the additional service is delivered in connection with, and the HELF for the additional service;
- that the individual will be charged at the time the service or additional service is delivered;
- that the individual will not be charged if the individual chooses not to, or is unable to, have the service, or the additional service, delivered.

The additional entry requirements for ad hoc HELF agreements are intended provide for a greater level of informality when contrasted to the additional requirements for standing HELF agreements under section 284-6 of the rules.

Section 284-10 – Requirements that higher everyday living agreements must comply with—all higher everyday living agreements

This section sets out the requirements that all HELF agreements must comply with.

Subsection (1) requires that the agreement is expressed in plain language and is readily understandable by the individual.

Subsection (2) requires that a HELF agreement must specify:

- the agreed amount for each HELF service and the funded aged care service that it is charged for or in connection with
- the frequency at which the service is charged
- if the agreement relates to the delivery of a funded aged care service—the standard at which the service is to be delivered, (which must be higher than that required under the Act)
- if the agreement relates to an additional service connected to a funded aged care service—the additional service, connected to the funded aged care service, that the

- provider must deliver
- that each agreed amount is subject to indexation in accordance with the Rules
- that the provider is required to inform the individual of the replacement agreed amounts as soon as practicable after each indexation day

The Note clarifies that an individual's accommodation agreement sets out when an individual may be required to move rooms on a non-voluntary basis, see section 294-5 of the rules.

Subsection (3) requires that the agreement be a standalone agreement. That is, it must not be incorporated as part of a service agreement or accommodation agreement.

Section 284-11 – Additional requirements—standing higher everyday living agreements

This section sets out additional requirements that standing HELF agreements must comply with. These requirements are supplementary to those prescribed under section 284-10 of the rules.

Subsection (1) requires a standing HELF agreement to be in writing.

Subsection (2) provides that HELF services can be offered as part of a bundle but only if:

- the bundled fee for each of the services is agreed between the registered provider and the individual; and
- the individual is not financially disadvantaged by having those services charged as a bundle. That is, the total of the fees for all the services included in the bundle cannot exceed the total of the standalone cost of each of the services the individual is able to use.

Subsection (3) provides that where services are delivered over a fixed term rather than on a continuing or ongoing basis the agreement must specify details of the fixed term.

Subsections (4) and (5) require that a HELF agreement must provide for an annual review of the services being provided. A registered provider is required to keep a written record of:

- each annual review
- the findings of the review
- the details of any variations agreed to as a result of the review
- any other agreement with the individual that has been reached as a result of an annual review.

The Note clarifies that for variations as a result of an annual review, see subsection (9).

Subsection (6) outlines that for short term funded aged care services, the term of the HELF agreement can only be the period for which the provider delivers those services to the individual.

Paragraph (7)(a) provides individuals with a 28-day cooling-off period after entering a standing HELF agreement. This is intended to allow time for the individual to reflect on the services they've agreed to and decide whether they wish to continue receiving those services. During the cooling-off period, the HELF agreement can be cancelled, and/or services can be varied for any reason. The provider cannot charge a fee for the variation or termination in either circumstance.

Paragraph (7)(b) provides that after the 28-day cooling-off period, an individual or provider may choose to vary or cancel a HELF agreement for any reason but must give the other party 28 days' notice. The provider cannot charge a fee for the variation or termination in either circumstance.

Subsection (8) and the associated note provides that a variation as mentioned in paragraph (7)(a) or (b) can include the addition of a funded aged care service or additional service connected to that service, the removal of such a service, or the frequency of such a service. However, it must not change the agreed amount for a service. The price can only be increased once per year in line with the indexation requirements as outlined in section 284-15 of the rules. The Note clarifies that examples of permitted variations include the addition of a funded aged care service or additional service connected to that service, the removal of such a service, or the frequency of such a service

Subsection (9) clarifies that if the agreement is varied or terminated after the 28-day cooling off period as per paragraph (7)(b), the provider may continue to charge fees (other than a fee for the variation or termination) under the agreement until the end of the 28-day notice period.

Subsection (10) provides that a standing HELF agreement may be cancelled or varied as a result of the annual review. The annual review provides an opportunity for both the individual and provider to reconsider the entire agreement and make any necessary changes, which can include varying, adding, or removing services. This variation cannot change the agreed amount for the service, which would need to occur in line with the indexation requirements as outlined in section 284-15.

Subsections (11) and (12) allow the individual to cancel the agreement without notice if the provider can no longer deliver the service at the specified level or can no longer deliver the additional service. If the service is cancelled in these circumstances the provider cannot charge a fee for the termination. In some cases, an individual may agree to an offer by the provider of a substitute service or agree to receive the service at a different standard or frequency. In these situations, the agreement must be revised immediately to reflect the change.

Under subsection (13) the agreement must be suspended if the individual is on extended hospital leave. If the individual is on another kind of leave permitted under the Act, the individual and the provider may agree to suspend the agreement for an agreed period.

Subsection (14) sets out the timeframes for refunding agreed amounts under a standing HELF agreement:

- if the agreement is terminated in accordance with subsection (7) the registered provider must, within 14 days of the agreement being terminated, refund the individual any agreed amounts paid in advance in respect of a period after the agreement is terminated.
- if the agreement is varied in accordance with subsection (7) or (10) in a way that reduces any of the agreed amounts specified in the agreement, the registered provider must, within 14 days after an agreement is varied under subsections (7) or (10), refund to the individual the amount of the reductions in the agreed amounts paid in advance in respect of a period after the agreement is varied.

- if the agreement is suspended in accordance with subsection (13), the registered provider must, within 14 days after the beginning of the suspension, refund to the individual any agreed amounts paid in advance in respect of the period of suspension.

Subsection (15) gives a registered provider the ability to deduct any unavoidable service costs from any proposed refund to the individual, if the variation or termination is on the initiative of the individual (other than as mentioned in paragraph (7)(a) and subsections (10), (11), (12)) or is suspended as mentioned in subsection (13). Providers must be able to justify these expenses and cannot charge more than what was actually incurred.

Subsection (16) defines ***unavoidable service cost***. These costs are limited to those that:

- relate to a service that would have been delivered to the individual under the agreement, had the agreement not been varied or terminated or suspended; and
- the registered provider is required to pay to a third party, irrespective of whether the provider delivers the service to the individual.

Most examples of unavoidable service costs would relate to amounts owed to an external party that has been contracted to deliver a service to a resident on a regular basis, for a set period. For example, a yoga teacher or art teacher who is contracted to run a weekly class for 12 weeks for a group of residents. The cost of the classes would still need to be met by the provider over the entire schedule of classes, even if a resident decides to cancel it. This is similar to a non-residential care setting, whereby the person would be liable for the entire term of classes.

Unavoidable service costs are not able to be charged when the agreement is varied or cancelled during the cooling off period, as a result of the annual review, or when a provider can no longer deliver a service. They can also not be charged when an agreement is suspended while the individual is on leave.

Subsection (17) limits the period during which a registered provider can recover unavoidable service costs from the individual to a maximum of 90 days from the end of the notice period or from the day any termination takes effect.

Subsection (18) specifies that the agreement must include the details of any unavoidable costs the individual would be responsible for.

Subsection (19) sets out the requirements for refunds relating to termination or variation in accordance with subsections (11) and (12). It sets out notification requirements in circumstances where:

- an individual initiates termination of the agreement without giving notice under paragraph, (11)(a) or (12)(a); or
- an agreed amount is removed or reduced by a variation under paragraphs 11(b), 11(c), 12(b) or 12(c).

In these circumstances the provider must, within 14 days after the agreement is varied, refund to the individual any agreed or reduced amounts paid in advance in respect of a period after the agreement is varied or terminated

Subsection (20) provides that where an individual initiates a variation or termination of the agreement without giving notice under paragraph (7)(a), (11)(a) or (12)(a) or the individual or

the provider initiate a variation or termination under paragraph (7)(b) or subsection (10), the registered provider must provide written notice to the individual within 14 days, beginning on the day the relevant change was initiated.

The notice must:

- acknowledge the variation or termination, or proposed variation or termination (as the case requires);
- set out the reasons for the variation or termination – if initiated by the provider
- set out the changes to be made to the agreement
- set out unavoidable costs the individual is required to pay
- set out any refund due to the individual under subsection (14) or (19), taking into account any deduction for unavoidable costs under subsection (15)

Section 284-13 – Additional requirements—ad hoc higher everyday living agreements

Section 284-13 sets out additional requirements that ad hoc HELF agreements must comply with. These requirements are supplementary to those prescribed under section 284-10.

Subsection (1) provides that an ad hoc HELF agreement may only relate to a single service, that is to be delivered on a single occasion, such as a cup of coffee. It means that if an individual wishes to buy a coffee on different days, then each purchase would represent a single individual ad hoc HELF agreement.

Subsection (2) provides that an ad hoc HELF agreement terminates once the service has been delivered to the individual and the individual has paid the agreed amount. As indicated, if the individual wishes to access the same service on another occasion, then this will involve a new ad hoc HELF agreement.

In contrast to standing HELF agreements, there is no requirement for an ad hoc HELF agreement to be in writing. As such, the agreement may be entered into verbally through the transaction process.

Section 284-15 – Indexation of agreed amounts

This section applies to all HELF agreements. It outlines the methodology and timing for the annual indexation of HELF.

Each year on 1 July, the agreed HELF base price for each service may be increased based on the All-Groups Consumer Price Index at March each year. This is the weighted average of the eight capital cities, as published by the Australian Bureau of Statistics.

To assist providers to calculate the indexed HELF price the methodology is prescribed as:

- Work out the indexation factor by dividing the most recent March Quarter Index Number by the highest March Quarter Index Number since March 2025 (called the base quarter). This is worked out to 3 decimal places.
- Multiply this indexation factor by the individuals current agreed HELF prices as of 1 July of the indexation year.
- The result, rounded to the nearest dollar, becomes the new agreed HELF amount for each service on the indexation day.

The replacement agreed amount applies to the delivery of the funded aged care service on or after the indexation day.

The indexation factor cannot be applied if it is less than 1, i.e. it can only be positive, if not indexation would not apply for that year.

Section 284-20 – Circumstances in which higher everyday living fee not to be charged to individuals—all higher everyday living agreements

This section applies to all HELF agreements. It sets out the circumstances in which a HELF must not be charged to an individual for or in connection with a particular funded aged care service.

A HELF must not be charged for any services in the service type residential accommodation. This is to ensure that an individual is only charged once for the same service, noting that accommodation pricing is the most appropriate channel for funding accommodation costs.

In addition, a provider cannot charge a HELF if

- the fee has not been agreed with the individual in a HELF agreement
- the provider is already charging the individual for or in connection with the service through another HELF agreement.

This is to protect an individual from being charged more than once for delivery of the same service.

This section should be read in conjunction with the overarching entry requirements set out in sections 284-5, 284-6 and 284-7 of the rules.

Section 284-25 – Circumstances in which higher everyday living agreement not to be entered into with individuals—all higher everyday living agreements

This section applies to all HELF agreements. It sets out the circumstances in which a provider must not enter a HELF agreement with an individual.

A provider must not enter an agreement with an individual if the agreement contains a HELF for or in connection with a funded aged care service in the service type residential accommodation. This is to ensure that an individual is only charged once for the same service, noting that accommodation pricing is the most appropriate channel for funding accommodation costs.

A provider is also prevented from entering into a HELF agreement if they have not first entered into a service agreement with the individual. This section should be read in conjunction with the overarching entry requirements set out in sections 284-5, 284-6 and 284-7 of the rules.

Subdivision G—Other matters

Section 285-5 – Refund of amounts paid in advance if individual dies or stops accessing services

This section provides that if an individual dies or stops accessing funded aged care services, and has paid an amount that the individual may be charged under Division 2 of Part 3 of Chapter 4 of the Act in advance for a day occurring after the individual dies or stops accessing those services, the registered provider to whom the individual paid the amount must refund the amount.

If the individual has died, the registered provider must refund the amount to the following persons in the following circumstances and timeframes:

- If, within 14 days after the provider becomes aware of the individual's death, the provider is shown the probate of the will of the individual or letters of administration of the estate of the individual, the registered provider must refund the amount to the individual's estate within 14 days after the day on which the provider was so shown
- If the above situation does not apply, the registered provider must refund the amount to a person that the provider is reasonably satisfied, on the basis of other evidence shown to the provider, that it is appropriate to pay the refund to within 14 days after the provider was shown the other evidence.

If the individual has not died, the registered provider must refund the amount to the individual within 14 days after the individual stops accessing those services.

Section 285-10 – Resident respite fees to be reduced by booking fee

This section provides that if a registered provider charges an individual a booking fee for or in connection with the delivery of short-term funded aged care services through the service group residential care to the individual for a period (the *respite period*), the total amount of the resident respite fees charged by the provider to the individual for the days in the respite period must be reduced by the amount of the booking fee.

Division 2A—Fees and contributions payable in an approved residential care home for transitional cohorts

Subdivision A—Prescribed amounts

Section 285A-3 – Purpose of this Subdivision

This section provides that this Subdivision prescribes amounts that a registered provider delivering ongoing funded aged care services through the service group residential care to an individual in a class of individuals referred to in section 275A of the Act may charge the individual for a day for or in connection with those services.

Section 285A-5 – Contributions for delivery of funded aged care services

This section provides that for the purposes of subsection 285A(1) of the Act, a registered provider delivering ongoing funded aged care services through the service group residential care to an individual in a class of individuals referred to in section 275A of the Act may charge the individual an amount (the *transitional resident contribution*) for or in connection with those services.

Subsection (2) provides that, subsection to section 285A-25 of the rules, the transitional resident contribution charged to the individual for the day must not exceed the maximum daily amount of the transitional resident contribution worked out for the day under section 285A-10 of the rules.

Subsection (3) provides that if the registered provider does not, or is taken not to, deliver funded aged care services to the delivery on the day, the registered provider must not charge the individual a transitional resident contribution under this section for the day.

The Note clarifies that the registered provider may charge an individual certain amounts for a day on which the provider does not deliver funded aged care services to the individual: see sections 285A-15 and 285A-20 of the rules.

Section 285A-10 – Maximum daily amount of transitional resident contribution

Subsection (1) provides a method statement for working out the *maximum daily amount of the transitional resident contribution* amount payable by an individual for a day.

Step 1 is to work out Work out the transitional basic daily fee for the individual (see section 285A-11).

Step 2 is to add the transitional compensation payment fee (if any) for the individual for the day (see subsection (2)).

Step 3 is to add either:

- for an individual in the pre-2014 residential contribution class—any income tested fee (see section 285A-13); or
- for an individual in the post-2014 residential contribution class—any means tested care fee (see section 285A-14).

Subsection (2) provides that the *transitional compensation payment fee* for the individual for the day is the amount equal to the transitional compensation payment reduction applicable to the individual on that day (see sections 242B-50 and 242B-55).

Section 285A-11 – Transitional basic daily fee

Subsection (1) provides that the *transitional basic daily fee* for an individual for a day is the amount worked out in accordance with this section.

Subsection (2) provides that if the individual is in the pre-2014 residential contribution class, the amount is whichever of the following applies:

- if the individual was a protected resident within the meaning of Transitional Act immediately before the transition time—the amount obtained by rounding down to the nearest cent an amount equal to 77.5% of the basic age pension amount (worked out on a per day basis);
- if section 58-3C of the Transitional Act applied to the individual immediately before the transition time—the amount obtained by rounding down to the nearest cent an amount equal to 96.5% of the basic age pension amount (worked out on a per day basis);

- for any other individual—the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis).

Subsection (3) provides that if the individual is in the post 2014 residential contribution class, the amount is the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis).

Section 285A-13 Income tested fee

Subsection (1) provides that, subject to subsections (2), (3), (4) and (5) the *income tested fee* for an individual in the pre-2014 residential contribution class is equal to the daily means tested amount for the individual for the day (see section 319-15).

Subsection (2) provides that, despite subsection (1), the individual's income tested fee is zero on a day if any of the following apply on the day:

- the individual has one or more dependent children;
- the individual is an individual described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war);
- the individual:
 - was provided with residential care (within the meaning of the Transitional Act, as in force before the transition time) at any time after 30 September 1997 and before 1 March 1998; or
 - was, before 1 March 1998, on leave, as described in subsection 42-3(3) of the Transitional Act (as in force before the transition time).

Subsection (3) provides that if at a time that is after the transition time, the individual is accessing funded aged care services at an approved residential care home of a registered provider and the individual dies before the registered provider is informed of the individual's income tested fee (as it would be but for the application of this subsection) then, despite subsection (1), the individual's income tested fee is zero on each day starting after that time.

Subsection (4) provides that if, at a time that is within 6 months after the transition time, the individual is not informed of the individual's income tested fee (as it would be but for the application of this subsection) then, despite subsection (1), the individual's income tested fee is zero on each day starting after that time.

Subsection (5) provides that if:

- at a time that is after the transition time, the individual is accessing funded aged care services at an approved residential care home of a registered provider on a day; and
- on a later day the individual ceases accessing funded aged care services at the approved residential care home without starting to access funded aged care services at another approved residential care home of the registered provider or any other registered provider; and
- the registered provider is not informed of the individual's income tested fee (as it would be but for the application of this subsection) before the later day;

then, despite subsection (1), the individual's income tested fee is zero on each day starting after that time.

285A-14 – Means tested care fee

Subsection (1) provides that subject to subsections (2) to (8), the *means tested care fee* for an individual in the post-2014 residential contribution class for a day is worked out in accordance with the method statement set out in that subsection.

Step 1. work out the daily means tested amount for the individual for the day using see section 319-20 of the rules;

Step 2. subtract this amount from the amount referred to in subparagraph 230-15(1)(a)(i) of the rules (which is the highest maximum accommodation supplement amount that can apply in relation to an individual to whom Division 4 of Part 2 of Chapter 4 of the Act applies).

Step 3. provides that if this amount is a negative amount, the means tested care fee will be zero

Step 4. If the amount worked out under Step 2 is greater than zero, work out the sum of the following amounts for the day (as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual):

- the individual's base rate (see section 229-5 of the rules);
- the provider's base provider amount (see section 238-5 of the rules) as if item 8 of the table in subsection 238-5(1) applies to the provider;
- the oxygen supplement (see section 230-11 of the rules) (if applicable);
- the enteral feeding supplement (see section 230-12 of the rules) (if applicable).

Step 5. If the amount worked out under Step 2 does not exceed the amount worked out under Step 4, and the individual does not have means not disclosed status, the means tested care fee for the individual for the day is the amount worked out under Step 2.

Step 6. If the amount worked out under Step 2 exceeds the amount worked out under Step 4, or the individual has means not disclosed status, the means tested care fee for the individual for the day is the amount worked out under Step 4.

Subsection (2) provides that the *annual cap period* for the individual is the period of 12 months starting on the day, in the 12 month period before the transition time, that is:

- the day (the *first day*) on which the individual first entered an aged care service (within the meaning of the old Act) other than as a continuing care recipient (within the meaning of the old Act); or
- a day that is an anniversary of the first day.

Subsection (3) provides that despite subsection (1), the individual's means tested care fee on a day is zero if:

- the day occurs during the annual cap period for the individual; and
- on a previous day the sum of the individual's means tested care fees under this instrument and the old Act during the annual cap period for the individual exceeded \$35,238.11.

Subsection (4) provides that, despite subsection (1), the individual's means tested care fee on a day is zero if, on a previous day, the sum of all the individual's means tested care fees under this instrument and the old Act exceeds *lifetime cap* \$84,571.66.

Subsection (5) provides that, despite subsection (1), the individual's means tested care fee on a day is zero if any of the following apply on the day:

- the individual has one or more dependent children;
- the individual is an individual described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war);
- the individual was a continuing home care recipient (within the meaning of the old Act) on 12 September 2024.

Subsection (6) provides that if:

- at a time that is after the transition time, the individual is accessing funded aged care services at an approved residential care home of a registered provider; and
- the individual dies before the registered provider is informed of the individual's means tested care fee (as it would be but for the application of this subsection);

then, despite subsection (1), the individual's means tested care fee is zero.

Subsection (7) provides that if, at a time that is within 6 months after the transition time, the individual is not informed of the individual's means tested care fee (as it would be but for the application of this subsection) then, despite subsection (1), the individual's means tested care fee is zero on each day starting after that time.

Subsection (8) provides that if:

- at a time that is after the transition time, the individual is accessing funded aged care services at an approved residential care home of a registered provider; and
- on a later day the individual ceases accessing funded aged care services at the approved residential care home without starting to access funded aged care services at another approved residential care home of the registered provider or any other registered provider; and
- the registered provider is not informed of the individual's means tested care fee (as it would be but for the application of this subsection) before the later day;
- then, despite subsection (1), the individual's means tested care fee is zero on each day starting after that time.

then, despite subsection (1), the individual's means tested care fee is zero on each day starting after that time.

285A-15 – Fees for transitional pre-entry period

Subsection (1) provides that, for the purposes of subsection 285A(1) of the Act, a registered provider delivering funded aged care services through the service group residential care in an approved residential care home may charge an individual an amount (the *transitional pre-entry fee*) for each day in the period set out in subsection (2) if:

- the individual is in a class of individuals referred to in section 275A of the Act; and
- the individual's access approval includes the ongoing classification type for the service group residential care.

Subsection (2) provides that the period (the *transitional pre entry period*) is the period:

- starting on the later of the following:
- the day the individual enters into a service agreement with the provider;
- the day that is 7 days before the individual's start day; and
- ending at the end of the day before that start day.

The note under subsection (2) clarifies that the registered provider is taken not to be delivering funded aged care services to the individual on a day in the transitional pre entry period, so section 285A-5 does not apply to the day.

Subsection (3) clarifies that the maximum amount of the transitional pre entry fee that the registered provider may charge the individual under this section for a day in the transitional pre entry period is the amount of the transitional basic daily fee for the individual.

285A-20 – Fees for reserving a bed

Subsection (1) provides that for the purposes subsection 285A(1) of the Act, a registered provider delivering ongoing funded aged care services through the service group residential care to an individual in a class of individuals referred to in section 275A of the Act in an approved residential care home may charge the individual an amount (the *transitional bed reservation fee*) for a day to reserve a bed if subsection (2) applies to the individual on that day.

Subsection (2) provides that this subsection applies to the individual on the day if the individual:

- is absent from the approved residential care home on the day; and
- is not on leave from the approved residential care home on the day (see section 244 of the Act); and
- would have been on social leave from the approved residential care home on the day except that the individual has previously been on social leave during the current financial year for 52 days.

The note under subsection (2) clarifies that the registered provider is taken not to be delivering funded aged care services to the individual on a day if subsection (2) applies to the individual on the day, so section 285A-5 does not apply to the day.

Subsection (3) provides that the maximum amount of the transitional bed reservation fee that the registered provider may charge the individual under this section for the day is the sum of the following amounts:

- the maximum daily amount of the transitional resident contribution that would have been payable by the individual for the day (see section 285A-10);
- the individual's base rate (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual);
- the standard base provider amount for a day for the individual (worked out as if Division 4 of Part 2 of Chapter 4 of the Act applied in relation to the individual);

calculated as if the registered provider delivered an ongoing funded aged care service to the individual through that service group in that approved residential care home on the day and as if item 8 of the table in subsection 238-5(1) applied to the provider.

285A-25 – Fees for higher everyday living

Subsection (1) provides that where a registered provider delivers ongoing funded aged care services through the service group residential care to an individual in a class of individuals referred to in section 275A of the Act they may charge the individual an additional amount (called a *transitional higher everyday living fee*) for or in connection with a particular funded aged care service.

Subsection (2) provides that the amount agreed (the *transitional agreed amount*) between the registered provider and the individual in the *transitional higher everyday living agreement* is the transitional higher everyday living fee. The subsection also provides that the agreement must be entered into in accordance with the requirements already prescribed for all other higher everyday living agreements, in Subdivision F of Division 2 of Part 2 of this Chapter and must meet the requirements prescribed by that Subdivision.

The Note under subsection (2) refers to the more detailed explanation of what requirements must be met in subsection (7)

Subsection (3) provides that the registered provider cannot charge a transitional higher everyday living fee before the individual has entered into the transitional higher everyday living agreement.

Subsection (4) provides that the registered provider cannot ask the individual to pay a transitional higher everyday living fee for a service, or offer to enter a transitional higher everyday living agreement with the individual, before the individual's start day.

Subsection (5) provides that, although subsection (1) allows the provider to charge a transitional higher everyday living fee, the registered provider must not:

- charge the individual a transitional higher everyday living fee in circumstances prescribed by Subdivision F of Division 2 of Part 2 of this Chapter; or
- enter into a transitional higher everyday living agreement with the individual in circumstances prescribed by Subdivision F of Division 2 of Part 2 of this Chapter.

The Note under subsection (5) also refers to subsection (7) for how that Subdivision applies to transitional higher everyday living fees.

Subsection (6) clarifies that a transitional higher everyday living fee may be charged for a service that is not included on the list of services referred to in subsection 8(1) of the Act if the service is incidental to, or capable of enhancing the quality of, a particular funded aged care service that is included on that list.

Subsection (7) provides that, for the purposes of subsections (2) and (5), Subdivision F of Division 2 of Part 2 of this Chapter applies as if:

- Division 2 of Part 3 of Chapter 4 of the Act applied in relation to the individual; and
- a reference in that Subdivision to a higher everyday living fee were a reference to a transitional higher everyday living fee; and
- a reference in that Subdivision to an agreed amount were a reference to a transitional agreed amount; and
- a reference in that Subdivision to a higher everyday living agreement were a reference to a transitional higher everyday living agreement.

Subdivision B—Other matters

285A-30 - Refund of amounts paid in advance if individual dies or stops accessing services

This section provides that if an individual in the pre 2014 residential contribution class or in the post 2014 residential contribution class dies or stops accessing funded aged care services, and has paid an amount that the individual may be charged under Division 2A of Part 2 of Chapter 8 of the Rules in advance for a day occurring after the individual dies or stops accessing those services, the registered provider to whom the individual paid the amount must refund the amount.

If the individual has died, the registered provider must refund the amount to the following persons in the following circumstances and timeframes:

- If, within 14 days after the provider becomes aware of the individual's death, the provider is shown the probate of the will of the individual or letters of administration of the estate of the individual, the registered provider must refund the amount to the individual's estate within 14 days after the day on which the provider was so shown
- If the above situation does not apply, the registered provider must refund the amount to a person that the provider is reasonably satisfied, on the basis of other evidence shown to the provider, that it is appropriate to pay the refund to within 14 days after the provider was shown the other evidence.

If the individual has not died, the registered provider must refund the amount to the individual within 14 days after the individual stops accessing those services.

Division 3—Fees and contributions for specialist aged care programs

Section 286-5 – Fees and contributions for delivery of funded aged care services

This section sets out that this Division makes provision for:

- the amounts that a registered provider delivering funded aged care services through a service group under a specialist aged care program to an individual may charge the individual; and
- refunds of amounts paid in advance if the individual dies or stops accessing funded aged care services; and
- other requirements relating to amounts that may be charged under section 286 of the Act.

Section 286-10 – Amounts that may be charged—specialist aged care program fee (for programs other than CHSP)

Subsection (1) provides that a registered provider delivering funded aged care services through a service group under a specialist aged care program other than the CHSP on a day to an individual may charge the individual an amount (the *specialist aged care program fee*) for or in connection with those services.

Subsection (2) provides that, subject to subsection (3), the specialist aged care program fee for an individual for a day is the amount agreed between the registered provider and the individual in a written agreement.

Subsection (3) provides that the specialist aged care program fee for an individual for a day must not exceed:

- if the funded aged care services are delivered through the residential care service group—the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis); or
- if the funded aged care services are delivered through the home support, assistive technology or home modifications service group—the amount obtained by rounding down to the nearest cent the amount equal to 17.5% of the basic age pension amount (worked out on a per day basis).

Section 286-15 – Amounts that may be charged—CHSP contribution (for CHSP only)

Subsection (1) provides that a registered provider delivering funded aged care services through a service group under the CHSP on a day to an individual may charge the individual an amount (the CHSP contribution) for or in connection with those services.

Subsection (2) provides that the CHSP contribution for the delivery of the funded aged care service to the individual on the day is the amount agreed between the registered provider and the individual in a written agreement.

Subsection (3) provides that the written agreement must include how and when CHSP contributions are to be paid.

Section 286-17 – Refund of amounts paid in advance if individual dies or stops accessing services

This section provides that if an individual dies or stops accessing funded aged care services, and has paid an amount that the individual may be charged under section 286 of the Act in advance for a day occurring after the individual dies or stops accessing those services, the registered provider to whom the individual paid the amount must refund the amount.

If the individual has died, the registered provider must refund the amount to the following persons in the following circumstances and timeframes:

- If, within 14 days after the provider becomes aware of the individual's death, the provider is shown the probate of the will of the individual or letters of administration of the estate of the individual, the registered provider must refund the amount to the individual's estate within 14 days after the day on which the provider was so shown
- If the above situation does not apply, the registered provider must refund the amount to a person that the provider is reasonably satisfied, on the basis of other evidence shown to the provider, that it is appropriate to pay the refund to within 14 days after the provider was shown the other evidence.

If the individual has not died, the registered provider must refund the amount to the individual within 14 days after the individual stops accessing those services.

Section 286-20 – Other requirements—financial hardship policy

Subsection (1) provides that a registered provider delivering funded aged care services through a service group under a specialist aged care program must have a financial hardship policy that covers the following:

- how an individual can apply for a waiver or reduction of the specialist aged care program fee or CHSP contribution for the individual due to financial hardship;
- what evidence of financial hardship the individual must submit to the provider, and how that evidence must be submitted;
- the principles or calculations the provider will use to determine the amount and duration of the waiver or reduction of the fee or contribution if the individual's application is successful.

Subsection (2) provides that a registered provider must make the financial hardship policy publicly available.

Section 286-25 – Other requirements—CHSP and NATSIFACP—consumer contribution policy

Subsection (1) provides that a registered provider delivering funded aged care services through a service group under the CHSP or the NATSIFACP must:

- have a consumer contribution policy that takes into account the capacity of individuals to contribute toward the cost of the services delivered to them; and
- set their specialist aged care program fees and CHSP contributions in accordance with that policy.

Subsection (2) provides that a registered provider must make the consumer contribution policy publicly available.

Chapter 9 – Funding of aged care services – accommodation payments and accommodation contributions etc.

Part 1 – Introduction

Section 287-5 – Simplified outline of this Chapter

This Chapter provides for matters relating to payments made by individuals under Part 4 of Chapter 4 of the Act in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home.

Part 2 of this Chapter prescribes requirements in relation to accommodation bonds, accommodation charges and entry contributions for individuals in the pre-2014 accommodation class, and deals with:

- circumstances in which registered providers may enter into accommodation bond agreements with individuals and requirements for the accommodation bond agreements; and
- requirements for the charging of accommodation bonds, the maximum amount of accommodation bonds, permitted uses of accommodation bonds and matters relating to the payment of accommodation bonds; and
- the retention, deduction, refund and transfer of accommodation bond balances; and
- the payment of interest in relation to the refund of accommodation bond balances; and
- circumstances in which registered providers may enter into accommodation charge agreements with individuals and requirements for the accommodation charge agreements; and

- the maximum daily accrual amount of accommodation charges and matters relating to the payment of accommodation charges; and
- the payment of interest in relation to the refund of entry contribution balances.

Part 3 of this Chapter relates to accommodation payments and accommodation contributions, and deals with:

- prescribing certain provisions of Part 4 of Chapter 4 of the Act that do not apply in relation to certain specialist aged care programs; and
- maximum accommodation payment amounts and publication of certain amounts by the System Governor; and
- matters relating to accommodation agreements, including what must be set out in accommodation agreements, other requirements for agreements, and methods for working out payments, contributions and refunds; and
- requirements of registered providers in relation to charging accommodation payments and accommodation contributions; and
- matters relating to the charging of daily payments, including interest, indexation and refunds; and
- matters relating to refundable deposits, including deductions from refundable deposit balances, requirements for the use of refundable deposits, refunds of refundable deposits, transfers of refundable deposits between registered providers and payments of interest. Compliance with the requirements in this Chapter is a condition of registration under section 151 of the Act.

Subsection 582(1) of the Act provides that the System Governor may, in writing, arrange for the use, under the System Governor's oversight, of computer programs to take administrative action that must be taken by the System Governor under this Act. This includes administrative actions under Parts 2 to 5 of Chapter 4 of the Act as provided for by paragraph 582(2A)(e) of the Act. The rules in Chapter 9 are made for the purposes of sections 287 to 313 in Part 4 of the Act and include administrative actions that may be automated.

Part 2 – Accommodation bonds and accommodation charges

Division 1 – Application of this Part

Section 287-10 – Application of this Part

The class of individuals in the pre-2014 accommodation class is prescribed in this Part for the purposes of subsection 287(2) of the Act.

The purpose of this Part is also to prescribe requirements for the purposes of subsection 287(3) of the Act in relation to the following:

- the entering of agreements for, and the charging, payment and use of, accommodation bonds for the delivery of ongoing funded aged care services to an individual in the pre-2014 accommodation class;
- the retention of, deduction of amounts from, transfer of, refund of, and payment of interest in relation to the refund of, an accommodation bond balance in relation to an individual in the pre-2014 accommodation class;

- the entering of agreements for, and the charging and payment of, accommodation charges for the delivery of ongoing funded aged care services to an individual in the pre-2014 accommodation class;
- the transfer of, and the payment of interest in relation to the refund of, entry contribution balances in relation to an individual in the pre-2014 accommodation class

Division 2 – Accommodation bond agreements

Section 287-13 – Entry into accommodation bond agreements

This section sets out that a registered provider may enter into an accommodation bond agreement with an individual in the pre-2014 accommodation class, after transition time in relation to an approved residential care home if:

- one of the following situations applies to the individual:
 - immediately before the transition time, a formal agreement (within the meaning of the old Act) or an accommodation bond agreement (within the meaning of the Transitional Act) was in effect for the individual;
 - at the transition time, the most recent agreement under the old Act that had been in effect for the individual was an agreement of a kind mentioned in subparagraph (i);
 - immediately before the transition time, the individual was eligible under the old Act to enter into an accommodation bond agreement (within the meaning of the Transitional Act); and
- the individual ceased (whether before or after the transition time) accessing funded aged care services in another approved residential care home and will start, or has started, accessing funded aged care services in the new home.

Note 1 to this section states that the new home and the former home may be approved in relation to the same registered provider.

Note 2 to this section states that an individual in the pre-2014 accommodation class may change homes before the transition time and still be a member of that class as provided for by paragraph (b) of the definition of pre-2014 accommodation class.

Section 287-15 – Information to be given before registered provider enters into an accommodation bond agreement with an individual

This section provides that, before a registered provider enters into an accommodation bond agreement with an individual, the provider must give the individual a copy of the proposed agreement that meets the requirements set out in section 287-25 of the rules; and inform the individual of the matters prescribed.

A registered provider must enter into an accommodation bond agreement with an individual in relation to an approved residential care home before, or within 21 days after, the individual's start day for the home.

Section 287-20 – Time within which registered providers must enter into accommodation bond agreements

This section provides that a registered provider must enter into an accommodation bond agreement with an individual in relation to an approved residential care home before, or within 21 days after, the individual's start day for the home.

Section 287-25 – Accommodation bond agreements

This section sets out matters that must be specified in an accommodation bond agreement between a registered provider and an individual. Specifically, that the accommodation bond agreement must include:

- the individual's start day, or proposed start day, for the home;
- the accommodation bond that:
 - will be payable if the individual starts accessing the services in the home; or
 - is payable if the individual has already started to access the services in the home;
- how the accommodation bond is to be paid, and if the bond is to be paid by periodic payment, the conditions relating to the payments (which must comply with the requirements of section 287-70 of the rules);
- when the accommodation bond is payable;
- the amount of each accommodation bond retention amount that will be deducted from the accommodation bond balance;
- when accommodation bond retention amounts and other amounts permitted by section 287-90 of the rules to be deducted from the accommodation bond balance will be deducted;
- the individual's room that the accommodation bond entitles the individual to be provided with;
- any services that the accommodation bond entitles the individual to be provided with;
 - that a transitional fee reduction supplement under section 242B-27 of the rules may apply to the individual and reduce the accommodation bond, including to nil;
- that, if the individual changes the individual's room in the home, this will not change the individual's start day for the home;
- the circumstances in which the accommodation bond balance must be refunded and the way the amount of the refund will be worked out;
- the rate of interest, or interest equivalent, payable if the accommodation bond:
 - is paid in whole or in part as a lump sum after the due date; or
 - is paid by periodic payment; or
 - is not paid when it is due to be paid;
- the way interest, or interest equivalent, charges are calculated;
- the total amount of interest, or interest equivalent, charges payable under the agreement:
 - if they can be calculated when the agreement is made; and
 - assuming that the individual will make all payments when they are due;
- the accommodation bond retention amounts payable if the provider delivers the services to the individual in the home for 2 months or less;
- the frequency at which interest, or interest equivalent, charges will be debited.

Subsection (2) of this section provides that subsection (3) applies if the individual elects to pay the accommodation bond by periodic payment, in whole or in part.

Subsection (3) of this section provides that in addition to the matters specified in subsection (1), the accommodation bond agreement must state:

- the amount of the lump sum equivalent; and
- the amount and frequency of the periodic payments; and
- the components of each periodic payment representing:
 - the amount of the retention component; and
 - interest; and
- that the individual may, at any time, pay as a lump sum the whole or a part of the lump sum equivalent. Additional matters in relation to voluntary moves to an approved residential care home of another registered provider

Subsection (4) of this section provides that the accommodation bond agreement must state that, if the individual wishes to move from the approved residential care home of the registered provider (the original home) to an approved residential care home of another registered provider (the new home), the registered provider of the original home may ask the individual for permission to provide the following information to the registered provider of the new home:

- whether the individual has agreed to pay an accommodation bond;
- if so, the amount agreed and, if the individual has agreed to pay the amount in whole or in part by periodic payments, the lump sum equivalent;
- the period remaining during which, under sections 287-95 and 287-100 of the rules, accommodation bond retention amounts may be deducted from the individual's accommodation bond balance;
- amounts that may be deducted from the accommodation bond balance.

Section 287-30 – Accommodation bond agreements may be incorporated into other agreements

This section provides that an individual is taken to have entered into an accommodation bond agreement if the individual has entered into an agreement that contains the provisions required by section 287-25 of the rules.

Section 287-35 – Accommodation bond agreements cannot affect requirements of this Division

This section provides that the requirements of this Division apply despite any provision of an accommodation bond agreement, or any other agreement, to the contrary.

Division 3 – Accommodation bonds

Subdivision A – Charging of accommodation bonds

Section 287-40 – Charging of accommodation bonds

This section provides that a registered provider must comply with the following in relation to the charging of an accommodation bond to an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home (the *new home*) of the provider:

- subject to this section, an accommodation bond must be charged if the individual ceased accessing the services in another approved residential care home (the *former home*) and started accessing the services in the new home and the individual paid an accommodation bond or entry contribution, or an accommodation bond was payable by the individual, to access the services in the former home.

The Notes to this paragraph provide that the new home and the former home may be approved in relation to the same registered provider, and an individual in the pre-2014 accommodation class may change homes before the transition time and still be a member of that class (see paragraph (b) of the definition of pre-2014 accommodation class).

- the accommodation bond must not exceed the maximum amount under section 287-45 of the rules, and the individual must not be charged more than one accommodation bond to access the services in the home;
- if a transitional fee reduction supplement under section 242B-27 of the rules applies to the individual—the accommodation bond must be reduced (but not below zero) to reflect any amount of the supplement that is applied towards the payment;
- payment of the accommodation bond can only be required during a period specified in section 287-65 of the rules;
- payment of the accommodation bond by periodic payments must meet the requirements set out in section 287-70 of the rules;
- the registered provider must not use the accommodation bond unless the use of the bond is permitted (see section 287-101 of the rules);
- the registered provider is entitled to income derived from investing the accommodation bond balance (see section 287-85 of the rules);
- amounts must not be deducted from the accommodation bond balance, except for amounts deducted under section 287-90 of the rules.

Subdivision B – Accommodation bonds

Section 287-45 – Maximum amount of accommodation bonds

Subsection (1) of this section provides that, subject to subsection (2) of this section, the maximum accommodation bond that may be charged for the delivery of ongoing funded aged care services to an individual through the service group residential care in an approved residential care home of a registered provider is the lowest of the following:

- the amount of the accommodation bond that was specified in the most recent accommodation bond agreement that was in effect for the individual;
- an amount that, when subtracted from an amount equal to the value of the individual's assets at the start of the individual's start day for the home, leaves an amount at least equal to the individual's pre2014 minimum permissible asset value (see subsection (3) of this section);
- if paragraph 287-40(a) of the rules applies in relation to an individual who paid an accommodation bond—the accommodation bond balance that was refunded or is payable to the individual under section 287-102 of the rules in respect of the accommodation bond referred to in subparagraph 287-40(a)(ii) of the rules;
- if paragraph 287-40(a) of the rules applies in relation to an individual who paid an entry contribution—the entry contribution balance that was refunded or is payable to the individual in respect of the entry contribution referred to in subparagraph 287-40(a)(ii) of the rules.

The note following the paragraph provides that the operation of this section may be modified if, before entering an accommodation bond agreement, the individual gives the registered provider a determination under section 329 of the Act of the value of the individual's assets: see subsection (5) of this section.

Subsection (2) of this section provides that if an individual seeking to access ongoing funded aged care services through the service group residential care in an approved residential care home of a registered provider does not, before entering into an accommodation bond agreement, give the provider sufficient information about the individual's assets for the provider to be able to determine the amount referred to in paragraph (1)(b) of this section, the maximum amount of the individual's accommodation bond is the lesser of the amount referred to in paragraph (1)(a) of this section and the amount referred to in paragraph (1)(c) or (d) of this section, as applicable.

Subsection (3) of this section provides that an individual's *pre-2014 minimum permissible asset value* is:

- if the individual's start day is before 20 September 2009—the amount obtained by rounding to the nearest \$500.00 (rounding \$250.00 upwards) an amount equal to 2.5 times the basic age pension amount at the start of the individual's start day for the home; and
- if the individual's start day is on or after 20 September 2009—the amount obtained by rounding to the nearest \$500.00 (rounding \$250.00 upwards) an amount equal to 2.25 times the basic age pension amount at the start of the individual's start day for the home.

Subsection (4) of this section provides that the value of an individual's assets is to be worked out in accordance with section 330 of the Act, but:

- taking into account only the assets of the individual of the kinds referred to in subsection 44(2) of the *Aged Care (Transitional Provisions) Principles 2014* as in force immediately before the transition time; and
- disregarding subsection 330(7) of the Act (value of home).

This subsection preserves the asset test provided for in the Transitional Act and *Aged Care (Transitional Provisions) Principles 2014*.

Subsection (5) of this section provides that subsections (1), (2) and (3) are modified as described in the following table, and subsection (4) does not apply, if, before entering the accommodation bond agreement, the individual gives the registered provider a copy of a determination that:

- is a determination under section 329 of the Act of the value of the individual's assets at a time (the **valuation time**) that is before or at the start of the individual's start day for the home; and
- is in force at the start of the start day, if that is after the valuation time.

Item 1 of the table provides that if the valuation time is before the start of the start day for the home, subsections (1), (2) and (3) have effect as if the references in paragraph (1)(a) and subsection (3) to the start of the individual's start day for the home were references to the valuation time and the value of the individual's assets at the valuation time were the value specified in the determination.

Item 2 of the table provides that if the valuation time is at the start of the start day for the home the value of the individual's assets at the start of the individual's start day for the home were the value specified in the determination.

Subdivision C – Payment of accommodation bonds

Section 287-65 – Period for payment of accommodation bond

This section provides that an individual must not be required to pay an accommodation bond before the day that is 6 months after the individual's start day for the approved residential care home to which the payment relates.

The note to this section states that, however, under sections 287-85 and 287-95 of the rules, amounts representing income derived and accommodation bond retention amounts are payable from the day an individual starts accessing ongoing funded aged care services.

Section 287-70 – Payment of accommodation bonds by periodic payment

Subsection (1) of this section provides that an individual may elect to pay an accommodation bond, in whole or in part, by periodic payment.

Subsection (2) of this section provides that if the individual elects to pay the bond by periodic payment, the registered provider for the approved residential care home to which the bond relates and the individual must agree on the frequency of payments and the amount of a payment, worked out in accordance with subsection (3) of this section.

Subsection (3) of this section provides that, for the purposes of paragraph (2)(b), the formula for working out the amount of a periodic payment is as follows:

$$\frac{(LSE \times IR) + RC}{NPP}$$

The rules include the following defined terms:

IR is the lower of the interest rate stated in the individual's accommodation bond agreement and the pre-2014 maximum permissible interest rate for the individual's start day for the home.

LSE is the amount of the individual's lump sum equivalent.

NPP is the number of periodic payments payable by the individual in the relevant year.

RC is the amount of the retention component worked out:

- if no part of the accommodation bond is paid as a lump sum—in accordance with subsection (4); or
- if part of the accommodation bond is paid as a lump sum—in accordance with subsections (5) and (6) and, if applicable, (7).

The Note to subsection (2) provides that in relation to this subsection to also see section 287-95 of the rules.

Subsection (4) of this section provides that the amount of the retention component must not exceed the maximum accommodation bond retention amount that may be deducted under section 287-95 of the rules, during the year beginning on the individual's start day for the home, from the amount that would have been the accommodation bond balance if the individual had paid the whole of the accommodation bond as a lump sum.

The Note to subsection (4) of this section clarifies that an amount deducted from an accommodation balance in accordance with section 57-19 of the old Act before the transition time is taken to have been deducted from an accommodation bond balance in accordance with section 287-90 of the rules.

Subsection (5) of this section provides if part of the accommodation bond is paid as a lump sum, the amount of the retention component of the periodic payments is reduced, on a proportionate basis, in accordance with the ratio of the lump sum equivalent to the amount of the accommodation bond.

Subsection (6) of this section provides that if the lump sum is sufficient to cover the total of the accommodation bond retention amounts for the period of 5 years for the whole of the accommodation bond, including the lump sum equivalent, and the individual elects:

- the amount of the retention component is nil; and
- the total of the accommodation bond retention amounts, including the retention component that would otherwise be payable on the lump sum equivalent, may be deducted from the amount paid as a lump sum.

Subsection (7) of this section provides that for the purposes of subsection (6):

- the period of 5 years begins on the individual's start day for the home; and
- the individual's election must be made in writing and given to the registered provider.

Section 287-75 – Minimum amount of periodic payments

Subsection (1) of this section provides that the minimum amount of a periodic payment payable by an individual is the amount representing the periodic payments that would have been payable for 3 calendar months.

Subsection (2) of this section provides that if a registered provider ceases to deliver ongoing funded aged care services to an individual through the service group residential care in an approved residential care home of the provider, the provider may charge the individual the full amount of a periodic payment that is payable for the month in which the provider ceases to deliver the services.

Section 287-80 – Payment if agreed accommodation bond not paid

Subsection (1) of this section provides that this section applies if:

- an individual has agreed to pay an accommodation bond to a registered provider in whole or in part as a lump sum; and
- the provider ceases to deliver ongoing funded aged care services to the individual through the service group residential care in the approved residential care home to which the payment relates; and
- the provider delivered the services to the individual for more than 2 months; and

- the individual does not pay the accommodation bond before the provider ceases to deliver the services to the individual.

Subsection (2) of this section provides that the individual may be required to pay an amount (the ***interest equivalent amount***) worked out in accordance with subsection (3) of this section, in relation to the individual's accommodation bond balance, to the registered provider.

The Note to subsection (2) of this section provides that this subsection has effect subject to section 287-86 of the rules.

Subsection (3) of this section provides that for the purposes of subsection (2) of this section, the interest equivalent amount, in relation to the individual's accommodation bond balance, is the amount worked out in accordance with the following formula:

$$\frac{I \times LS \times D}{365}$$

The rules include the following defined terms:

D is the number of days in the period beginning on the first day of the month in which the lump sum was to be paid and ending on the last day of the month in which the individual ceases to access the services.

I is the lower of the interest rate stated in the individual's accommodation bond agreement and the pre-2014 maximum permissible interest rate for the individual's start day for the home.

LS is the amount of the accommodation bond agreed to be paid as a lump sum.

Subdivision D—Retention, deduction and transfer of accommodation bond balances

Section 287-85 – Registered provider may retain income derived

Subsection (1) of this section provides that a registered provider may retain income derived from the investment of an accommodation bond balance in respect of an accommodation bond paid to the provider for the delivery of ongoing funded aged care services to an individual through the service group residential care in an approved residential care home of the provider.

Subsection (2) of this section provides that, despite section 287-65 of the rules, if an individual pays an accommodation bond to a registered provider in whole or in part as a lump sum after the individual's start day for the home to which the payment relates, the individual may be required to pay to the provider an amount (the interest equivalent amount) worked out in accordance with subsection (3) of this section that is equivalent to the income the provider could be expected to have derived, through investing the accommodation bond balance, during the period beginning on the start day for the home and ending on the day on which the accommodation bond was paid.

The note to this subsection provides that this subsection has effect subject to section 287-86 of the rules.

Subsection (3) of this section provides that for the purposes of subsection (2) of this section, the interest equivalent amount, in relation to the individual's accommodation bond balance, is the amount worked out in accordance with the following formula:

$$\frac{IR \times LS \times ND}{365}$$

The rules include the following defined terms:

IR is the lower of the interest rate stated in the individual's accommodation bond agreement and the pre-2014 maximum permissible interest rate for the individual's start day for the home.

LS is the amount of the lump sum.

ND is the number of days in the period beginning on the individual's start day for the home and ending on the day when the accommodation bond was paid in whole or in part as a lump sum.

Subsection (4) of this section provides that if a registered provider delivers ongoing funded aged care services to an individual through the service group residential care at an approved residential care home of the provider for 2 months or less, the individual may be required to pay to the provider an amount (the interest equivalent amount) worked out in accordance with subsection (5) or (6) of this section representing the income the provider could be expected to have derived, through investing the accommodation bond balance, during the whole of the month in which the provider delivered the services and the 2 following months.

The note following subsection (4) of this section provides that this subsection has effect subject to section 287-86 of the rules.

Subsection (5) of this section provides that if the individual pays the accommodation bond in whole or in part as a lump sum and the amount paid as a lump sum is refunded to the individual within 3 months after the individual's start day for the home; the interest equivalent amount, in relation to the individual's accommodation bond balance, is the amount worked out in accordance with the following formula:

$$\frac{IR \times LS \times ND}{365}$$

The rules include the following defined terms:

IR is the lower of the interest rate stated in the individual's accommodation bond agreement to which the payment relates and the pre-2014 maximum permissible interest rate for the individual's start day for the home.

LS is the amount of the lump sum.

ND is the number of days in the period beginning on the day when the lump sum was refunded and ending 3 months after the start day for the home.

Subsection (6) of this section provides that, if the individual has agreed to pay the accommodation bond in whole or in part as a lump sum and does not pay the lump sum before the individual ceases to access ongoing funded aged care services in the home, the interest equivalent amount, in relation to the individual's accommodation bond balance, is the amount worked out in accordance with the following formula:

$$\frac{IR \times LS \times ND}{365}$$

IR is the lower of the interest rate stated in the individual's accommodation bond agreement and the pre-2014 maximum permissible interest rate for the individual's start day for the home.

LS is the amount of the lump sum.

ND is the number of days in 3 calendar months from the individual's start day for the home.

Subsection (7) of this section provides that an individual cannot be required to pay the interest equivalent amounts worked out under both subsections (3) and (6) of this section.

Subsection (8) of this section provides that the registered provider may require payment of an amount less than the interest equivalent amount required to be paid under subsection (2) or (4) of this section.

Section 287-86 – Restriction on retention of income derived

This section provides that despite subsections 287-80(2) and 287-85(1), (2) and (4) of the rules, if a transitional fee reduction supplement under section 242B-27 of the rules applies to an individual and is reducing the individual's accommodation bond, a registered provider must not do either of the following in respect of the period for which the supplement applies to the individual:

- retain income derived from the investment of the individual's accommodation bond balance in accordance with subsection 287-85(1) of the rules;
- require the individual to pay an interest equivalent amount under subsection 287-80(2) or subsections 287-85(2) or (4) of the rules in relation to the individual's accommodation bond balance.

Section 287-90 – Amounts to be deducted from accommodation bond balance

Subsection (1) of this section provides that a registered provider to whom an accommodation bond was paid by an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider may deduct from the accommodation bond balance:

- an accommodation bond retention amount in respect of the accommodation bond (see section 287-95) of the rules; and
- an amount owed to the registered provider by the individual under an accommodation bond agreement or a service agreement; and

- subject to subsection (3), an amount of interest on the amount referred to in paragraph (b) that does not exceed the pre-2014 maximum permissible interest rate for the individual's start day for the home.

Subsection (2) of this section provides that the registered provider must not deduct any other amounts from the accommodation bond balance.

Subsection (3) of this section provides that the registered provider may only charge interest for the period:

- beginning on the day that is 1 month after the day on which the amount was payable under the accommodation bond agreement or service agreement; and
- ending on the earlier of the day either on which the amount was paid or the day the provider ceased delivering the services to the individual at the home of the provider.

Section 287-95 – Accommodation bond retention amounts

Subsection (1) of this section provides that the maximum accommodation bond retention amount that may be deducted, from an individual's accommodation bond balance, during a year (the **first year**) beginning on the individual's start day for an approved residential care home, or a year (a **later year**) beginning on the anniversary of the individual's start day for the home, is:

- if the accommodation bond is not more than the lower threshold amount— 10% of the lower threshold amount; or
- if the accommodation bond is more than the lower threshold amount but not more than the higher threshold amount—10% of the accommodation bond; or
- if the accommodation bond is more than the higher threshold amount— 10% of the higher threshold amount.

Subsection (2) of this section provides that despite subsections (3) and (4) of this section, the maximum accommodation bond retention amount for the individual for a later year is the same as the maximum accommodation bond retention amount for the first year.

Subsection (3) of this section provides that in subsection (1) of this section:

higher threshold amount is:

- for a year beginning in a financial year beginning on or after 1 July 1997 and before 1 July 2025—an amount equal to the amount Y worked out for the year in accordance with sections 97 and 98 of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time; or
- for a year beginning in a later financial year—the amount specified in column 3 of the table in subsection (4) for the financial year.

lower threshold amount is:

- for a year beginning in a financial year beginning on or after 1 July 1997 and before 1 July 2025—the amount equal to the amount X worked out for the year in accordance with sections 97 and 98 of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time; or
- for a year beginning in a later financial year—the amount specified in column 2 of the table in subsection (4) for the financial year.

Subsection (4) of this section provides that for the financial year beginning on 1 July 2025, the lower threshold amount is \$28,200 and the higher threshold amount is \$54,540.

Subsection (5) of this section provides that the maximum monthly accommodation bond retention amount is the amount worked out in accordance with subsection (1) of this section divided by 12.

Section 287-100 – Restriction on deduction of accommodation bond retention amounts

Subsection (1) of this section provides that, if a transitional fee reduction supplement under section 242B-27 of the rules applies to an individual and is reducing the accommodation bond balance, the registered provider delivering ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider must not deduct any accommodation bond retention amounts from the individual's accommodation bond balance during the period for which the supplement applies to the individual.

Subsection (2) of this section provides that subject to subsections (3) and (5) of this section, a registered provider may deduct an accommodation bond retention amount from an accommodation bond balance for each month, or part of a month, during which the provider is delivering ongoing funded aged care services to the individual in an approved home of the provider in respect of which the accommodation bond was paid.

Subsection (3) of this section provides that, subject to subsection (5) of this section, accommodation bond retention amounts may only be deducted during the period of 5 years beginning on the individual's start day for the first approved residential care home for which the individual paid an accommodation bond.

Subsection (4) of this section provides that the 5 year period referred to in subsection (3) of this section is extended by one day for each day during any period:

- for which a transitional fee reduction supplement under section 242B-27 of the rules applies to the individual and is reducing the accommodation bond balance; or
- during which the individual is not accessing ongoing funded aged care services in an approved residential care home.

Subsection (5) of this section provides that if, before the accommodation bond was paid, amounts had already been deducted from an accommodation bond balance in respect of another accommodation bond previously paid by the individual for another approved residential care home, the period of 5 years referred to in subsection (3) of this section is reduced by each month in respect of which an accommodation bond retention amount was so deducted.

The note following subsection (5) of this section provides that the effect of this subsection is that all periods spent accessing ongoing funded aged care services in the service group residential care after an accommodation bond is first paid will count towards the 5 year maximum under subsection (3) of this section for deducting accommodation bond retention amounts.

Subsection (6) of this section provides that, for the purposes of this section, if the registered provider delivers the services to the individual for 2 months or less, the individual is taken, for the purposes of working out the accommodation bond retention amounts payable, to have

received the services during the whole of the month in which the provider started delivering the services to the individual and the 2 following months.

Section 287-101 – Accommodation bonds to be used only for permitted purposes

Subsection (1) of this section provides that a registered provider must not use an accommodation bond unless the use is permitted by this section.

The permitted uses of accommodation bonds are consistent with the rules and principles that dictate the permitted uses of refundable deposits and their intent, as per section 310 of the Act and the sections made for the purpose of that section in the rules. Permitted uses of accommodation bonds are intended to reduce the risk of providers defaulting on obligations to repay accommodation bonds. Like refundable deposits, accommodation bonds are intended to provide a source of funding for capital investment in residential aged care infrastructure, for prudent financial investment and for refunding other accommodation payments, such as refundable deposits, accommodation bonds and entry contributions.

Permitted uses

Subsection (2) of this section prescribes that a registered provider is permitted to use an accommodation bond for the following purposes:

- for capital expenditure of a kind covered by subsection (3);
- to invest in a financial product (within the meaning of Division 3 of Part 7.1 of the *Corporations Act 2001*) covered by subsection (4);
- to make a loan in relation to which the following conditions are satisfied:
 - the loan is not made to an individual;
 - the loan is made on a commercial basis;
 - there is a written agreement in relation to the loan;
 - it is a condition of the agreement that the money loaned will only be used as mentioned in paragraph (a), (b), (d) or (e) of this subsection;
- to refund, or to repay debt accrued for the purposes of refunding, accommodation bond balances, entry contribution balances or refundable deposit balances;
- to repay debt accrued for the purposes of capital expenditure of a kind covered by subsection (3);
- to meet reasonable businesses losses that are incurred in the course of delivering funded aged care services within the period of 12 months after the day the registered provider begins to deliver funded aged care services to the individual through the service group residential care;
- to invest in a fund, but not a controlling entity of a fund, listed in item 2 of the first Schedule to *Banking exemption No. 1 of 2021* made under the *Banking Act 1959*.

Subsection (3) of this section prescribes that for the purposes of paragraphs (2)(a) and (e) of this section, a registered provider may use accommodation bonds for the following kinds of capital expenditure:

- accommodation bonds may be used to acquire land on which are, or are to be built, the premises needed for delivering funded aged care services through the service group residential care, but only to the extent that the expenditure relates to those premises;
- accommodation bonds may be used to acquire, erect, extend or significantly alter premises used, or proposed to be used, for delivering funded aged care services

through the service group residential care, but only to the extent that the expenditure relates to the delivery of those funded aged care services;

- accommodation bonds may be used to acquire or install furniture, fittings or equipment for premises used, or proposed to be used, for delivering funded aged care services through the service group residential care, when those premises are initially erected or following an extension, a significant alteration or a significant refurbishment, but only to the extent that the expenditure relates to the delivery of those funded aged care services;
- accommodation bonds may be used for expenditure that is directly connected to expenditure covered by the three aforementioned paragraphs.

Subsection (4) of this section prescribes the types of financial products that a registered provider may invest in, using accommodation bonds, as for the purposes of paragraph (2)(b) of this section. This includes the following:

- an accommodation bond may be used to invest in any deposit-taking facility made available by an authorised deposit-taking institution in the course of its banking business (within the meaning of *the Banking Act 1959*), other than a retirement savings account;
- an accommodation bond may be used to invest in a debenture, stock or bond issued, or proposed to be issued, by the Commonwealth, a State or a Territory;
- an accommodation bond may be used to invest in a security;
- an accommodation bond may be used to invest in any of the following in relation to a registered scheme (within the meaning of the *Corporations Act 2001*):
 - an interest in the scheme;
 - a legal or equitable right or interest in an interest covered by subparagraph (i);
 - an option to acquire, by way of issue, an interest or right covered by subparagraph (i) or (ii);
- an accommodation bond may be used to invest in an interest in a scheme that has been established for the purpose of investing in the delivery of funded aged care services. The aged care services in questions must be delivered through the service group residential care in an approved residential care home. The scheme must:
 - be a managed investment scheme within the meaning of the *Corporations Act 2001*; and
 - not be a registered scheme within the meaning of the *Corporations Act 2001*;
- an accommodation bond may be used to invest a legal or equitable right or interest in an interest covered by paragraph (e) of this subsection;
- an accommodation bond may be used to enter an option to acquire, by way of issue, an interest or right covered by paragraph (e) or (f) of this subsection .

Section 287-102 – Refund of accommodation bond balance

Circumstances in which accommodation bond balance must be refunded

Subsection (1) of this section provides that if an accommodation bond is paid to a registered provider, the provider must refund the accommodation bond balance if the individual dies or the registered provider ceases to deliver ongoing funded aged care services to the individual through the service group residential care in the approved residential care home to which the payment relates (other than because the individual is on leave) and the registered provider has

not transferred, or is not required to transfer, the accommodation bond balance to another registered provider under section 287-103 of the rules.

Subsection (2) of this section provides that if paragraph (1)(a) applies, the accommodation bond balance must be refunded:

- if the registered provider is shown the probate of the will of the individual or letters of administration of the estate of the individual—within 14 days after the day on which the provider was so shown; or
- if the registered provider is not shown the probate of the will of the individual or letters of administration of the estate of the individual and the registered provider is shown other evidence that satisfies the provider that the accommodation bond balance is to be refunded to a person—within 14 days after the other evidence is shown to the provider.

Subsection (3) of this section provides that if paragraph (1)(b) applies, the accommodation bond balance must be refunded in accordance with the table.

Item 1 of the table provides that the accommodation bond balance must be refunded on the day on which the registered provider ceased delivering the services mentioned in subparagraph (1)(b)(i) if the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care and the individual notified the registered provider of the move more than 14 days before the day.

Item 2 of the table provides that the accommodation bond balance must be refunded within 14 days after the day on which the notice was given to the provider if the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care and the individual notified the registered provider of the move within 14 days before the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i).

Item 3 of the table provides that the accommodation bond balance must be refunded within 14 days after the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i) if the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care and the individual did not notify the provider of the move before the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i).

Item 4 of the table provides if Items 1 to 3 of the table do not apply, the accommodation bond balance must be refunded either within 14 days after the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i) or if the individual has agreed with the registered provider as mentioned in subsection (4) and the individual has notified the registered provider, in writing, that they wish to cease that agreement—within 14 days after the day on which the individual has notified the provider

Subsection (4) of this section provides that the agreement is an agreement between the individual and the registered provider to delay refunding the accommodation bond balance on condition that, if the individual requests re-entry to the approved residential care home, the registered provider must allow entry to the individual if a room, or part of a room, is vacant in the approved residential care home and the individual has an access approval in effect that includes the classification type ongoing for the service group residential care.

Section 287-103 – Transfer of accommodation bond balance to another registered provider

This section prescribes the requirements of registered providers to transfer an individual's accommodation bond balance from an outgoing provider to an incoming provider. An outgoing provider is the registered provider ceasing operations for the respective aged care service. The incoming provider is the registered provider taking over operations of the respective aged care service.

Subsection (1) of this section explains when this section applies, and a transfer is required.

Paragraph (1)(a) provides that an accommodation bond must have been paid by an individual to a registered provider (the *outgoing provider*) for accommodation in an approved residential care home.

Paragraph (1)(b) provides that the accommodation bond was paid in whole or in part as a lump sum.

Paragraph (1)(c) provides that the outgoing provider ceases delivery of aged services.

Paragraph (1)(d) provides that, despite the cessation of delivery by the outgoing provider, services continue to be delivered to the individual in the same care home by another registered provider (the *incoming provider*).

Subsection (2) of this section outlines when an accommodation bond balance must not be transferred.

Paragraph (2)(a) of this subsection provides that if the incoming provider delivers ongoing residential aged care services through a specialist aged care program, then an accommodation bond balance must not be transferred to the incoming provider. Services delivering specialist aged care programs operate under a different funding model and do not collect or hold accommodation bonds.

Paragraph (2)(b) of this subsection provides that if the incoming provider does not deliver residential aged care services, then the accommodation bond balance must not be transferred.

The note following subsection (2) of this section states that when a transfer must not be made, it must instead be refunded in accordance with section 287-102 of the rules: see subparagraph 287-102(1)(b)(ii) of the rules.

Subsection (3) of this section requires the outgoing provider to give a written notice to the incoming provider. The notice must be given before the transfer day. The notice must include the following information:

- the day the transfer of the accommodation bond balance will take place;
- the amount of interest (if any), calculated in accordance with section 287-103A of the rules, that is payable to the individual on or before the transfer day
- the individual's respective entry in the provider's refundable deposit register (see section 150A of the rules).

Subsection (4) of this section requires the outgoing provider to give a written notice to the individual, with details of their accommodation bond balance transfer. This notice must be given to the individual before the transfer day. The notice must include the following:

- details about the incoming provider (this may include, but not be limited to, the incoming provider's name, quality ratings and service offerings).
- the transfer day of the individual's accommodation bond balance.

Subsection (5) of this section explains what must occur when the intended transfer day changes. For example, a transfer day may change due to a delay in negotiating the sale terms, or due to a technical error in any financial transfer. If the transfer day changes, the outgoing provider must give a written notice to the individuals. The written notice should inform the individual of the new transfer day. The notice should be given as soon as practicable to the individual, and before the revised transfer day.

Subsection (6) of this section determines that the outgoing provider must transfer the accommodation bond balance to the incoming provider on the transfer day, as per the date given to the individual in the written notice mentioned in subsection (3), or subsection (4) (where applicable). On the transfer day, the incoming provider assumes responsibility of the accommodation bond balance liability, and all requirements associated with the collection, holding and use of accommodation bonds.

Section 287-103A – Payment of interest – refund of accommodation bond balances

Subsection (1) of this section provides that a registered provider must pay an amount of interest relating to a refund of an accommodation bond balance, worked out in accordance with subsections (2) and (3), to an individual on the day on which the registered provider refunds the accommodation bond balance to the individual if the registered provider is required under section 287-102 of the rules to refund the accommodation bond balance to the individual.

Amount of base interest—balance refunded on or before last day of refund period

Subsection (2) of this section provides that if a registered provider refunds an accommodation bond balance on or before the last day of the refund period, the amount of base interest on the accommodation bond balance is the amount worked out in accordance with the following formula:

$$\frac{BIR \times AB \times ND}{365}$$

This section defines the following terms:

AB is the amount of the accommodation bond balance.

BIR is the base interest rate, calculated on the first day of the refund period.

ND is the number of days in the period beginning on the day after the day on which the refunding event occurred and ending on the day on which the accommodation bond balance is refunded.

The note following subsection (2) of this section, provides that subsection (2) does not apply in the situation described in item 1 of the table in subsection 287-102(3) of the rules because column 2 of item 1 does not specify a refund period.

Amount of base interest plus pre-2014 maximum permissible interest rate— balance refunded after last day of refund period

Subsection (3) of this section provides that if a registered provider refunds an accommodation bond balance after the last day of the refund period, or after the day referred to in column 2 of Item 1 of the table in subsection 287-102(3) of the rules, the amount of interest on the accommodation bond balance is the amount worked out in accordance with the following formula:

$$\left(\frac{BIR \times AB \times ND(RP)}{365} \right) + \left(\frac{MPIR \times AB \times ND(PP)}{365} \right)$$

This section defines the following terms:

AB is the amount of the accommodation bond balance.

BIR is the base interest rate, calculated on the first day of the refund period.

MPIR is the pre-2014 maximum permissible interest rate for:

- if Item 1 of the table in subsection 287-102(3) of the rules applies—the day after the day referred to in column 2 of item 1 of that table; or
- if Item 2, 3 or 4 of the table in subsection 287-102(3) of the rules applies—the day after the last day in the refund period.

ND(PP) is the number of days in the period beginning on:

- if Item 1 of the table in subsection 287-102(3) of the rules applies—the day after the day referred to in column 2 of item 1 of that table; or
- if Item 2, 3 or 4 of the table in subsection 287-102(3) of the rules applies—the day after the last day of the refund period; and (b) ending on the day on which the accommodation bond balance is refunded.

ND(RP) is equal to:

- if Item 1 of the table in subsection 287-102(3) of the rules applies—zero; or
- if Item 2, 3 or 4 of the table in subsection 287-102(3) of the rules applies—the number of days in the period beginning on the day after the day on which the refunding event occurred and ending on the last day of the refund period.

Division 4—Accommodation charge agreements

Section 287-104 – Entry into accommodation charge agreement

This section provides that a registered provider may enter into an accommodation charge agreement with an individual in the pre-2014 accommodation class after the transition time in relation to an approved residential care home (the **new home**) if:

- one of the following applies to the individual:

- immediately before the transition time, an accommodation charge agreement (within the meaning of the Transitional Act, as in force immediately before the transition time) was in effect for the individual;
- at the transition time, the most recent agreement that had been in effect for the individual was an agreement of the kind mentioned in subparagraph (i);
- immediately before the transition time, the individual was eligible under the old Act to enter into an agreement of the kind mentioned in subparagraph (i); and
- the individual ceased (whether before or after the transition time) accessing funded aged care services in another approved residential care home and will start, or has started, accessing funded aged care services in the new home.

Note 1 to this section provides that the new home and the former home may be approved in relation to the same registered provider.

Note 2 to this section provides that an individual in the pre-2014 accommodation class may change homes before the transition time and still be a member of that class: see paragraph (b) of the definition of *pre-2014 accommodation class*.

Section 287-105 – Information to be given before registered provider enters into an accommodation charge agreement with an individual

This section provides that before a registered provider enters into an accommodation charge agreement with an individual the provider must:

- give the individual a copy of the proposed accommodation charge agreement that meets the requirements set out in section 287-115 of the rules; and
- inform the individual of the following:
 - that, if the individual has given the provider sufficient information to determine the value of the individual's assets, the provider is required to leave the individual with assets with a value at least equal to the individual's pre-2014 minimum permissible asset value;
 - the interest rate to be charged on amounts owed under the accommodation charge agreement;
 - the accommodation charge;
 - when an accommodation charge is not required;
 - when an accommodation charge must not be charged at more than a specified daily amount because a transitional fee reduction supplement under section 242B-27 of the rules applies to the individual and is reducing the individual's accommodation charge;
 - if an accommodation charge is paid—when the charge is refundable.

Section 287-110 – Time within which registered providers must enter into accommodation charge agreement

This section provides that a registered provider must enter into an accommodation charge agreement with an individual in relation to an approved residential care home before, or within 21 days after, the individual's start day for the home.

Section 287-115 – Accommodation charge agreements

This section provides that an accommodation charge agreement between a registered provider and an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider must set out the following:

- the individual's start day, or proposed start day, for the home;
- the accommodation charge that:
 - will accrue for each day (including a day on which the individual is on leave from the home) if the individual starts accessing the services at the home; or
 - if the individual has already started to access the services at the home—has accrued and will accrue for each day (including a day on which the individual is on leave from the home);
- how the accommodation charge is to be paid;
- when the accommodation charge is payable;
- the individual's room that the accommodation charge entitles the individual to be provided with;
- any services that the accommodation charge entitles the individual to be provided with;
- that a transitional fee reduction supplement under section 242B-27 of the rules may apply to the individual and reduce the accommodation charge, including to nil;
- that if the individual wishes to move from the approved residential care home (the *original home*) of the provider to another approved residential care home (the *new home*) of another registered provider, the registered provider of the original home may ask the individual for permission to provide the following information to the registered provider of the new home:
 - whether the individual has agreed to pay an accommodation charge;
 - if so, the payment agreed;
 - the number of days for which the payment accrued under the agreement.

Section 287-120 – Accommodation charge agreements may be incorporated into other agreements

This section provides that for the purposes of this Division, an individual is taken to have entered into an accommodation charge agreement if the individual has entered into an agreement that contains the provisions required by section 287-115 of the rules.

Section 287-125 – Accommodation charge agreements cannot affect requirements of this Division

This section provides that the requirements of this Division apply despite any provision of an accommodation charge agreement, or any other agreement, to the contrary.

Division 5 – Accommodation charges

Subdivision A – Charging of accommodation charges

Section 287-130 – Charging of accommodation charges

This section provides that a registered provider must comply with the following in relation to the charging of an accommodation charge to an individual for the delivery of ongoing funded

aged care services to the individual through the service group residential care in an approved residential care home (the ***new home***) of the provider:

- subject to this section, an accommodation charge must be charged if:
 - the individual ceased accessing the services in another approved residential care home (the ***former home***) of the provider or another registered provider and started accessing the services in the new home; and
 - the individual paid an accommodation charge to access the services in the former home;
- the daily amount at which the accommodation charge accrues must not exceed the maximum provided for by section 287-135 of the rules, and the individual must not be charged more than one accommodation charge to access the services in the home;
- the accommodation charge must not accrue after the day on which the registered provider ceases to deliver the services to the individual in the new home;
- if a transitional fee reduction supplement under section 242B-27 of the rules applies to the individual—the accommodation charge must be reduced (but not below zero) to reflect any amount of the supplement that is applied towards the payment;
- the registered provider must comply with the requirements of section 287-150 of the rules relating to payment of the accommodation charge;
- the individual may be required to pay interest to the registered provider in accordance with section 287-155 of the rules if some or all of the accommodation charge is not paid within the time that section permits.

Subdivision B – Daily accrual amounts of accommodation charges

Section 287-135 – Maximum daily accrual amount of accommodation charge

Subsection (1) of this section provides that, subject to subsection (2) of this section and paragraph 287-130(d) of the rules, the maximum daily amount at which an accommodation charge accrues is the lowest of the following:

- the amount of the daily accrual of the accommodation charge that was specified in the most recent accommodation charge agreement that was in effect for the individual;
- the amount (rounded down to the nearest cent) obtained by:
 - taking the amount that, when subtracted from an amount equal to the value of the individual's assets at the start of the individual's start day for the approved residential care home to which the payment relates, leaves an amount at least equal to the individual's pre-2014 minimum permissible asset value; and
 - dividing the result by 2,080;
- if sections 117 and 119, or section 118 of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time, applied to the individual as at that time—the amount worked out in accordance with whichever of those sections was applicable.

The note following subsection (1) of this section provides that the operation of this section may be modified if, before entering into an accommodation charge agreement, the individual gives the registered provider a determination under section 329 of the Act of the value of the individual's assets. See subsection (4) of this section.

Subsection (2) of this section provides that if an individual seeking to access ongoing funded aged care services through the service group residential care at an approved residential care

home of a registered provider does not, before entering into an accommodation charge agreement, give the provider sufficient information about the individual's assets for the provider to be able to determine the amount referred to in paragraph (1)(b), the maximum daily amount at which the individual's accommodation charge accrues is:

- if sections 117 and 119, or section 118, of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time, applied to the individual as at that time—the lesser of:
 - the amount referred to in paragraph (1)(a); and
 - the amount referred to in paragraph (1)(c); and
- otherwise—the amount referred to in paragraph (1)(a).

Subsection (3) of this section provides that the value of an individual's assets is to be worked out in accordance with section 330 of the Act, but:

- taking into account only the assets of the individual of the kinds referred to in subsection 44(2) of the *Aged Care (Transitional Provisions) Principles 2014* as in force immediately before the transition time; and
- disregarding subsection 330(7) of the Act (value of home).

This subsection preserves the asset test provided for in the Transitional Act and *Aged Care (Transitional Provisions) Principles 2014*.

Subsection (4) of this section provides that subsections (1) and (2) are modified in circumstances set out in the table, and subsection (3) does not apply, if, before entering into the accommodation charge agreement, the individual gives the registered provider a copy of a determination is a determination under section 329 of the Act of the value of the individual's assets at a time (the valuation time) that is before or at the start of the individual's start day for the home and is in force at the start of the start day, if that is after the valuation time.

Item 1 of the table provides that the valuation time is before the start of the start day for the home, subsections (1) and (2) have effect as if the reference in paragraph (1)(b) to the start of the individual's start day for the home were a reference to the valuation time, and the value of the individual's assets at the valuation time were the value specified in the determination, and the value of the individual's assets at the valuation time were the value specified in the determination).

Item 2 of the table provides that if the valuation time is at the start of the start day for the home, the value of the individual's assets at the start of the individual's start day for the home were the value specified in the determination.

Subdivision C – Payment of accommodation charges

Section 287-150 – Accommodation charge may be payable not more than one month in advance

Subsection (1) of this section provides that an individual may be required to pay an accommodation charge from the day that is one month before the day for which the payment will accrue.

Subsection (2) of this section provides that if the accommodation charge does not in fact accrue, the individual is entitled to a refund of the amount paid.

Section 287-155 – Registered provider may charge interest

Subsection (1) of this section provides that the individual may be required to pay interest to the registered provider from the day that is one month after the day for which the payment accrues while the balance remains unpaid if:

- an individual is required, under an accommodation charge agreement, to pay an amount of accommodation charge to a registered provider; and
- the individual does not pay the required amount before the day that is one month after the day for which the payment accrues; and
- the agreement provides for interest to be charged on the balance outstanding at a specified rate.

Subsection (2) of this section provides that the rate at which the interest is charged must not be more than twice the below threshold rate determined by the Minister under subsection 1082(1) of the Social Security Act.

Division 6 – Entry contributions

Section 287-160 – Payment of interest – refund of entry contribution balances

Subsection (1) of this section provides that a registered provider must pay an amount of interest relating to a refund of an entry contribution balance, worked out in accordance with subsection (2) of this section, to an individual in the pre-2014 accommodation class on the day on which the registered provider refunds the entry contribution balance to the individual if:

- the formal agreement between the registered provider and the individual requires the registered provider to refund the entry contribution balance to the individual; and
- either:
 - the registered provider has not made an agreement with the individual to delay refunding the balance; or
 - such an agreement was made but has ceased to be in effect between the registered provider and the individual.

Subsection (2) of this section provides that if the registered provider refunds the entry contribution balance after the last day specified in the formal agreement for the entry contribution balance to be refunded to the individual (the **refund day**), the amount of interest on the entry contribution balance is the amount worked out in accordance with the following formula: where:

$$\frac{\text{MPIR} \times \text{ECB} \times \text{ND(PP)}}{365}$$

The rules define the following terms:

ECB is the amount of the entry contribution balance.

MPIR is the pre-2014 maximum permissible interest rate for the day after the refund day.

ND(PP) is the number of days in the period beginning on the day after the refund day and ending on the day on which the entry contribution balance is refunded.

Subsection (3) of this section provides that subsection (2) of this section applies as if the reference in paragraph (a) of the definition of ND(PP) to the day after the refund day were a reference to the day after the day on which probate of the will of the individual is, or letters of administration of the estate of the individual are, shown to the registered provider if:

- the registered provider is required, under the formal agreement, to refund the entry contribution balance because the individual in relation to whom the entry contribution was paid has died; and
- the entry contribution balance is refunded after the refund day; and
- the entry contribution balance is refunded after the refund day because neither the probate of the will nor letters of administration of the estate were shown to the registered provider before the refund day.

Division 7 – Miscellaneous

Section 287-165 – Pre-2014 maximum permissible interest rate

This section provides for the calculations methodology for the pre-2014 maximum permissible interest rate for a day which is worked out by working out the general interest charge rate for the day under subsection 8AAD(1) of the *Taxation Administration Act 1953*, multiplying this rate by the number of days in the calendar year in which the day falls, and subtract 3 percentage points from the number of days in the calendar year in which the day falls.

Part 3 – Accommodation payments and accommodation contributions

Division 1 – Application to specialist aged care programs

This Division provides for the application provisions to specialist aged care programs for this Part.

Section 288-5 – Provisions that do not apply in relation to certain specialist aged care programs

Subsection 288-5(1) specifies that the following provisions of Part 4, Chapter 4 of the Act do not apply in respect of the delivery of funded aged care services to an individual under the MPSP:

- paragraph 294(1)(c);
- paragraph 294(1)(d);
- subsection 294(3);
- subsection 294(4) (to the extent that it relates to subsection 294(3));
- section 298;
- subsection 307(3); and
- section 309.

The provisions listed above relate to the charging and payment of accommodation contributions and certain deductions that can be taken from an individual's refundable deposit balance.

A registered provider delivering funded aged care services under the MPSP is prevented from charging an accommodation contribution by operation of section 288-25(3) of the rules. Accordingly, this subsection ensures that a registered provider delivering funded aged care

services under the MPSP is not required to comply with any of the requirements Part 4, Chapter 4 of the Act to the extent that they relate to accommodation contributions.

Subsection 288-5(2) specifies that the entirety of Part 4, Chapter 4 of the Act does not apply in respect of the delivery of funded aged care services to an individual under the NATSIFACP.

A registered provider delivering funded aged care services under the NATSIFACP is prevented from charging an accommodation contribution or an accommodation payment by operation of sections 288-25(2)-(3) of the rules. Accordingly, this subsection ensures that a registered provider delivering funded aged care services under the NATSIFACP is not required to comply with any of the requirements of Part 4, Chapter 4 of the Act.

Section 288-10 – Specialist aged care programs for which specified provisions do not apply

Section 288-10 specifies that for the purposes of paragraph 288(1)(c) of the Act, the following specialist aged care programs are prescribed:

- MPSP;
- NATSIFACP.

Section 288-20 – Specialist aged care programs – accommodation agreements

This section provides that an accommodation agreement between a registered provider delivering funded aged care services to an individual under the MPSP and the individual must set out information for the individual about accessing the provider's financial hardship policy.

A note clarifies that the accommodation agreement must also comply with the requirements in section 294-5 of the rules.

Section 288-25 – Specialist aged care programs – charging of accommodation payments and accommodation contributions

Subsection (1) provides that, for the purposes of paragraph 288(2)(c) of the Act, if a registered provider is satisfied that an individual to whom the registered provider is delivering ongoing funded aged care services through the service group residential care in an approved residential care home under the MPSP is experiencing financial hardship, the provider must:

- provide the individual with a copy of the provider's financial hardship policy referred to in section 286-20 of the rules; and
- comply with the policy (including reducing or waiving the accommodation payment in accordance with the terms of the policy).

Subsection (2) provides that, for the purposes of paragraph 288(2)(c) of the Act, a registered provider delivering funded aged care services to an individual through the service group residential care in an approved residential care home under the NATSIFACP must not charge the individual an accommodation payment for the delivery of those services.

Subsection (3) provides that, for the purposes of paragraph 288(2)(c) of the Act, a registered provider delivering funded aged care services to an individual through the service group

residential care in an approved residential care home under the MPSP or NATSIFACP must not charge the individual an accommodation contribution for the delivery of those services.

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

Subdivision A – Maximum accommodation payment amount

Section 289-5 – Maximum accommodation payment amount

For the purposes of subsection 289(1) of the Act, this section states that \$758,627 is prescribed as the maximum amount of accommodation payment that a provider may charge a person. This reflects the amount that has applied from 1 July 2025 under *the Aged Care (Subsidy, Fees and Payments) Determination 2014*. The maximum amount of accommodation payment will be indexed on 1 July each year through an amendment to these rules to ensure it keeps up with inflation.

The maximum accommodation payment amount is expressed as a refundable accommodation deposit amount. If providers wish to charge more than the maximum amount current at the time, they must apply to the Pricing Authority for approval.

Section 289-10 – Maximum accommodation payment amount – daily accommodation payment amount

For the purposes of subsection 289(3) of the Act, this section specifies the method for working out the maximum daily accommodation payment amount that an approved provider may charge based on the maximum refundable accommodation deposit amount described in the above section.

An accommodation payment can be paid as a refundable accommodation deposit, daily accommodation payment or a combination of both.

Subdivision B – Application to Pricing Authority for approval of higher maximum accommodation payment amount

Section 290-15 – Requirements for application

This section sets out the requirements that must be complied with for an application made to the Pricing Authority for approval for the provider to agree to, and charge, an accommodation payment that is higher than the maximum accommodation payment amount.

For the purposes of paragraph 290(3)(a) of the Act, the application must:

- be in writing; and
- be in a form approved by the Pricing Authority; and
- be accompanied by any information or documents specified by the approved form; and
- relate to only one residential care home; and
- specify each room, or each part of a room, in the residential care home for which approval is sought to charge a higher maximum accommodation payment amount; and
- specify each of those higher maximum accommodation payment amounts (expressed as a refundable accommodation deposit amount).

A note is included to clarify that while applications may be made under section 290 of the Act in relation to residential care homes that are not approved residential care homes, only a registered provider delivering funded aged care services through the service group residential care in an approved residential care home may charge an amount of accommodation payment. The ability to apply for an approval before an aged care home is built helps providers and investors to plan and make investment decisions.

Section 290-20 – Restriction on application period

This section prescribes that an application must not be made within 4 months for the purposes of subparagraph 290(3)(b)(i) of the Act.

Section 290-25 – Decision of Pricing Authority on application

This section is made for the purposes of subsections 290(6) and (12) of the Act. This section requires the Pricing Authority to consider certain factors when deciding whether to approve a higher maximum amount of accommodation payment and allows the Pricing Authority to approve or not to approve an application subject to conditions.

Matters that must be considered

Subsection (2) of this section provides that in deciding whether to approve a higher maximum accommodation payment for the room, or a part of the room, in the relevant service, the Pricing Authority must consider:

- the proposed higher maximum accommodation payment amount;
- the location of the residential care home;
- the quality, condition, size and amenity of the room or the part of the room;
- whether the room has access to a shared bathroom or has a private ensuite;
- whether the room, or the part of the room, has any specific accommodation or design features;
- the number of individuals to whom ongoing funded aged care services may be delivered through the service group residential care in the room;
- the quality, condition, size and amenity of the common areas in the residential care home that would be accessible to those individuals;
- whether the residential care home has any specific accommodation or design features that would be accessible to those individuals.

The Pricing Authority may also consider any other additional matters that it considers relevant.

Subsection (3) requires the Pricing Authority to notify, in writing, an applicant of a decision whether or not the higher maximum amount of accommodation payment is approved. The notice must include the following:

- the unique identification number that corresponds to the registered provider's application;
 - if the approval is not subject to conditions;
 - the day on which the approval takes effect; and
- the period during which the approval is in effect (see subsection (8));

- if the approval is subject to conditions in accordance with section 290-30—the conditions to which the approval is subject.

Notes to the section clarify that that:

An approved higher maximum amount of accommodation payment only applies to individuals who, at the date of the approval, had not entered into an accommodation agreement with the provider, and who enter the relevant service on or after the date of approval or who are voluntarily moving rooms within a service and have not yet agree a room price for the voluntary move.

While the approval with conditions is in effect, subsection 290-30(2) will operate to prevent the provider from agreeing to or charging an accommodation payment under that approval until the necessary conditions have been met, at which point the approval is no longer conditional.

Under subsection (4), a decision of the Pricing Authority not to approve a higher maximum accommodation payment amount in relation to a registered provider must include the details of the decision, the reasons for the decision and details about how the provider may apply for the reconsideration of the decision.

The note provides that a decision of the Pricing Authority not to approve a higher maximum accommodation payment amount is a reviewable decision under section 558 of the Act.

Subsection (5) specifies that the notice may relate to more than one decision for a room or a part of a room.

Period within which decision must be made and notification given

Subsection (6) requires the Pricing Authority to notify, in writing, an applicant of a decision whether or not the higher maximum amount of accommodation payment is approved. This must be done within 60 days of receiving an application.

Under subsection (7), if further information is given under subsection 290(4) of the Act in relation to a decision not to approve, the 60 day period does not include the period beginning on the day the request was made and ending on the day that is 28 days after the day the information was received.

When approval is in effect – approval not subject to conditions

If the approval does not relate to a proposed room or part of a room that is subject to conditions, the approval is to take effect on the start day of the notice at subparagraph (3)(b)(i) and lasts for 4 years from that day.

Section 290-30 – Condition on approval relating to a room, or part of a room, subject to construction or refurbishment

Purpose and application of section

The purpose of this section is to provide rules for approvals by the Pricing Authority that relate to approvals for a higher maximum accommodation payment amount that is subject to conditions because the room or part of the room is being or is proposed to be constructed or

refurbished. Conditional approvals aim to give providers and financiers confidence to invest in these developments.

Condition on approval

Such approvals are subject to the condition that the approval does not take effect until:

- the provider gives the Pricing Authority, within the period of 4 years beginning on the day the Pricing Authority gave notice of the approval, the following information in writing:
 - information demonstrating the accommodation is completed and the completed accommodation is equivalent to, or better than, what was proposed;
 - information setting out the total actual cost of the completed construction or refurbishment; and
- the Pricing Authority is satisfied, after having regard to the above information:
 - that the completed accommodation is equivalent to, or better than, was proposed; and
 - that if the actual cost of the construction or refurbishment is significantly lower than the proposed cost, if this lower cost had been the proposed cost in the original application, that the Pricing Authority would still have approved the higher maximum accommodation payment amount.

Decision on information and notification of decision

The Pricing Authority must within 28 days of receiving the information from the provider, notify the provider (in writing) of the decision.

If the Pricing Authority is not satisfied by the information, the notice of the decision must specify details of the decision, the reasons for the decision and details about how the provider may apply for the reconsideration of the decision.

A note provides that a decision not to approve a higher maximum amount of accommodation payment, because the Pricing Authority is not satisfied of the matters detailed above, is a reviewable decision under section 557 of the Act: see section ^558-5 of the rules.

When approval is in effect

If the Pricing Authority is satisfied that conditions of approval have been met, the Pricing Authority is required to include in the notice of decision the date that the approval takes effect and the period the approval is in effect. The period of effect is 4 years from the date specified in the notice.

Section 290-40 – Indexation of higher maximum accommodation payment amount

This section provides for the higher maximum amount of accommodation payment approved by the Pricing Authority to be indexed annually by the All Groups Consumer Price Index, but does not require indexation be done. Indexation may be applied by the approved provider to the approved higher maximum amount of accommodation payment no earlier than the first day of the second, or a later, approval year.

The section provides that the indexed amount is rounded to the nearest whole dollar with 50 cents rounded down.

The section also provides for circumstances where the Australian Statistician amends an index number or an index reference period. If the Australian Statistician publishes an index number for a quarter in substitution of a previously published index number for that quarter, the later publication is to be disregarded. If the Australian Statistician changes an index reference period for the Consumer Price Index, then only index numbers published for the new index reference periods are to be used.

Subsection (2) provides that if a higher maximum accommodation payment amount is indexed under this section, the Act and the rules have effect as if the indexed amount were substituted for the higher maximum accommodation payment amount.

Subsection (3) provides that the indexed amount applies only in relation to individuals who have yet to agree a room price for entry to care or for a voluntary move to a new room within an aged care home.

Subdivision C – Notification and publication of accommodation payment amounts 42

Section 291-5 – Notification

Subsection 291(1) of the Act provides that a registered provider must, in accordance with the rules, notify the System Governor about accommodation payment amounts the provider will charge. This section of the rules sets out the requirements that providers must follow for the purposes of notification and publication of accommodation payment amounts.

Providers must give the System Governor a notice setting out the following information that must be made publicly available if the registered provider intends to charge individuals an accommodation payment for a room, or part of a room in the home:

The notice must include:

- a statement that describes the key accommodation features of the room, or part of the room. This statement must include:
- the maximum accommodation payment amount (expressed as a refundable accommodation deposit amount, and as a daily accommodation payment amount worked out in accordance with section 294-10 of the rules) that the provider could charge an individual for the room or the part of the room;
- if the registered provider proposes to charge an accommodation payment in relation to the room or the part of the room that exceeds the maximum accommodation payment amount—a copy of the notice given to the provider by the Pricing Authority under subsection 290(6) of the Act, and section 290-30 of the rules (if applicable), that covers the charging of the higher amount.

For the purposes of paragraph 291-5(1)(a) of the rules, the statement describing the key accommodation features of the room or the part of the room must include the following information:

- a description of the quality, condition, size and amenity of the room or the part of the room;
- whether the room or the part of the room has access to a shared bathroom or has a private ensuite;
- a description of any specific accommodation or design features in the room or the part of the room;

- the number of individuals to whom ongoing funded aged care services may be delivered through the service group residential care in the room;
- a description of the quality, condition, size and amenity of the common areas in the approved residential care home that would be accessible to those individuals;
- a description of any specific accommodation or design features in the approved residential care home that would be accessible to those individuals.

Section 291-10 – Publication of notification

Prescribes that for the purposes of paragraph 291(4)(d) of the Act, the other information to be published is the information provided at subsection 291-5(2) of the rules.

Division 3 – Accommodation agreements

Section 292-5 – Information to be given before provider enters into an accommodation agreement with an individual – daily accommodation payment amount

This section describes the method for working out the amount of daily accommodation payment that is equivalent to a given amount of refundable accommodation deposit for the purpose of the information that must be given to the individual on published accommodation payment amounts for the home.

The provider's daily accommodation payment amount is calculated by multiplying the maximum permissible interest rate (MPIR) for the relevant day by the refundable accommodation deposit amount and dividing this amount by 365 days.

The *maximum permissible interest rate* for a day is defined in section 5-5 of the rules to mean the maximum rate for the day worked out in accordance with section 301-5 of the rules.

Section 294-5 – Accommodation agreements – other matters to be included in accommodation agreement

Section 294 of the Act sets out matters that must be included in an accommodation agreement. This section of the rules describes additional matters that must also be included in an accommodation agreement.

The note to subsection (1) provides that an accommodation agreement between a registered provider and an individual to whom the provider is delivering funded aged care services under the multi-purpose service program must also comply with section 288-20 of the rules

General matters

Subsection (2) sets out additional general matters regarding accommodation payments.

An accommodation agreement must set out the following:

- the individual's room that the accommodation payment entitles the individual to be provided with;
- any services that the accommodation payment entitles the individual to be provided with;
- that, if the individual changes the individual's room in the approved residential care home, this will not change the individual's start day for the approved residential care home

Additional matters in relation to voluntary and non-voluntary moves within the approved residential care home

The section also specifies additional matters that must be included in the accommodation agreement in relation to:

- voluntary moves between rooms within the approved home; and
- non-voluntary moves between rooms within the approved home.

Subsection (6) of this section provides that a move is not voluntary if:

- the move is necessary on genuine medical grounds as assessed by:
 - an approved needs assessor; or
 - at least 2 medical or other health practitioners who meet the relevant criteria; or
- the move is necessary to carry out repairs or improvements to the premises of the approved residential care home.

For the above, the relevant criteria for medical or other health practitioners are:

- one practitioner must be independent of the registered provider and the approved residential care home, and must be chosen by the individual; and
- both practitioners must be competent to assess the aged care needs of the individual.

For a voluntary move within an approved home and the individual proposes to change the individual's room in the approved residential care home, the accommodation agreement must set out that:

- the accommodation agreement must be varied, before the move occurs, to specify the new room; and
- the day on which the agreement is varied will become the price agreement day for the individual and the approved residential care home; and
- the individual may be charged an accommodation payment amount, after the move, that is higher or lower than the accommodation payment amount the individual is paying before the move; and
- the individual must not be charged an accommodation payment amount that is higher than the published accommodation payment amount for the individual's new room on the day the agreement is varied; and
- if the individual is to be charged a higher accommodation payment amount for the individual's new room—the individual may choose to pay the additional accommodation payment amount by:
 - daily payments; or
 - refundable deposit; or
 - a combination of refundable deposit and daily payments.

For a move that is not voluntary and is for less than 28 days, the accommodation agreement must set out that:

- the provider must notify the person in writing of the new accommodation before the move occurs; and
- there will be no change to the person's price agreement day or to the amount of accommodation payment they are paying, and
- the individual will continue to be charged the same accommodation payment amount that the individual is paying before the move.

For a move that is not voluntary and is for 28 days or longer, the accommodation agreement must set out that:

- the provider must notify the person in writing of the new accommodation before the move occurs;
- the day on which notice is given will become the price agreement day for the person;
- the person must not be charged
 - an accommodation payment that is higher than the amount they were paying before the move; and
 - if the published maximum accommodation payment amount for the new accommodation is lower than the person was paying before the move, the person may be charged no more than the published maximum accommodation payment amount for the new accommodation.

Section 294-10 – Accommodation agreements – daily accommodation payment amount

For the purposes of subparagraph 294(2)(b)(iii) of the Act, this section provides the method to work out an individual's daily accommodation payment amount in relation to an agreed accommodation payment amount is the method referred to in subsection 296-5(3) of the rules.

This applies where a person has paid no refundable accommodation deposit, paying for all of their accommodation via a daily accommodation payment.

Section 294-15 – Accommodation agreements—method for working out amounts payable as a combination of refundable accommodation deposit and daily accommodation payments

For the purposes of paragraph 294(2)(d) of the Act, the accommodation agreement must also set out the method for working out amounts payable as a combination of refundable accommodation deposit and daily accommodation payments. This is the method referred to in subsection 296-5(4) of the rules.

Section 294-20 – Accommodation agreements—method for working out amounts payable by refundable accommodation contributions

For the purposes of subparagraph 294(3)(c)(i) of the Act, this section prescribes the method for working out an individual's refundable accommodation contribution. This is the method referred to in subsection 298-10(3) of the rules.

This applies where a person has paid no refundable accommodation contribution, paying for all of their accommodation via a daily accommodation contribution.

Section 294-25 – Accommodation agreements—method for working out amounts payable by combination of refundable accommodation contributions and daily accommodation contributions

For the purposes of subparagraph 294(3)(c)(ii) of the Act, this section prescribes the method for working out amounts payable by combination of refundable accommodation contributions and daily accommodation contributions. This is the method referred to in subsection 298-10(4) of the rules.

Division 4 – Charging of accommodation payments

Section 296-5 – Charging of accommodation payments – requirements

This section specifies the rules that must be complied with by a registered provider in relation to charging accommodation payments. These rules expand on those set out in section 296 of the Act.

Subsection (2) of this section specifies that it is the responsibility of registered providers to ensure that, for the ***relevant day***, there is equivalence between the refundable accommodation deposit amount and the daily accommodation payment amount that the provider could charge the individual.

Subsection (3) of this section provides a method for calculating the equivalent daily accommodation payment a provider could charge for the relevant day if the individual had not paid a refundable deposit on or before that day. The steps are:

- work out the MPIR for the individual's price agreement day;
- multiply the rate at step 1 by the agreed accommodation payment amount;
- work out the individual's ***maximum possible daily accommodation payment amount*** by dividing the amount worked out at step 2 by 365 (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more);
- Apply any applicable indexation to the step 3 amount in accordance with section 302-10 of the rules.

Notes provide that:

If the individual's accommodation agreement is varied because the individual's room changes, the individual's price agreement day and agreed accommodation payment amount may change for the purposes of this section

Indexation is not applied for certain classes of individuals specified in section 302-17 of the rules.

Subsection (4) of this section provides a method for calculating the equivalent daily accommodation payment amount that the provider could charge the individual for the relevant day if the individual has paid a refundable deposit on or before that day.

This method extends the steps used in subsection (3) of this section, reducing the amount of daily accommodation payment payable to take account of:

- the amount of refundable deposit held for the individual; and
- amounts that have previously been deducted for retention purposes under section 308 of the Act.

The steps are:

- Work out the amount under subsection (3) that the provider could charge if the individual had not paid any refundable accommodation deposit on or before the relevant day
- Work out the individual's refundable deposit balance for the relevant day and add to this the amount of any retention deductions made under section 308 of the Act.
- Divide the step 2 amount by the agreed accommodation payment amount.

- Subtract the step 3 amount from 1
- Multiply the step 4 amount by the step 1 amount (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more).

Division 5 – Charging of accommodation contributions

Section 298-5 – Charging of accommodation contributions – prescribed circumstances

This section prescribes the circumstances in which paragraph 298(c) of the Act does not apply in relation to the charging of an accommodation contribution for the delivery of ongoing funded aged care services to an individual through the service group residential care in an approved residential care home.

Paragraph 298(c) of the Act establishes a new limitation on the maximum amount of daily accommodation contribution that may be charged to an individual, by preventing providers from charging an accommodation contribution that is greater than the agreed accommodation payment amount expressed as a Daily Accommodation Payment. This works in conjunction with the other limitations provided for in paragraph 298(b) of the Act, which have been carried across from the old Act.

This section provides that paragraph 298(c) of the Act will only apply to an individual in the post-2014 residential accommodation class when the individual enters an aged care home after the transition time. In all other cases, paragraph 298(c) of the Act will not apply to members of this class.

This rule is designed so that arrangements that apply to existing residents are not disturbed by this new requirement.

Section 298-10 – Charging of accommodation contributions – requirements

This section applies to the charging of accommodation contributions.

Subsection (2) of this section requires a registered provider to ensure that for a relevant day, there is equivalence between the individual's daily accommodation contribution amount and the maximum refundable accommodation contribution amount that the individual may be charged.

Subsection 3 provides a method for calculating the equivalent refundable accommodation contribution a provider could charge for the relevant day. The steps are:

- Work out the maximum daily accommodation contribution the individual could be charged having regard to paragraphs 298(b) and (c) of the Act.
- Multiply the amount worked out at step 1 by 365 (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more).
- Divide the amount worked out at step 2 by the maximum permissible interest rate for the individual's start day for the classification type ongoing for the service group residential care in relation to the approved residential care home.
- Subtract from the amount worked out at Step 3 the sum of any deductions made on or before the relevant day from the refundable accommodation contribution in accordance with section 308 of the Act

Subsection (4) of this section provides for the additional calculations to calculate the daily accommodation contribution amount payable where part of the accommodation contribution has been paid as a refundable accommodation contribution on or before the relevant day. The steps are:

- Work out the maximum permissible interest rate for the individual's start day for the classification type ongoing for the service group residential care in relation to the approved residential care home.
- Work out the amount that is the difference between:
 - the maximum refundable accommodation contribution amount for the individual for the relevant day worked out under subsection (3); and
 - the individual's refundable deposit balance for the relevant day.
- Multiply the rate worked out at step 1 by the amount worked out at step 2
- Divide the amount worked out at step 3 by 365 (rounding the result to 2 decimal places, rounding up if the third decimal place is 5 or more).

Division 6—Charging of daily payments

Section 301–5 – Charging interest

Subsection 301(3) of the Act states that the interest rate charged on the balance of any amount of daily payment must not exceed the maximum rate prescribed by the rules.

In accordance with that subsection, this section specifies the maximum rate for a day for the charging of interest and the method for working it out.

Section 302–10 – Daily accommodation payments – indexation

This section describes the method for working out the indexation of daily accommodation payments. Indexation is to be applied to the individual's maximum possible daily accommodation payment amount on an indexation day.

In step 1 of the method, any indexation previously applied to that amount under the section is to be disregarded, resetting the base amount to the DAP corresponding to the agreed price for the individual.

In step 2 of the method, an indexation factor is determined by dividing the DAP index number for the indexation day by the DAP index number on the individual's indexation reference day.

In step 3 of the method, the amount worked out at step 1 is multiplied by the amount worked out at step 2 to give the maximum possible daily accommodation payment amount.

Indexation is to be applied by the registered provider on 20 March and 20 September each year. This is designed to be consistent with the dates for changes in the Age Pension rates.

The formula relies on an indexation factor which is worked out using the *indexation day* and *reference indexation day*.

The note in the formula refers readers to section 302-15 of the rules for DAP index numbers.

The terms *indexation day* and *reference indexation day* are defined in subsection 302-10(2) of these Rules as follows:

- ***indexation day*** means 20 March and 20 September.
- ***reference indexation day*** for an individual and an approved residential care home means the indexation day before the first indexation day that occurs after the later of the individual's start day in relation to the approved residential care home and if the individual moves to a new room, or part of a room, in the approved residential care home—the day the individual occupies the new room or the part of the room.

Section 302-15 – Daily payments—DAP index numbers.

For the above formula, this section provides the ***DAP index number*** for an indexation day.

The ***DAP index number*** is worked out using the table. Item 1 of the table provides that for 20 September 2025, the DAP index number is 1.0.

This table will be updated twice per year through amendments to the rules as new index numbers are created based on changes to the consumer price index.

Section 302-17 – Daily payments—circumstances in which daily accommodation payment is not to be indexed

This section prescribes the circumstances in which daily accommodation payment is not to be indexed relating to certain classes of individuals. The classes of individuals referred to in the section are the post-2014 residential accommodation class and the post-2014 flexible accommodation class.

These are defined in section 5-5 of the rules.

Section 302-20 – Daily payments—circumstances in which an amount of daily payment may be refunded

For the purposes of paragraph 302(cb) of the Act, this section prescribes requirements that apply to registered providers in relation to the refund of an ***overpaid amount*** of daily accommodation payment or daily accommodation contribution.

The note to this section provides that section 304-5 of the rules separately provides for the refund of an overpayment of refundable accommodation deposit or refundable accommodation contribution.

The section describes the refund arrangements if an individual has paid a higher amount of daily accommodation payment or daily accommodation contribution than was properly payable.

In such a case, the provider must refund the overpaid amount, being the difference between the amount that was properly payable and the amount that was paid.

This section also provides that:

- As per subsection (4) of this section the individual may ask the registered provider, in writing, to refund the overpaid amount; and
- As per subsection (5) of this section if the provider does not refund the overpaid amount within 28 days of receiving a written request for refund from the individual or becoming aware of the overpayment (whichever is the earlier) they must pay an

amount of interest to the individual. The section sets out the formula for calculating this interest.

$$\frac{\text{MPIR} \times \text{OA} \times \text{ND(PP)}}{365}$$

The rules define the terms as follows:

MPIR is the maximum permissible interest rate for the day that is 28 days after the day referred to in paragraph (a) or (b) (as the case requires) of this subsection.

ND(PP) is the number of days in the period beginning on the day that is 28 days after the day referred to in paragraph (a) or (b) (as the case requires) of this subsection and ending on the day on which the overpaid amount is refunded.

OA is the overpaid amount.

Division 7—Refundable deposits

Section 304-5 – Refundable deposits—circumstances in which an amount of refundable deposit may be refunded

For the purposes of paragraph 304(a) of the Act, this section prescribes requirements that apply to registered providers in relation to the refund of an overpaid amount of refundable accommodation deposit or refundable accommodation contribution.

The note to this section provides that section 302-20 of the rules separately provides for the refund of an overpayment of daily accommodation payment or daily accommodation contribution.

The section describes the refund arrangements if an individual has paid a higher amount of refundable accommodation deposit or refundable accommodation contribution than was properly payable.

In such a case, the provider must refund the overpaid amount, being the difference between the amount that was properly payable and the amount that was paid.

Subsection (4) of this section provides that the individual may ask the registered provider, in writing, to refund the overpaid amount.

Subsection (5) of this section provides that if the provider does not refund the overpaid amount within 28 days of them receiving a written request for refund from the individual or them becoming aware of the overpayment (whichever is the earlier) they must pay an amount of interest to the individual. The section sets out the formula for calculating this interest.

$$\frac{\text{MPIR} \times \text{OA} \times \text{ND(PP)}}{365}$$

The rules define the terms as follows:

MPIR is the maximum permissible interest rate for the day that is 28 days after the day referred to in paragraph (a) or (b) (as the case requires) of this subsection.

ND(PP) is the number of days in the period beginning on the day that is 28 days after the day referred to in paragraph (a) or (b) (as the case requires) of this subsection and ending on the day on which the overpaid amount is refunded.

OA is the overpaid amount.

Section 307-5 – Amounts to be deducted from refundable deposit balances – deductible amount

For the purposes of paragraph 307(3)(a) of the Act, this section prescribes the amounts a registered provider may deduct from an individual's refundable deposit balance when the registered provider ceases to deliver services.

Section 308-10 – Amounts that must be deducted from refundable deposit balances – retention amounts – timing of deductions

This section provides the timing, under paragraph 308(3)(a) of the Act, for when retention amounts may be deducted if retention amounts are outstanding on the day a registered provider ceases to deliver services. It states that the provider deducts retention amounts prior to refunding the refundable deposit balance or transferring the refundable deposit balance to another provider.

The note in the section states the frequency of retention deductions set out in section 308 of the Act. See subsections 308(3A) and (4) of the Act.

Section 308-11 – Amounts that must be deducted from refundable deposit balances—retention amounts—circumstances in which a retention amount may be refunded

For the purposes of paragraph 308(3)(b) of the Act, this section prescribes requirements that apply to registered providers in relation to the refund of an overcharged retention amount.

This applies when a person has been charged a higher retention amount than was properly payable. This is intended to provide a mechanism in situations where a provider charged retention when there was no need to charge it or overcharges retention.

The provider is required to refund the difference between the retention amount that was properly chargeable and the retention amount that was charged. This must occur within 14 days after the earlier of the provider receiving a written request from the individual for a refund or the provider becoming aware of the overcharged amount.

Interest would only be payable on the overcharged amounts when a person exits care since it is limited to the time when the refundable deposit balance must be refunded.

When providers refund an overcharged retention amount they must also recalculate any subsequent retention amounts. As retentions are calculated on a daily basis on the refundable deposit balance on the day, when an incorrectly deducted retention amount is rectified, it will change the refundable deposit balance for that and subsequent days. When an overcharged amount is refunded, the refundable deposit balance will need to be adjusted retrospectively (that is the refunded overcharged amount corrects the error as at the day the error was made).

Section 308-12 – Amounts that must be deducted from refundable deposit balances—retention amounts—classes of individuals for whom amounts must not be deducted

This section prescribes the classes of individuals for whom amounts must not be deducted for the purposes of retention deductions under subsection 308(7) of the Act.

Section 309-5 – Rules about deductions

Prescribes the order in which deductions are to be made. These relate to both general deductions under section 307 of the Act and retention deductions under section 308 of the Act.

Section 310-5 – Refundable deposits to be used only for permitted purposes—capital expenditure

Registered providers that hold refundable deposits must not use refundable deposits for any purpose other than those listed under the Act or the rules.

For the purposes of paragraph 310(2)(a) of the Act, the rules may prescribe permissible uses of refundable deposits for capital expenditure. The following are permitted uses of refundable deposits:

- refundable deposits may be used to acquire land on which are, or are to be built, the premises needed for delivering funded aged care services through the service group residential care, but only to the extent that the expenditure relates to those premises;
- refundable deposits may be used to acquire, erect, extend or significantly alter premises used, or proposed to be used, for delivering funded aged care services through the service group residential care, but only to the extent that the expenditure relates to the delivery of those funded aged care services;
- refundable deposits may be used to acquire or install furniture, fittings or equipment for premises used, or proposed to be used, for delivering funded aged care services through the service group residential care, when those premises are initially erected or following an extension, a significant alteration or a significant refurbishment, but only to the extent that the expenditure relates to the delivery of those funded aged care services;
- refundable deposits may be used for expenditure that is directly connected to expenditure covered by the three aforementioned paragraphs.

Section 310-15 – Refundable deposits to be used only for permitted purposes—capital expenditure debt

For the purposes of paragraph 310(2)(e) of the Act, the kinds of capital expenditure to which debt is accrued and can be paid off using refundable deposits, are the kinds of capital expenditure referred to in section 310-5 of the rules.

Section 310-20 – Refundable deposits to be used only for permitted purposes—other

For the purposes of paragraph 310(2)(f) of the Act, a registered provider may also use refundable deposits for the following purposes:

- Per paragraph (a), a registered provider may use refundable deposits to meet reasonable business losses that are incurred in the course of delivering funded aged care services. The business losses must be incurred within the period of 12 months

after the day the registered provider begins to deliver funded aged care services to the individual through the service group residential care;

- Per paragraph (b), a registered provider may use refundable deposits to invest in a fund, but not a controlling entity of a fund, listed in item 2 of the first Schedule to Banking exemption No. 1 of 2021 made under the *Banking Act 1959*.

Section 310-30 – Refundable deposits to be used only for permitted purposes – financial product

For the purposes of paragraph 310(3)(e) of the Act, a registered provider may use refundable deposits for the following purposes, relating to financial products:

- to purchase an interest in a scheme. The scheme must be established for the purpose of investment in the delivery of funded aged care services. The aged care services must be delivered through the service group residential care in an approved residential care home. The scheme must be:
 - a managed investment scheme within the meaning of the *Corporations Act 2001*; and
 - not a registered scheme within the meaning of the *Corporations Act 2001*.
- to invest in a legal or equitable right or interest, in an interest covered by paragraph (a);
- to invest in an option to acquire, by way of issue, an interest or right covered by paragraph (a) or (b).

Section 311-5 – Refund of refundable deposit – manner of refund

This section prescribes the manner in which a refundable deposit balance must be refunded under the Act. This includes by cash, cheque, bank cheque or electronic transfer.

Section 311-15 – Refund of refundable deposit balances—death of individual—circumstances and period

For the purposes of paragraph 311(3)(b) of the Act, this section specifies the period in which the refundable deposit balance must be refunded when a registered provider is not shown the probate of the will of the individual who has died or letters of administration of the estate of the individual who has died; and the registered provider is shown other evidence that satisfies the provider that the refundable deposit balance is to be refunded to a person.

Section 311-20 – Refund of refundable deposit balances – registered provider ceases services and has not transferred refundable deposit balance – circumstances and period

The table in subsection 311(4) of the Act provides for when a refundable deposit balance must be refunded. For the purposes of paragraph (b) of the column headed “the refundable deposit balance must be refunded...” in Item 4 of that table, this section prescribes:

- the circumstances in which a registered provider must refund a refundable deposit balance; and
- the period within which the refundable deposit balance must be refunded.

This section specifies the conditions under which an individual and a provider may agree to delay the refund of a refundable deposit balance or accommodation bond in order to secure re-entry to the service

Section 312-5 – Transfer of refundable deposit balance to another registered provider – requirements

For the purposes of subsection 312(2) of the Act, this section prescribes the requirements of registered providers for transferring an individual's refundable deposit balance from an outgoing provider to an incoming provider. An outgoing provider is the registered provider ceasing operations for the respective aged care service. The incoming provider is the registered provider taking over operations of the respective aged care service.

Subsection (2) provides that the outgoing provider must give a written notice to the incoming provider. The written notice must be given before the day of transfer. The written notice must include the following information:

- The day the transfer of the refundable deposit balance will take place
- The amount of interest (if any), calculated in accordance with section 313-5 of the rules, that is payable to the individual on or before the transfer day.
- The individual's respective entry in the provider's refundable deposit register (see section 150A of the Act).

Subsection (3) provides that the outgoing provider must give a written notice to an individual, whose refundable deposit is proposed to be transferred to the incoming provider, before the transfer day. The written notice must include the following information:

- Details about the incoming provider (this may include, but not be limited to, the incoming provider's name, quality ratings and service offerings).
- The transfer day of the individual's refundable deposit balance.

Subsection (4) provides that if the intended transfer day changes (for example, due to a delay in negotiating the sale terms, or due to a technical error in any financial transfer), then the outgoing provider must give a written notice to the individuals. The written notice should inform the individuals of the new transfer day. The notice should be given as soon as practicable to the individuals, and before the revised transfer day.

Subsection (5) provides that the outgoing provider must transfer the refundable deposit balance to the incoming provider on the transfer day, as per the date given to the individual in the written notice mentioned in paragraph (3), or paragraph (4) (where applicable). On the transfer day, the incoming provider assumes responsibility of the refundable deposit balance liability, and all requirements associated with the collection, holding and use of refundable deposits.

Section 312-10 – Circumstances in which refundable deposit balance must not be transferred to another registered provider

For the purposes of subsection 312(4) of the Act, this section prescribes the circumstances where an individual's refundable deposit must not be transferred between an outgoing provider and an incoming provider.

Paragraph (a) provides that if the incoming provider delivers residential care under a specialist aged care program, then a refundable deposit balance must not be transferred from the outgoing provider to the incoming provider. Services delivering specialist aged care programs operate under a different funding model and do not collect or hold refundable deposits.

Paragraph (b) provides that if the incoming provider does not deliver residential aged care services, then the refundable deposit balance must not be transferred from the outgoing provider to the incoming provider.

Under both scenarios, a refundable deposit balance should be refunded to respective individuals in accordance with subsection 311(1)(b) of the Act.

Section 313-5 – Payment of interest—refundable deposit balances

This section requires the registered provider to pay an amount of interest relating to a refund of refundable deposit balance, worked out in accordance with section 313-10 of the rules, to an individual on the day on which the registered provider refunds the refundable deposit balance, for refunds required under section 311 of the Act.

Section 313-10 – Working out of amount of interest on refundable deposit balance

This section sets out the formula for calculating the amount of interest to be paid by the registered provider, when refunding a refundable deposit balance to an individual. The interest may be base interest only or may also include maximum permissible interest depending on when the refund was made.

Subsection (1) provides that if a registered provider refunds a refundable deposit balance on or before the last day of the refund period, the amount of base interest on the refundable deposit balance is the amount worked out in accordance with the following formula

$$\frac{BIR \times RDB \times ND}{365}$$

The rules define the terms as follows:

BIR is the base interest rate, calculated on the first day of the refund period.

ND is the number of days in the period beginning on the day after the day on which the refunding event occurred and ending on the day on which the refundable deposit balance is refunded.

RDB is the amount of the refundable deposit balance.

The legislative Note confirms that subsection (1) does not apply in the situation described in item 1 of the table in subsection 311(4) of the Act because column 2 of Item 1 does not specify a refund period.

Subsection (2) provides that if a registered provider refunds a refundable deposit balance after the last day of the refund period, or after the day referred to in column 2 of Item 1 of the table in subsection 311(4) of the Act, the amount of interest on the refundable deposit balance is the amount worked out in accordance with the following formula:

$$\left(\frac{BIR \times RDB \times ND(RP)}{365} \right) + \left(\frac{MPIR \times RDB \times ND(PP)}{365} \right)$$

The rules define the terms as follows:

BIR is the base interest rate, calculated on the first day of the refund period.

MPIR is the maximum permissible interest rate for:

- if item 1 of the table in subsection 311(4) of the Act applies—the day after the day referred to in column 2 of item 1 of that table; or
- if item 2, 3 or 4 of the table in subsection 311(4) of the Act applies—the day after the last day in the refund period.

ND(PP) is the number of days in the period beginning on:

- if item 1 of the table in subsection 311(4) of the Act applies—the day after the day in column 2 of item 1 of that table; or
- if item 2, 3 or 4 of the table in subsection 311(4) of the Act applies—the day after the last day of the refund period and ending on the day on which the refundable deposit balance is refunded.

ND(RP) is equal to:

- if item 1 of the table in subsection 311(4) of the Act applies—zero; or
- if item 2, 3 or 4 of the table in subsection 311(4) of the Act applies—the number of days in the period beginning on the day after the day on which the refunding event occurred and ending on the last day of the refund period.

RDB is the amount of the refundable deposit balance.

Chapter 10 – Funding of aged care services – means testing

Part 1 – Introduction

Section 314-5 – Simplified outline of this Chapter

This section sets out a simplified outline of the rules in Chapter 10 which provides for matters relating to means testing for funded aged care services under Part 5 of Chapter 4 of the Act. Division 1 of Part 2 sets out rules for means testing in a home or community setting, while Division 2 of Part 2 sets out rules for means testing in an approved residential care home.

Section 582(1) of the Act provides that the System Governor may, in writing, arrange for the use, under the System Governor's oversight, of computer programs to take administrative action that must be taken by the System Governor under this Act. This includes administrative actions under Parts 2 to 5 of Chapter 4 of the Act as provided for by subparagraph 582(2A)(e) of the Act. The rules in Chapter 10 are made for the purposes of sections 314 to 337 in Part 5 of the Act and include administrative actions that may be automated.

Part 2 – Means testing

Division 1 – Means testing in a home or community setting

Subdivision A – Determination of individual contribution rates for individuals for means testing categories

Section 314-10 – Method for determining individual contribution rate

Section 314-10 sets out the criteria and method for determining the individual contribution rate for an individual for each means testing categories in a home or community setting for the purposes of paragraph 314(1)(a) of the Act. This consists of two steps.

Subsection 314-10(1) provides the first step is to work out the individual's means testing class in accordance with Subdivision B. The second step is to work out the percentage for the means testing category for that class under subsections (2) to (10). Subsection 8(4) of the Act provides the means testing category for a service type delivered in a home or community setting as: clinical supports; independence; and everyday living.

Individual contribution rates for each means testing category for an individual's means testing class will be set as a percentage of the price of each service. This means an individual will pay an individual contribution equal to the individual contribution rate per service they receive, and the Government will pay the remainder of the price as a subsidy to the provider.

Subsection 314-10(2) provides a table setting out the percentages for individual contribution rates for individuals for mean testing classes and categories which apply to individuals at from the commencement of the new Act.

The means testing classes for which different individual contribution rates will be calculated based on an individual's eligibility for the following pension classes:

- Full-pensioner;
- Part-pensioner;
- Seniors health card holder; and
- Self-funded retiree.

The means testing class for an individual is worked out in accordance with Subdivision B. For the means testing category – clinical supports – an individual will contribute 0% for all means testing classes – they being full-pensioner, part-pensioner, seniors health card holder and self-funded retiree.

For the means testing category – independence, a full pensioner will contribute 5%, a part pensioner and seniors health card holder will contribute the amount of percentage calculated in accordance with section 314-55 and a self-funded retiree will contribute 50%.

For the means testing category – everyday living, a full-pensioner would contribute 17.5%, a part-pensioner and seniors health card holder would contribute the amount of the percentage calculated in accordance with section 314-55, and a self-funded retiree would contribute the maximum rate of 80%.

Subsection (3) provides a table setting out the percentages for individual contributions rates for means testing classes and categories which apply to an individual in the post-2014 home contribution class who immediately before the transition time, was not a continuing care

recipient under the old Act. Individuals in the post-2014 home contribution class who are not home care recipients under the old Act applies to individuals who entered home care before 1 July 2014 and exited their current home care arrangements by a home care service for a continuous period of more than 28 days (other than because the person is on leave).

The means testing classes for which different individual contribution rates will be calculated includes: full-pensioner; part pensioner; seniors health card holder and self-funded retiree. The means testing class an individual falls under is set out in Subdivision B.

For the means testing category – clinical supports – an individual will contribute 0% for all means testing classes – they being full-pensioner, part-pensioner, seniors health card holder and self-funded retiree.

For the means testing category – independence, a full-pensioner will contribute 0%, a part-pensioner and seniors health card holder will contribute the amount of percentage calculated in accordance with section 314-55 and a self-funded retiree would contribute 25%.

For the means testing category – everyday living, a full-pensioner would contribute 0%, a part-pensioner and seniors health card holder would contribute the amount of the percentage calculated in accordance with section 314-55 of the rules, and a self-funded retiree would contribute the maximum rate of 25%. This means that a full-pensioner, cannot be asked to pay contributions if the individual is in the post-2014 home contribution class and not a continuing care recipient.

Subsection (4) provides that for individuals in the post-2014 home contribution class who were a continuing home care recipient under the old Act, and are not covered by any of subsections (6) to (11), the percentage for each means testing category is 0%. Individuals in the post-2014 home contribution class who were continuing care recipients under the old Act is an individual 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 or before moving to another home care service made a written choice, in accordance with the *Fees and Payment Principles 2014 (No. 2)*, to be covered by Chapter 3 and 3A of the old Act, to be covered by Chapter 3 and 3A of the old Act.

The percentage for the individual contribution rate for each means testing category is also 0% for the following:

- individuals with a classification level STRC (Short-Term Restorative Care) class in a classification type short term and are accessing funded aged care services through the service group home support, and are not covered by any of subsections (6) to (11) (subsection 314-19(5))
- individuals who, immediately before the transition time, were accessing flexible care through an innovative care service (within the meaning of the *Fees and Payments Principles 2014 (No. 2)*) (subsection 314-10(6))
- individuals who are described in paragraph 85(4)(b) of the Veterans' Entitlements Act (which describes former prisoners of war) (subsection 314-10(7))
- individuals who have been awarded the Victoria Cross or the Victoria Cross for Australia (both within the meaning of the Veterans' Entitlements Act) (subsection 314-10(8))

- individuals who die before the individual's contribution rate is first determined under subsection 314(1) of the Act (subsection 314-10(9))
- individuals who are being delivered funded aged care services through a service group, and cease being delivered those services before the individual's contribution rate is first determined under subsection 314(1) of the Act (subsection 314-10(10))
- individuals who were immediately before the transition time approved under section 22-1 of the old Act as a recipient of home care, and who provided the System Governor sufficient information to enable the working out of the individual's care subsidy reduction under sections 48-7 and 48-8 of the old Act and whose individual contribution rate was not determined within 6 months of first being provided with home care (subsection 314-10(11))

Section 314-15 – Period for determining individual contribution rate

Subsection 314-15(1) provides that section 314-15 sets out the period for determining the individual contribution rate for an individual for each means testing category for the purposes of paragraph 314(1)(b) of the Act.

Subsection 314-15(2) provides that this section applies to an individual if a registered provider provides a start notification of a day (the ***start notification day***) to the System Governor and the Commissioner about the delivery of funded aged care services to the individual. This section does not apply, however, when the start notification is given in connection with the transfer of a service delivery branch of a registered provider to another registered provider, or the merger of 2 or more service delivery branches of a registered provider into a single delivery branch of the provider.

Subsection 314-15(3) provides that if on the start notification day the System Governor has the information referred to in paragraphs 314A-5(1)(a) to (d) of the rules in relation to the individual (the ***required information***) the period is 28 days from the start notification day. Subsection 314-15(4) provides that if on the start notification day, the System Governor does not have the required information and within 3 days from the start notification day, the individual provides the required information to the System Governor, the period is 28 days from the day the individual provided the required information.

Subsection 314-15(5) provides that if on the start notification day the System Governor does not have the required information, the individual does not provide the required information within 3 days of the start notification day and the System Governor requests the required information under subsection 343(1) of the Act, the individual has 28 days from the day the System Governor requests the information to provide that information. After which, the System Governor will have 28 days from the date individual provided the required information to determine the individual's means testing class.

Subsection 314-15(6) provides that if the System Governor requests the required information under subsection 343(1) of the Act, and either the individual does not provide the required information to the System Governor within the period mentioned in paragraph (5)(d), or the individual makes an election under section 314B of the Act before the end of that period, the period is 3 days from the end of the period mentioned in paragraph (5)(d).

Section 314-20 – Other matters to be included in notice of determination

Section 314-20 specifies the matters a notice given by the System Governor of a determination of an individual's contribution rate for an individual for each means testing category, must include for the purposes paragraph 314(3)(e) of the Act. These include the previous individual contribution rate, if any, for each means testing category and the date of effect of the determination as worked out in accordance with section 314-25 of the rules.

Section 314-25 – Day determination takes effect

Section 314-25 prescribes the start date upon which a determination of an individual's contribution rate for an individual for each means testing category takes effect for the purposes subsection 314(4) of the Act. The start date on which an individual contribution rate takes effect is:

- if on the day the determination was made, an individual contribution rate determination was not in force for the individual – the day the start notification mentioned under subsection 314-15(2) of the rules relating to the individual was provided to the System Governor and the Commissioner;
- in any other case – the day the determination was made.

The note refers to section 318A-15 of the rules for the day of effect for determinations made following revocation of individual contribution rate determinations.

Subdivision B – Working out means testing classes for individuals

Subdivision B sets out the means testing classes for individuals. The individual contribution rate will be based on the individual's means testing class. The individual's means testing class will be determined based on an individual's eligibility for the following pension classes:

- Full-pensioner;
- Part pensioner;
- Seniors health card holder; and
- Self-funded retiree.

Section 314-30 – Full-Pensioner

Subsection 314-30(1) provides that an individual is in the means testing class full-pensioner if the individual is not permanently blind and is a current means tested income support recipient under Social Security Act (e.g. Aged Pension, Disability Support Pensioner, etc) with a maximum rate of any means tested income support payment.

The note under subsection (1) explains that, for example, the maximum payment rate for aged and disability support pensions and carer payment for people who are not blind is the rate worked at out step 4 of the method statement in Module A of Pension Rate Calculator A in Division 1 of Part 3.12 of Chapter 3 of the Social Security Act.

Subsection 314-30(2) provides that an individual is in the means testing class full-pensioner on a day if the individual is either permanently blind or not receiving income support payment, and if the individual were receiving aged care pension, the individual's payment rate would be the maximum payment for the aged care pension under the Social Security Act.

Subsection 314-30(3) provides that an individual is in the means testing class full-pensioner if on a day the individual is in the post-2014 home contribution class and immediately before

the transition time, the income tested care fee for the individual under section 52D-2 of the old Act was nil.

Subsection 314-30(4) provides that, despite any other provision of this Subdivision, an individual is in the means testing class full-pensioner on a day if the individual has accessed funded aged care services on or after the transition time, and the individual has provided the information referred to in paragraphs 314A-5(1)(a) to (d) of the rules to enable the first determination the individual's contribution rate under subsection 314(1) of the Act, and the individual's contribution rate has not been determined within 6 months of the day that information was first provided. the individual's contribution rate under subsection 314(1) of the Act, and the individual's contribution rate has not been determined within 6 months of the day that information was first provided.

Section 314-35 – Part pensioner

Section 314-35 provides an individual is a part pensioner if they are a current means tested income support payment recipient under the Social Security Act (e.g. Age Pension, Disability Support Pensioner, etc) receiving less than (but greater than zero) the maximum payment rate of any means tested income support payment, or the System Governor has worked out the individual's total assessable income and value of assets and has assessed the individual as having means that would make them eligible for a part pension under the income and assets test under Social Security Act.

Subsection 314-35(1) provides that an individual is in the means testing class part pensioner on a day if the individual is not permanently blind and receiving income support payments, and the individual's payment rate for the income support payment is less than the maximum payment rate for that payment for that individual.

The note under subsection (1) explains that, for example, the maximum payment rate for age and disability support pensions and carer payment for people who are not blind is the rate worked out at step 4 of the method statement in Module A of Pension Rate Calculator A in Division 1 of Part 3.12 of Chapter 3 of the Social Security Act.

Subsection 314-35(2) provides that an individual is in the means testing class part pensioner on a day if either they are permanently blind or not receiving an income support payment and if the individual were receiving age pension calculated in accordance with Pension Rate Calculator A, the individual's payment rate would be less than the maximum payment rate for age pension under that calculator for that individual, but not nil, if the value of the individual's assets were worked out in accordance with Division 1 of Part 3.12 of the Social Security Act.

Section 314-40 – Seniors health card holder

Subsection 314-40(1) provides an individual is in the means testing class seniors health card holder on a day if the individual is not receiving the aged care pension and the individual holds a seniors health card.

Subsection 314-40(2) provides that an individual is in the means testing class seniors health card holder on a day if the individual is not receiving age pension and the individual does not hold a seniors health card but would satisfy the seniors health card income test in section

1071 of the Social Security Act if the value of the individual's assets were worked out in accordance with Division 1 of Part 3.12 of that Act.

Section 314-45 – Self funded retiree

Section 314-45 provides an individual is in the means testing class self-funded retiree on a day if:

- the individual is not in the means testing class full-pensioner, part-pensioner or seniors health card holder; or
- the individual has means not disclosed status; or
- the individual is an individual in relation to whom subsection 48-7(3) of the old Act applied to as at immediately before the transition time.

Subsection 314A(1) of the Act provides that an individual accessing funded aged care services in a home or community setting has means not disclosed status if either the System Governor determines that the individual has means not disclosed status because the individual is asked to provide specified information and fails to do so, or the individual elects not give information relating to the individual's means status.

Subdivision C – Calculating amounts of percentages for the means testing categories independence and everyday living

Subdivision C sets out the methods for calculating the amounts of percentages for the means testing categories independence and everyday living, for individuals in the means testing classes part pensioner and seniors health card holder. There will be no contribution for services in the clinical supports category, with assessed clinical care fully funded by the Commonwealth.

An 'independence rate means test' and the 'everyday living rate means test' will use an individual's assets and income to work out the individual contribution rate for their supports for independence and everyday living.

For individuals in the means testing classes part pensioner and seniors health card holder generally, the 'independence rate means test' will be applied on a tapered rate between 5% and 50% and the 'everyday living rate means test' will be applied on a tapered rate between 17.5% and 80%.

For individuals in the means testing classes part pensioner and seniors health card holder, in the post-2014 home contribution class who were not continuing home care recipients under the old Act, the 'independence rate means test' and the 'everyday living rate means test' will be applied on a tapered rate between 0% and 25% for both means testing categories.

Section 314-55 – Calculation method

Subsections 314-55(1) and (2) prescribe the following steps for calculating the percentage rates for the means testing category independence and everyday living for individuals in the means testing classes part pensioner and seniors health card holder, generally and in the post-2014 home contribution class who are not continuing home care recipients under the old Act as follows:

- Step 1: Work out the income reduction amount under section 314-60.
- Step 2: Work out the assets reduction amount under section 314-65.

- Step 3: Work out the maximum reduction amount under section 314-70.
- Step 4: Work out the input contribution rate under section 314-75.
- Step 5: Work out the percentage rate:
 - for the means testing category independence – under subsection 314-80(1) for individuals generally and under subsection 314-80(2) for individuals in the post-2014 home contribution class who were not continuing home care recipients under the old Act.
 - for the means testing category everyday living – under subsection 314-85(1) for individuals generally and under subsection 314-85(2) for individuals in the post-2014 home contribution class who were not a continuing home care recipients under the old Act.

Section 314-60 – Working out the income reduction amount

Section 314-60 sets out the method for working out the income reduction amount as follows:

- Step 1: Work out the amount that would be worked out as the individual's ordinary income for the purpose of applying Module E of Pension Rate Calculator A at the end of section 1064 of the Social Security Act.
- Step 2: Work out the amount that would be worked out as the individual's ordinary income free area under point 1064-E4 of that Module.
- Step 3: Subtract the amount under Step 2 from the amount under Step 1.
- Step 4: Multiply the amount under Step 3 by 0.5 and round to the nearest dollar.

The result is the income reduction amount.

For example:

- Step 1: Determine Brett's annual income:
 - Brett is single and has a private income of \$26,000 annually and receives a part-pension of \$19,708 per annum.
 - Total annual assessable income: \$26,000
- Step 2: Work out the income free area:
 - The income free area is the amount of income that is not counted in the means test. This is \$5,668 per annum.
- Step 3: Subtract the income free area from Brett's annual income:
 - Remaining income after free area: $\$26,000 - \$5,668 = \$20,332$
- Step 4: Apply the 50% reduction:
 - The means test reduces the remaining income by 50% to calculate the income reduction amount.
 - Income reduction amount: $\$20,332 \times 0.5 = \$10,166$ annually.

Section 314-65 – Working out the assets reduction amount

Section 314-65 sets out the method for working out the assets reduction amount as follows:

- Step 1: Work out the value of the individual's assets in accordance Division 1 of Part 3.12 of the Social Security Act, reduced by any amounts mentioned in section 314BE of this instrument received by the individual.
- Step 2: Work out the amount that would be worked out as the individual's assets value limit under point 1064-G3 of Module G of Pension Rate Calculator A at the end of section 1064 of the Social Security Act.

- Step 3: Subtract the amount under Step 2 from the amount under Step 1.
- Step 4: Multiply the amount under Step 3 by 0.078 and round to the nearest dollar.

The result is the assets reduction amount.

For example:

- Step 1: Determine Brett's total assessable assets:
 - Brett has assessable assets worth \$350,000.
- Step 2: Work out the asset free area:
 - The assets free area is the amount of assets that are not countered in the means test. This is \$321,500.
- Step 3: Subtract the asset free area from Brett's total assessable assets:
 - Remaining assets after free area: $\$350,00 - \$321,500 = \$28,500$
- Step 4: Apply the 7.8% reduction:
 - Multiply the remaining assets after free area by 7.8% to calculate the assets reduction amount.
 - Assets reduction amount: $\$28,500 \times 0.078 = \$2,223$

Section 314-70 – Working out the maximum reduction amount

Section 314-70 sets out the method for working out the maximum reduction amount as follows:

- Step 1: Work out the individual's senior's health card income limit under point 1017-12 of the Seniors Health Card Income Test Calculator at the end of section 1071 of the Social Security Act.
- Step 2: Subtract the individual's ordinary income free area (worked out under Step 2 of the method statement in section 314-60 of the rules) from the individual's senior's health card income limit.
- Step 3: Multiply the amount under Step 2 by 0.5 and round to the nearest dollar.

The result is the maximum reduction amount.

For example:

- Step 1: Maximum income limit:
 - The annual maximum income limit for Brett is \$101,105.
- Step 2: Subtract the income free area from Brett's maximum income limit:
 - Remaining income after free area is $\$101,105 - \$5,668 = \$95,437$.
- Step 3: Apply the 50% reduction
 - Multiply the remaining income free area by 50% to calculate the maximum reduction amount.
 - Maximum reduction amount: $\$95,437 \times 0.5 = \$47,719$.

Section 314-75 – Working out the input contribution rate

Section 314-75 sets out the method for working out the input contribution rate as follows:

- Step 1: Divide the greater of the income reduction amount and the assets reduction amount by the maximum reduction amount.
- Step 2: Express this figure as a percentage by multiplying the Step 1 amount by 100.

The result is the input contribution rate.

For example:

- Step 1: Divide the greater of the income reduction amount and assets reduction amount for Brett by the maximum reduction amount.
 - Brett's income reduction amount: \$10,166.
 - Brett's asset reduction amount: \$2,223.
 - Brett's maximum reduction amount: \$47,719.
 - $\$10,166 / \$47,719 = 0.2130388315$
- Step 2: Express this figure as a percentage
 - Calculate the input contribution rate for Brett = 21.30388315%
 - No rounding occurs at this step.

Section 314-80 – Working out the amount of the percentage for the means testing category independence

Subsection 314-80(1) sets out the following method for working out the percentage for the means testing category independence for individuals generally.

- Step 1: Multiply the input contribution rate by 0.45.
- Step 2: Add 5 to the Step 1 amount and round to 2 decimal places.

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

For example, calculate Brett's means tested percentage contribution for independence:
 $(21.30388315 \text{ (input contribution rate)} \times 0.45) + 5 = 14.58\%$.

Subsection 314-80(2) sets out the following method for working out the percentage for the means testing category independence for individuals in the post-2014 home contribution class who were not continuing home care recipients under the old Act.

- Step 1: Multiply the input contribution rate by 0.25 and round to 2 decimal places.

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

Section 314-85 – Working out the amount of the percentage for the means testing category everyday living

Subsection 314-85(1) sets out the following method for working out the percentage for the means testing category everyday living for individuals generally.

- Step 1: Multiply the input contribution rate by 0.625
- Step 2: Add 17.5 to the Step 1 amount and round to 2 decimal places.

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

For example, calculate Brett's means tested percentage contribution for everyday living:
 $(21.30388315 \text{ (input contribution rate)} \times 0.625) + 17.5 = 30.81\%$.

Subsection 314-85(2) sets out the method for working out the percentage for the means testing category everyday living for individuals in the post-2014 home contribution class who were not continuing home care recipients under the old Act.

- Step 1: Multiply the input contribution rate by 0.25 and round to 2 decimal places.

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

Subdivision D – Means not disclosed status

Section 314A-5 – Determination that individuals have means not disclosed status

Section 314A-5 provides that, for the purposes of paragraph 314A(2) of the Act, the specified information is:

- Information relating to the individual's marital status
- Information relating to whether the individual is a homeowner
- Information relating to the individual's total assessable income under section 322 of the Act;
- Information relating to the value of the individual's assets under section 329 of the Act.

Subsection (2) provides that, for the purposes of subsection 314A(2) of the Act, the specified period is 28 days from the day the System Governor requests the specified information from the individual under subsection 343(1) of the Act.

Section 314A-10 – Day determination takes effect

Section 314A-10 specifies that the System Governor may specify that the determination takes effect on the day that the determination is made, or if before that day, the specified day must be the start day for the delivery of the funded aged care service to the individual to which the start notification mentioned in subsection 314-15(2) of the rules for the individual relates.

Subdivision E – Requirement to notify event or change in circumstances

Section 315-5 – Circumstances in which notification of event or change in circumstances is required

Section 315-5 specifies the circumstances in which an individual for whom an individual contribution rate determination is in force must notify the System Governor of the occurrence of an event or a change in the individual's circumstances for the purposes of subsection 315(1) of the Act. These are:

- a decision under the social security law relating to the individual has been made;
- the individual's income changes;
- the individual's partner's income changes;
- the value of the individual's assets changes;
- the value of the individual's partner's assets changes;
- the individual starts or stops being a member of a couple;
- the individual is a member of a couple that stops or starts being an illness separate couple;
- the individual is a member of a couple that stops or starts being a respite care couple;
- the individual leaves Australia permanently.

Section 315-10 – Period for notification of event

Section 315-10 prescribes the period in which an individual must notify the System Governor of the event or change in circumstances listed under section 315-5 of the rules, for the purposes of paragraph 315(2)(a) of the Act. This period is 28 days from the day the event or change or circumstance occurs.

Section 315-15 – Manner for notification of event or change in circumstances

Section 315-15 prescribes the manner in which an individual must notify the System Governor of the event or change in circumstance listed under section 315-5 of the rules, for the purposes of paragraph 315(2)(b) of the Act. That is an individual must notify the System Governor in the approved form.

Subdivision F – Varying or revoking individual contribution rate determination

Section 316-5 – Other matters to be included in notice of determination

Section 316-5 prescribes the matters a notice of a decision in relation to a varied individual contribution rate determination which must be given to the System Governor, must contain for the purposes of paragraph 316(4)(f) of the Act. This includes the individual contribution rate for the individual for each means testing category specified in the notice given under subsection 314(2) of the Act in relation to the old determination for the individual.

Section 317-5 – Period for deciding if individual contribution rate determination is no longer correct following certain social security decisions

Section 317-5 prescribes the period within which the System Governor must consider certain social security decisions and decide whether a determination of an individual contribution rate is no longer correct because of the decision for the purposes of subsection 317(2) of the Act. This period is 28 days from the day the decision mentioned in subparagraph 317(1)(b)(i) of the Act is made.

Section 318-5 – Period for deciding whether to vary or revoke individual contribution rate determination following event or change in circumstances

Section 318-5 prescribes the period within which the System Governor must consider the event or change in circumstances and decide whether the determination of an individual contribution rate is no longer correct because of the event or a change in an individual's circumstances for the purposes of subsection 318(2) of the Act. This period is 28 days from the day the System Governor is notified or satisfied as mentioned in subparagraph 318(1)(b)(i) or (ii) of the Act respectively (as applicable).

Section 318-10 – Variation or new determination following event or change in circumstances to take effect on specified day in specified circumstances

Subsection 318(6) of the Act provides for the rules to specify the day a variation or new determination takes effect in particular circumstances. The day cannot be earlier than the day the System Governor was notified under paragraph 318(1)(b).

Section 318-10 describes the circumstances, being that the System Governor is not notified of an event or change within the period at 315-10 (28 days from the event or change of circumstances) and, that the variation or new determination results in an increase to the individual contribution rate for the individual for a means testing category.

If these circumstances apply, section 318-10 provides that the variation or new determination takes effect on the day the System Governor was notified of the event or change in individual's circumstances under paragraph 318(1)(b) of the Act.

For example, if an individual had assets that increased in value and did not notify the System Governor until more than 28 days after the increase, and, if the increase in value resulted in an increase in the individual's contribution rate, the variation or new determination would apply from the date the System Governor was notified of the change.

Section 318A-5 – Period for deciding whether to revoke incorrect individual contribution rate determination

Section 318A-5 prescribes the period of time the System Governor has for deciding whether to revoke incorrect individual contribution rate determination. That period is 28 days from the day the System Governor is satisfied as mentioned in paragraph 318A(1)(b) of the Act.

Division 2 – Means testing in approved residential care home

The rules for this Division address means testing in residential care. The rules reflect existing arrangements under Subdivisions C to D of Division 4 of Part 3 of Chapter 2 of the *Subsidy Principles 2014*, with some changes to reflect the recommendations of the Taskforce.

Subdivision A – Daily means tested amounts

Section 319-5 – Income and asset thresholds

Section 319-5 prescribes the income and asset thresholds for the purposes of subsection 319(4) of the Act.

Subsections (2) to (5) provide that the income thresholds are as follows:

- The **first income threshold** is:
 - for an individual who is a member of an illness separated couple—\$85,678.32; or
 - for an individual who is not a member of a couple—\$86,406.32.
- The **second income threshold** is \$101,105.00.
- The **third income threshold** is \$117,230.20.
- The **fourth income threshold** is:
 - for an individual who is a member of an illness separated couple—\$136,136.00; or
 - for an individual who is not a member of a couple—\$139,048.00.

Subsections (6) to (9) provide that the asset thresholds are as follows:

- The **first asset threshold** is \$210,555.20.
- The **second asset threshold**:
 - for an individual in the post 2014 residential contribution class—is \$505,665.60; or
 - in any other case—is \$252,000
- The **third asset threshold** is \$355,366.66.
- The **fourth asset threshold** is \$532,055.20.

Section 319-10 – Working out the daily means tested amount – classes of individuals

Section 319-10 prescribes the class of individuals, in which the daily means tested amount for the individual prescribed in the rules apply for the purposes of subsection 319(5) of the Act. These classes are:

- the pre-2014 residential contribution class
- the post-2014 residential contribution class.

Section 319-15 – Working out the daily means tested amount – individuals in pre-2014 residential contribution class

Section 319-15 sets out the method for calculating the daily means tested amount for an individual in the pre-2014 residential contribution class. The method for calculating this individual's daily means tested amount is set out in the Act and rules. In simple terms it stipulates that where an individual's assessable income exceeds the income free areas, their daily means test amount is equal to a proportion of that excess, depending on the specific value of the excess. The method for determining the value of the individual's assessable income, and how to determine an individual's income free area is set out in the Act. The method for determining the specific proportions of income value that contributes to the daily means tested amount is set out in the rules.

Specifically, section 319-15 provides the following method for calculating the daily means tested amount for an individual in the pre-2014 residential contribution class:

- Step 1: Work out the individual's total assessable income which is determined under section 322 of the Act.
- Step 2: Work out the individual's total assessable income free area, see subsection (2).
- Step 3: If the individual's total assessable income does not exceed the individual's total assessable income free area, the daily means tested amount is zero.
- Step 4: If the individual's total assessable income exceeds the individual's total assessable income free area, the smallest of the following amounts (rounded down the nearest cent), is the daily means tested amount:
 - The amount equal to 5/12 of that excess, divided by 364;
 - The amount equal to 135% of the basic aged pension amount for that day, divided by 364;
 - The sum of the individual's base rate (see section 229-5) and the provider's base provider amount (see section 238-5) for the individual for the day.

Subsection (2) provides that an individual's total assessable income free area is the sum of:

- the amount for the day for the individual worked out by applying point 1064-B1 of Pension Rate Calculator A at the end of section 1064 of the Social Security Act (noting that if the individual was a protected resident within the meaning of the Transitional Act immediately before the transition time, this section as in force on 19 September 2009); and
- the amount worked out under point 1064-BA4 of Pension Rate Calculator A at the end of section 1064 of the Social Security Act; and
- the amount worked out by applying point 1064-E4 of Pension Rate Calculator A at the end of section 1064 of the Social Security Act.

Section 319-20 – Working out the daily means tested amount – individuals in post-2014 home contribution class or post-2014 residential contribution class

Subsection 319-20(1) provides that the method for calculating the daily means tested amount for an individual in the post-2014 residential contribution class is the sum of:

- the per day income tested amount worked out under subsection (2); and

- the per day asset tested amount worked out under subsection (3).

The per day income tested amount is set out in the Act and subsection 319-20(2) of the rules. In simple terms it stipulates that where an individual's assessable income exceeds the income free area, their per day income tested amount is equal to a proportion of that excess, depending on the specific value of the excess. The method for determining the value of the individual's assessable income and how to determine an individual's income free area is set out in the Act. The method for determining the specific proportions of income value that contributes to the per day incomes tested amount is set out in the rules.

Specifically, subsection 319-20(2) provides that the per day income tested amount is worked out as follows:

- Step 1: Work out the individual's total assessable income (which is determined under section 322 of the Act).
- Step 2: Work out the individual's total assessable income free area (see subsection 319(2) of the Act).
- Step 3: If the individual's total assessable income does not exceed the individual's total assessable income free area, the ***per day income tested amount*** is zero.
- Step 4: If the individual's total assessable income exceeds the individual's total assessable income free area, the ***per day income tested amount*** is 50% of that excess divided by 364.

The per day asset tested amount is set out in the Act and subsection 319-20(3) of the rules. In simple terms it stipulates that where an individual's assets exceeds the asset free area, their per day asset tested amount is equal to proportion of that excess, depending on the specific value of the excess. The method for determining the value of the individual's assets and how to determine an individual's asset free area is set out in the Act. The method for determining the specific proportions of asset value that contributes to the per day asset tested amount as the value exceeds certain thresholds is set out the rules.

Specifically, subsection 319-20(3) provides that the per day asset tested amount is worked out as follows:

- Step 1: Work out the value of the individual's assets (which is determined under section 329 of the Act).
- Step 2: If the value of the individual's assets does not exceed the asset free area, the ***per day asset tested amount*** is zero.
- Step 3: If the value of the individual's assets exceeds the asset free area but not the first asset threshold, the ***per day asset tested amount*** is 17.5% of the excess divided by 364.
- Step 4: If the value of the individual's assets exceeds the first asset threshold but not the second asset threshold, the ***per day asset tested amount*** is the sum of the following divided by 364:
 - 1% of the excess;
 - 17.5% of the difference between the asset free area and the first asset threshold.
- Step 5: If the value of the individual's assets exceeds the second asset threshold, the ***per day asset tested amount*** is the sum of the following divided by 364:
 - 2% of the excess;

- 1% of the difference between the first asset threshold and the second asset threshold;
- 17.5% of the difference between the asset free area and the first asset threshold.

Subdivision B – Means not disclosed status

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

Section 320-5 – Determination that individuals have means not disclosed status

Subsection 320(2) of the Act provides that the System Governor must determine that an individual has means not disclosed status if the individual is asked to provide specified information prescribed by the rules within a specified period prescribed by the rules to assist the System Governor to determine the individual's daily means tested amount and the individual fails to do so. This section sets out the specified information and the specified period for the purposes of subsection 320(2) of the Act.

Section 320-5 provides that, for the purposes of subsection 320(2) of the Act, the specified information is:

- Information relating to the individual's total assessable income in accordance with section 323 of the Act; and
- Information relating to the individual's assets in accordance with section 330 of the Act.

Section 320-5 also provides that, for the purposes of section 320(2) of the Act, the specified period is 28 days from the day the System Governor requests specified information from the individual under subsection 343(1) of the Act.

Section 320-10 – Day determination takes effect

Subsection 320(3) of the Act provides a determination under paragraph 320(1)(a) of the Act takes effect of the day specified by the System Governor in the notice under subsection 320(5). The day may be before the day on which the determination is made but must be in accordance with the rules.

Section 320-10 provides that the day specified by the System Governor as the day the determination takes effect must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsections 322-5(2) or 329-5(2) of the rules for the individual relates.

Subdivision C – Determining an individual's total assessable income

Section 322-5 – Period for determining an individual's total assessable income

Section 322-5 details the process and timeframes the System Governor must follow before determining an individual's total assessable income for the purposes of subsection 322(1) of the Act. The series of information requests and notifications that must be followed include when an individual provides the required information, and when an individual does not

provide required information, to allow the system Governor to determine the individual's assessable income.

Subsection 322-5(2) provides that section 322-5 applies to an individual if a registered provider provides a start notification on a day (the ***start notification day***) to the System Governor and the Commissioner about the delivery of funded aged care services to the individual.

Subsection 322-5(3) specifies the period for determining an individual's total assessable income if, on the start notification day, the System Governor has the required information to determine the individual's total assessable income. This period is 28 days from the start notification day.

Subsection 322-5(4) specifies the period for determining an individual's total assessable income if the individual provides the required information without request from the System Governor. Specifically, if:

- on the start notification day, the System Governor does not have the required information to determine the individual's total assessable income; and
- within 3 days from the start notification day, the individual provides the required information to the System Governor;

the period is 28 days from the day the individual provided the information.

Subsection 322-5(5) specifies the period for determining an individual's total assessable income if the individual provides the required information on request from the System Governor. Specifically, if:

- on the start notification day, the System Governor does not have the required information; and
- within 3 days from the start notification day, the individual does not provide information to the System Governor the required information, and
 - the System Governor requests information or documents from the individual under subsection 343(1) of the Act (which provides the System Governor may request a person to give the System Governor any information or documents the System Governor reasonably believes that the person has relevant to the System Governor's functions) to enable the System Governor to determine the individual's total assessable income;

the period is 28 days from the day the individual provided the information or documents requested by the System Governor to determine the individual's total assessable income.

Subsection 322-5(6) specifies the period for determining an individual's total assessable income if the individual does not provide required information or elects to have means not disclosed status under section 321 of the Act.

Specifically if, after 3 days from the start notification day the individual has not provided the required information to the System Governor and the System Governor requests the required information from the individual under subsection 343(1) of the Act, and either the individual does not, within 28 days from the day the System Governor requested the information, provide required information; or the individual makes an election under section 321 of the Act before the end 28 days from the day the System Governor requests the required information the period is 3 days from the day the System Governor requests the information.

Section 322-10 – Day determination take effect

Section 322-10 specifies the day the determination of an individual's total assessable income takes effect which must be contained in the System Governor's notice for the purposes of subsection 322(6) of the Act. The day specified by the System Governor as the day the determination takes effect must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsection 322-5(2) of the rules for the individual relates.

Section 322-15 – Other matters to be included in notice of determination

Section 322-15 prescribes the matters that the written notice of the determination of an individual's total assessable income the System Governor must give to the individual under subsection 322(8) of the Act must contain for the purposes of paragraph 322(9)(g) of the Act. These matters include:

- a summary of the individual's sources of income; and
- the assessed amounts for each of those sources of income.

Subdivision D – Working out an individual's total assessable income – excluded amounts

The rules under Subdivision D sets the types of amounts to be excluded when determining an individual's assessable income. These rules will replicate Subdivision C and Subdivision CA of Division 4 of Part 3 of Chapter 2 of the *Subsidy Principles 2014*.

Section 323-5 – Purpose of this Subdivision

Section 323-5 sets out the purpose of Subdivision D, which is to prescribe amounts that are to be taken, in relation to specified kinds of individual, to be excluded from:

- a determination of an individual's total assessable income if the individual is not entitled to an income support payment under subsection 323(1) of the Act; or
- the amount the System Governor determines to be the amount that would be worked out as the individual's ordinary/adjusted income under paragraph 323(2)(b) of the Act, in calculating the individual's total assessable income if the individual is entitled to a service pension; or
- the amount the System Governor determines to be the amount that would be worked out as the individual's ordinary/adjusted income under paragraph 323(3)(b) of the Act, in calculating the individual's total assessable income if the individual is entitled to an income support supplement; or
- the amount the System Governor determines to be the amount that would be worked out as the individual's ordinary/adjusted income under paragraph 323(4)(b) of the Act, in calculating the individual's total assessable income, if an individual entitled to a veteran payment; or

- the amount the System Governor determines to be the amount that would be worked out as the individual's ordinary income under paragraph 323(5)(b) of the Act, in calculating the individual's total assessable income if the individual is entitled to an income support payment (other than service pension, an income support supplement or a veteran payment).

Section 323-10 – Disability pensions and permanent impairment compensation payments

Subsection 323-10(1) provides that the amount of disability pension paid to a person who has qualifying service under section 7A of the Veterans' Entitlements Act (or is the partner of such a person) should be an excluded amount when determining the care recipient's total assessable income. The amount will only be an excluded amount if it is also exemption under section 5H of the Veterans' Entitlement Act.

Subsection 323-10(2) provides for a person who is or has been a member as defined under the MRC Act (or their partner) excluded amounts are:

- any compensation for permanent impairment paid to the person under Part 2 of Chapter 4 of the MRC Act; and
- any amount of Special Rate Disability Pension paid to the person under Part 6 of Chapter 4 of the MRC Act.

Section 323-15 – Gifts

Subsection 323-15(1) provides that for a person who disposed of ordinary income on or prior to 20 August 1996, the amount of ordinary income disposed of is an excluded amount for the purposes of calculating the individual's total assessable income. This subsection also notes those sections listed in paragraphs 323-15(1)(a) and (b) are sections of the Social Security Act and the Veterans' Entitlement Act that deal with disposal of ordinary income.

Subsection 323-15(2) provides that for a person who disposed of assets on or prior to 20 August 1996, the amount of ordinary income the person is taken to have received is an excluded amount from the individual's total assessable income. This subsection also notes that the sections set out in paragraphs 323-15(2)(a) and (b) are the sections of the Social Security Act and the Veterans' Entitlement Act that deal with deemed income on financial assets.

Section 323-20 – Rent receipts

Section 323-20 provides that this section applies to an individual for whom an accommodation contribution or an accommodation payment is payable, who first entered residential care (within the meaning of the old Act) on or before 31 December 2015, and for whom since the individual first entered residential care there has not been a continuous period of more than 28 days in which the individual was not either receiving residential care (other than because the person was on leave within the meaning of the old Act), or accessing funded aged care services in an approved residential care home.

Subsection (2) provides that the amount of any income received by the individual or the individual's partner from rental of the individual's principal home to another person is to be excluded from a determination of the individual's total assessable income.

Section 323-25 – GST compensation

Subsection 323-25(1) provides that this section applies to:

- a person who receives a pension under Part II or IV of the Veterans' Entitlement Act at a rate determined through that Act by reference to the following provisions of that Act:
 - section 22, for a person on a disability pension at the general rate;
 - sections 22 and 27, for a person on a disability pension at the general rate plus an increased rate for war-related injury;
 - section 23, for a person on a disability pension at the intermediate rate or such a person who also has an increased rate for war-related injury;
 - sections 23 and 27, for an individual receiving a disability pension payable at the intermediate rate including an increased rate for a war-caused injury or disease;
 - section 24, for a person on a disability pension at the special rate;
 - subsection 30(1), for a person receiving a war widow or widower pension
- a person who receives a payment under Part 6 of Chapter 4 or Part 2 of Chapter 5 of the MRC Act at a rate determined under the following provisions of that Act:
 - sections 198 and 204, for a person on a Special Rate Disability Pension;
 - subsection 234(5) for a person receiving weekly compensation for the death of a partner.

Subsection 323-25(2) provides that an amount equal to four per cent of the amount paid to person under the provisions of the Veterans' Entitlement Act listed above or the MRC Act listed above is an excluded amount when determining the individual's total assessable income.

Notes to this section explain that:

- pensions (other than service pensions) payable to veterans' and their dependants are dealt with in Part II of the Veterans' Entitlement Act;
- pensions that are payable to members of the Defence Force or a Peacekeeping Force and their dependants is dealt with in Part IV of the Veterans' Entitlement Act;
- a choice to receive a Special Rate Disability Pension instead of compensation is afforded to former members who are entitled to compensation for their incapacity to work in accordance with Part 6 of Chapter 4 of the MRC Act; and
- wholly dependent partners of deceased members are entitled to compensation which can be taken as a lump sum or as a weekly amount under Part 2 of Chapter 5 of the MRC Act.

Section 323-30 – Energy payments

Section 323-30 provides that, in relation to an individual to whom funded aged care services are being delivered through the service group residential care, each of the following amounts paid to the individual under the Social Security Act and Veterans' Entitlements Act is prescribed:

- Clean energy advance;
- Energy supplement;
- Quarterly energy supplement.

Subdivision E – Working out an individual’s total assessable income – application of social security law provisions

Section 323-35 – Application of Social Security Act provisions

Subsection 323-35(1) provides that this section applies to an individual who first entered residential care (within the meaning of the old Act) on or after 1 January 2016 and for whom, since the individual first entered residential care, there has not been a continuous period of more than 28 days in which the individual was not either receiving residential care (other than because the person was on leave within the meaning of the old Act) or accessing funded aged care services in an approved residential care home.

Subsection 323-35(2) provides that certain amounts – those being any rent from the individual’s principal home that the individual, or the individual’s partner, earns, derives, or receives from another individual while the individual is liable to pay all or some of a daily accommodation payment or a daily accommodation contribution – that would not be included when working out an individual’s ordinary income under the Social Security Act, will be included for the purposes of working out the individual’s total assessable income under this section.

Section 323-40 – Application of Veterans’ Entitlement Act provisions

Subsection 323-40(1) provides that this section applies to an individual who first entered residential care (within the meaning of the old Act) on or after 1 January 2016 and for whom, since the individual first entered residential care, there has not been a continuous period of more than 28 days in which the individual was not either receiving residential care (other than because the person was on leave within the meaning of the old Act) or accessing funded aged care services in an approved residential care home.

Subsection 323-40(2) provides that certain amounts, those being any rent from the individual’s principal home that the individual, or the individual’s partner, earns, derives or receives while the individual is liable to pay all or some of an accommodation bond by periodic payments – that would not be included when working out an individual’s ordinary/adjusted income under the Veterans’ Entitlements Act, will be included for the purposes of working out the individual’s total assessable income under this section.

Subdivision F – Varying or revoking an income determination

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

Section 324-5 – Day variation of income determination takes effect

Subsection 324-5(1) provides that the purpose of the section is to specify rules in relation to the day the System Governor specifies as the day a variation of an income determination for an individual takes effect for the purposes of subsection 324(5) of the Act.

Subsection 324-5(2) provides that, where the variation does not result in an increase to the individual’s daily means tested amount, the day specified must be the day the event or change in circumstances occurred.

Subsection 324-5(3) provides that where the variation results in an increase to the individual's daily means tested amount:

- if the decision under subsection 324(1) of the Act to vary the income determination is made within 28 days of the day the event or change in circumstances occurred, the day specified is the day notice of the decision is given;
- or otherwise, the day specified is 28 days before the day notice of the decision under subsection 324(1) of the Act is given.
- Subsection 324-5(4) provides that despite paragraph (3)(b), the day may instead be a day earlier than 28 days before the day notice of the decision is given, if the individual has provided false or misleading information under section 326 or 336 of the Act in relation to the decision.

Section 325-5 – Period for varying or revoking income determination—on notification of event or change in circumstances

Section 325-5 specifies the period within which the System Governor must decide whether to vary or revoke the income determination in force for the individual for the purposes of subsection 325(2) of the Act. The period for making a decision following the notification of the occurrence of an event or a change in the individual's circumstances under Subdivision D of Division 2 of Part 5 of Chapter 4 of the Act is 28 days from the day the notification is made.

Section 326-5 – Period for varying or revoking income determination—on application

Section 326-5 specifies the period within which the System Governor must make a decision on the application to vary or revoke an income determination by an individual for the purposes of paragraph 326(2)(b) of the Act. The period for making a decision on an application by an individual is 28 days from the day the application is made.

Section 327-5 – Period for varying or revoking income determination—on System Governor initiative

Section 327-5 specifies the period within which the System Governor must make a decision whether to vary or revoke the income determination on the System Governor's initiative for the purposes of paragraph 327(6)(b). The period for making a decision is 28 days from:

- if no submission is made in accordance with the invitation in the notice under paragraph 327(2)(b) of the Act – the end of the period specified in the notice (including that period as extended, if applicable, under subsection 327(5) of the Act which provides the System Governor may, at the request of the individual, extend the period for an individual to make a submission to the System Governor under paragraph 327(2)(b) or subsection 327(4) of the Act; or
- the later of:
 - if a submission is made in accordance with the invitation in the notice under paragraph 327(2)(b) of the Act and no further information is requested under subsection 327(4) of the Act – the day the submission is made; or
 - if a submission is made in accordance with the invitation in the notice under paragraph 327(2)(b) of the Act and further information is requested under subsection 327(4) of the Act – the day the individual gives the System Governor the further information.

Section 328-10 - Other matters to be included in notices of decisions other than reviewable decisions

Section 328-10 prescribes such other matters that a notice of a decision not to vary or revoke an income determination for an individual must include for the purposes of paragraph 328(4)(b) of the Act. Specifically, a notice given under subsection 328(3) of the Act must include the reasons for the decision.

Subdivision G – The value of an individual’s assets

Section 329-5 – Period for determining the value of an individual’s assets

Subsection 329-5(1) provides that this section sets out the period within which the System Governor must determine the value at a particular time of an individual’s assets for the purposes of subsection 329(1) of the Act.

Subsection 329-5(2) provides that this section applies to an individual if a registered provider provides a start notification on a day (the **start notification day**) to the System Governor and the Commissioner about the delivery of funded aged care services to the individual.

Subsection 329-5(3) specifies the period for determining the value of an individual’s assets where the individual provides required information without the information being requested from the System Governor. Specifically if, on the start notification day, the System Governor has the required information to determine the value of the individual’s assets, the period is 28 days from the start notification day.

Subsection 329-5(4) specifies a further period for determining the value of an individual’s assets where the individual provides the required information without request from the System Governor. If the System Governor does not have the required information to determine the value of the individual’s assets and within 3 days from the start notification day the individual provides that information, the period is 28 days from the day the individual provided the information.

Subsection 329-5(5) specifies the period for determining the value of an individual’s assets where the individual provides the required information after this information is requested from the System Governor. Specifically, it provides that if:

- on the start notification day, the System Governor does not have the required information to determine the value of the individual’s assets; and
- the individual does not provide the required information to the System Governor within 3 days of the start notification day; and
- the System Governor requests the required information from the individual under subsection 343(1) of the Act; and
- within 28 days from the day the System Governor requested the required information the individual provides the required information to the System Governor;

the period is 28 days from the day the individual provided the required information.

Subsection 329-5(6) specifies the period for determining the value of an individual’s assets where the individual does not provide the required information after this information is requested from the System Governor or the individual elects to have their means not disclosed under section 321 of the Act.

Specifically, it provides that if the System Governor does not have the required information within 3 days of the start notification day; within 28 days after requesting the required information under subsection 343(1) of the Act; or the individual makes an election under section 321 of the Act before the end of those 28 days, the period is 3 days from the end of those 28 days.

Section 329-10 – Day determination takes effect

Section 329-10 provides the day on which a determination of the value of an individual's assets by the System Governor takes effect, must be the start day for the delivery of funded aged care services to the individual to which the start notification mentioned in subsection 322-5(2) of the rules for the individual relates.

Section 329-15 – Other matters to be included in notice of determination

Section 329-15 sets out, for the purposes of paragraph 329(9)(g) of the Act the other matters that must be included in a notice under subsection 329(8) of the Act. The other matters are:

- a summary of the individual's assets;
- the assessed amounts for each of the individual's assets.

Subdivision H – Working out the value of an individual's assets – excluded amounts

Section 330-5 – Value of home

Section 330-5 sets the value above which the value of a homeowner's home is to be disregarded in working out the value, at a particular time, of a homeowner's assets for the purposes of 330(7) of the Act. The value is \$ 210,555.20.

Section 330-10 – Other amounts

Subsection 330-10(1) provides, for the purposes of subsection 330(9) of the Act, amounts that are to be taken, in relation to specified kinds of individuals, to be excluded from a determination under paragraph 330(2)(a) or (b) or (3)(a) or (b) or subsection 330(4) of the Act.

- Subsection 330-10(2) provides that in relation to all individuals, the following amounts are to be excluded from a determination under paragraph 330(2)(a) or (b) or (3)(a) or (b) or subsection 330(4) of the Act:
- any compensation payments received by the individual under the following:
 - the *Compensation (Japanese Internment) Act 2001*;
 - the *Veteran's Entitlements (Compensation – Japanese Internment) Regulations 2001*;
 - Part 2 of the *Veteran's Entitlements (Clarke Review) Act 2004*;
 - Schedule 5 to the *Social Security and Veteran's Affairs Legislation Amendment (One-off Payments and Other 2007 Budget Measures) Act 2007*;
- any redress payment paid to the individual, or to an administrator for the individual, under section 48 of the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018*. It should be noted that payments made under this Act are not excluded for an individual's income since these payments are already excluded under the Social Security Act.

A person who has experienced institutional childhood sexual abuse can receive a payment of up to \$150,000 under the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018*. Redress payments are not considered income at the time they are received in the income test component of the aged care means assessment (because they are not considered income for the purposes of calculating income support payments under the Social Security Act 1991). However, where the payment is held by the recipient at the time they enter residential care, it is considered an assessable asset for aged care purposes. This means that some redress payment recipients are currently asked to contribute more towards their residential aged care accommodation and care costs as a result of receiving the redress payment.

The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) identified that distrust and fear of institutions and authority are particular features of the effects of child sexual abuse in an institutional context. Thus, entering a residential aged care home can be highly traumatic for this vulnerable group, and even more so for individuals required to pay higher fees as a result of a redress payment. The exemption of redress payments from the aged care assets test under the Amending Instrument supports the Australian Government's response to the Royal Commission by safeguarding recipients of redress payments against additional trauma when entering a Government-funded institution (in this case, a residential aged care home).]

Subdivision J – Varying or revoking an asset determination

Section 331-5 – Day variation of asset determination takes effect

Subsection 331-5(1) provides that the purpose of this section is to specify the day a variation or revocation of an asset determination in relation to an individual takes effect for the purposes of subsection 331(5) of the Act.

Subsection 331-5(2) provides that if the variation does not result in an increase to:

- the amount of person-centred subsidy reduction for the individual for a day under section 235 of the Act; or
- the amount of provider-based subsidy reduction for the registered provider for the individual for a day under section 242 of the Act; or
- the amount of accommodation contribution that the individual may be charged under section 298 of the Act;

the day specified must be the day the event or change in circumstances occurred.

Subsection 331-5(3) provides that if the variation results in an increase to:

- the amount of person-centred subsidy reduction for the individual for a day under section 235 of the Act; or
- the amount of provider-based subsidy reduction for the registered provider for the individual for a day under section 242 of the Act; or
- the amount of accommodation contribution that the individual may be charged under section 298 of the Act;

The day specified must be the day notice of the decision is given if the decision under subsection 331(1) of the Act to vary the asset determination is made within 28 days of the day the event or change in circumstances occurred, or otherwise, 28 days before the day notice of the decision under subsection 331(1) of the Act is given.

Subsection (4) provides that, despite paragraph 331-5(3)(e), the day specified may instead be a day earlier than 28 days before the day notice of the decision is given if the individual has provided false or misleading information under sections 333 or 336 of the Act in relation to the decision.

Section 332-5 – Period for varying or revoking asset determination—on notification of event or change in circumstances

Section 332-5 provides that for the purposes of 332(2) of the Act the period for varying the asset determination is 28 days from the day the notification is made.

Section 333-5 – Period for varying or revoking asset determination—on application

Section 333-5 provides, for the purposes of paragraph 333(2)(b) of the Act that the period for making a decision on an application by an individual for the purposes of paragraph 331(2)(b) of the Act is 28 days from the day the application is made.

Section 334-5 Period for varying or revoking asset determination—on System Governor’s initiative

Section 334-5 provides that the period for making a decision about whether to vary or revoke an asset determination on the System Governor’s initiative for the purposes of paragraph 334(6)(b) of the Act, is 28 days from:

- if no submission is made in accordance with the invitation in the notice under paragraph 334(2)(b), the end of the period specified in the notice (including that period as extended at the request of the individual, if applicable, under subsection 334(5) of the Act); or
- the later of:
 - if a submission is made in accordance with the invitation in the notice under paragraph 334(2)(b) of the Act and no further information is requested under subsection 334(4) of the Act, the day the submission is made; and
 - if a submission is made in accordance with the invitation in the notice under paragraph 334(2)(b) of the Act and further information is requested under subsection 334(4) of the Act, the day the individual gives the System Governor the further information.

Section 335-10 Other matters to be included in notices of decisions other than reviewable decisions

Section 335-10 provides that for the purposes of paragraph 335(4)(b) of the Act, a notice not to vary or revoke an asset determination for an individual given under subsection 335(3) of the Act must include the reasons for the decision.

Subdivision K—Notifying of event or change in circumstances

Section 336-5 Notifications by individuals—manner and period

Section 336-5 specifies the manner in, and the period within, which a notification of the occurrence of an event or a change in an individual’s circumstances must be made by the individual accessing funded aged care services through the service group residential care for the purposes of subsection 336(2) of the Act. Specifically:

- an individual must make a notification in the approved form; and
- the notification must be made within 28 days from the day the event or change in circumstances occur.

Section 337-5 Notifications by registered providers—manner and period

Section 337-5 specifies the manner in, and the period within, which a registered provider delivering funded aged care services to the individual must notify the System Governor of the occurrence of an event or change in an individual's circumstances for the purposes of subsection 337(2) of the Act. Specifically:

- the manner in which a registered provider must make a notification under subsection 337(1) of the Act is:
 - in a claim made under section 251 of the Act (claim for subsidy); or
 - in the approved form; and
- the period in which the notification must be made is as soon as practicable after the end of the payment period in which the event or change of circumstances occurs.

Subsection 337-5(2) provides for the manner and period within which notifications must be made if the event or change in circumstances is a change in an individual's refundable deposit balance that has occurred since the most recent claim made by the registered provider under section 251 of the Act for subsidy for the delivery of a funded aged care service to the individual.

In this situation, paragraphs 337-5(2)(a) and (b) provide that the manner in which a registered provider must make a notification is in the next claim (the subsequent claim) made under section 251 of the Act for subsidy for the delivery of a funded aged care service to the individual, and the period in which the notification must be made is the period within which the subsequent claim may be made.

Chapter 11 – Governance of the Aged Care System

Part 1 – Introduction

Section 338-1 – Simplified outline of this Chapter

Section 338-1 provides a simplified outline of Chapter 11. This Chapter sets out aged care governance matters under Chapter 5 of the Act.

Part 1A prescribes certain requirements for identity cards issued by the System Governor to approved needs assessors.

Division 1A of Part 2 sets out the other functions of the Commissioner, including reconsidering certain decisions made personally by the Complaints Commissioner to ensure availability of an external review mechanism.

Division 1 of Part 2 sets out how the Commissioner may deal with reportable incidents notified by registered providers.

Division 2 of Part 2 sets out the requirements for the Complaints Commissioner to provide the Minister written reports in relation to complaints and feedback.

Division 3 of Part 2 establishes a scheme for the Complaints Commissioner to deal with feedback and complaints relating to compliance with the Act, as well as a registered provider acting in a way that is incompatible with the Statement of Rights. If the Complaints Commissioner receives a complaint, the Complaints Commissioner must decide to take no further action **in** relation to the complaint or decide to undertake a resolution process.

Division 4 of Part 2 prescribes certain matters that must be included in an annual report mentioned under section 372 of the Act for a reporting period

Part 1A- System Governor

Section 343A-5—Identity cards for approved needs assessors—form requirements

Section 343A-5 prescribes the form and content requirements for identity cards issued to approved needs assessors under paragraph 343A(2)(a) of the Act.

These cards support the visibility, legitimacy, and operational access of assessors conducting classification assessments and reassessments in residential aged care settings. These requirements replicate previous requirements under the former aged care legislative framework.

Subsection (1) confirms that for the purposes of paragraph 343A(2)(a) of the Act, an identity card must meet the form requirements prescribed in this section. Subsection (2) prescribes the physical dimensions of the identity card, requiring it to conform to the CR80 standard (85.60 mm by 53.98 mm).

Subsection (3) sets out what must be included on the front of the card being:

- the logo (if any) of the entity the approved needs assessor is employed or otherwise engaged by (see section 7-8 of the Rules)
- the name or an abbreviation of the name of the entity
- the full name of the assessor
- the photograph of the assessor as required by paragraph 343A(2)(b) of the Act.

Subsection (4) provides that the photograph on the identity card must meet the following requirements:

- be a coloured photograph
- show the assessor's full face
- have a resolution of at least 300 dpi; and
- have an aspect ratio (being width divided by height) of 0.75; and
- have dimensions of 35 mm to 40 mm in width and 45 mm to 50 mm in height.

Subsection (5) sets out that the back of the card must include:

- the Australian Government logo and the words "Department of Health, Disability and Ageing"
- a serial number
- an address for return if found
- the prescribed words specified in subsection (6).

Subsection 6 prescribes that the back of the card must include words confirming that the bearer of the card is an approved needs assessor under the Act and may perform the functions and exercise the powers of an approved needs assessor. The wording on the back of the card must also include words to confirm that a registered provider delivering funded aged care services under the Act must, in accordance with section 177 of the Act, cooperate with the bearer of the card, including by providing access to an approved residential care home for the assessor to perform classification assessments and classification reassessments

Section 343A-10—Identity cards for approved needs assessors—requirements for carrying and producing identity cards

Section 343A-10 sets out the obligations of approved needs assessors in relation to carrying and producing identity cards while performing functions under the Act. These requirements support transparency, accountability, and cooperation between assessors and registered providers.

Subsection (1) confirms that for the purposes of subsection 343A(3) of the Act, an approved needs assessor must carry and produce their identity card in accordance with this section.

Subsection (2) provides requirements for an approved needs assessor when performing functions or exercising powers under the Act.

Paragraph (2)(a) requires that the assessor carry their identity card at all times while performing functions or exercising powers under the Act.

Paragraph (2)(b) requires that if a person who apparently represents a registered provider requests to see the assessor's identity card, the assessor must produce the card when requested, or as soon as reasonably practicable if immediate production is not feasible.

Part 2—Aged Care Quality and Safety Commission

Division 1A—Other functions of the Commissioner

Section 348-5—Other functions of the Commissioner—reconsideration of certain decisions made personally by the Complaints Commissioner

Section 348-5 confirms that for the purpose of paragraph 348(1)(d) of the Act, the Commissioner has the function to reconsider decisions made personally by the Complaints Commissioner (see section 361-60) of the Rules.

This section acknowledges that where a decision is made by the Complaints Commissioner and a review of that decision is requested, a review by the Complaints Commissioner or a delegate of the Complaints Commissioner would raise potential conflict of interest concerns. In these circumstances, it is more appropriate that the review be undertaken by the Commissioner.

Division 1—Safeguarding functions of the Commissioner

Section 349-5—Actions the Commissioner may take in dealing with reportable incidents

Section 349-5 sets out the actions the Commissioner may take in dealing with reportable incidents. Section 349-5 is made under subsection 602(1) of the Act. It is necessary and

appropriate to provide for the Commissioner to take certain actions in response to a reportable incident, as incidental to the safeguarding functions of the Commissioner in paragraph 349(h) of the Act. These provisions are specified in delegated rather than primary legislation because they primarily provide guidance on actions that the Commissioner may take in response to receiving a reportable incident, providing an additional layer of detail to the broader function to respond under paragraph 349(h) of the Act. With the exception of a straightforward duty to acknowledge and consider reports (under subparagraph 349-5(1)) the functions conferred are not mandatory, are not themselves significant elements of the regulatory scheme, and are not tied to any financial penalties or other funding concerns.

Subsection (1) confirms the Commissioner must, upon receiving a notice about a reportable incident given by a registered provider under section 165A-25 or 165A-30, acknowledge receipt of the notice and take steps to consider the notice and the appropriateness of taking action in relation to that notice.

Subsection (2) allows the Commissioner to take certain actions upon receiving a notice about a reportable incident given by a registered provider under section 165A-25 or 165A-30 of the Rules. Where such a notice is received, the Commissioner may do one or more of the following:

- refer the incident to either the Australian Federal Police, the police force or police service of a State or Territory, or a person or body with responsibilities in relation to the incident;
- require or request the provider to undertake specified remedial action in relation to the incident within a specified period, including remedial action to ensure the safety, health and well-being of individuals receiving funded aged care services affected by the incident;
- carry out an inquiry in relation to the incident in accordance with section 349-10; or
- take any other action to deal with the reportable incident that the Commissioner considers reasonable in the circumstances.

In considering what other actions are reasonable in the circumstances, the Commissioner will consider all relevant matters, including the circumstances of the registered provider, and any persons affected by the reported incident.

Subsection (3) confirms the Commissioner may take certain actions upon receiving 2 or more notices about reportable incidents given by a registered provider under section 165A-30. This section allows the Commissioner to manage 2 or more notices about such reportable incidents through a single action where the Commissioner considers such action appropriate. In these circumstances, the Commissioner may do one or more of the following:

- refer the incident to either the Australian Federal Police, the police force or police service of a State or Territory or a person or body with responsibilities in relation to the incident;
- require or request the provider to undertake specified remedial action in relation to the incident within a specified period, including remedial action to ensure the safety, health and well-being of individuals accessing funded aged care services affected by the incident;

- carry out an inquiry in relation to the incident in accordance with section 349-10; or
- take any other action to deal with the reportable incident that the Commissioner considers reasonable in the circumstances.

Subsection (3) only applies to reportable incidents reported as priority 2 incidents under section 165A-30, being on the lower end of the severity scale. The Commission will take action under subsection 349-5(3) where multiple incidents are identified as having a single root cause or are related to a single event and/or person, allowing the Commission to more effectively and efficiently access and respond to any potential or realised risk.

An example of such incidents would be a single failure in the organisation in medication administration which results in multiple aged care recipients receiving their medications 15 minutes after their scheduled medication time. A separate incident would be raised for each affected recipient, but the Commission may take a single action in relation to the underlying failure to more effectively reduce further risks.

Section 349-10—Commissioner’s inquiries in relation to reportable incidents

Section 349-10 sets out the scope of what the Commissioner may inquire into regarding reportable incidents. Section 349-10 is made under subsection 602(1) of the Act. It is necessary and appropriate to provide for the Commissioner to undertake inquiries in relation to a reportable incident, as incidental to the safeguarding functions of the Commissioner in paragraph 349(h) of the Act. These provisions are specified in delegated rather than primary legislation because they only provide guidance on actions that the Commissioner may take in response to receiving a reportable incident, providing an additional layer of detail to the broader function to respond under paragraph 349(h) of the Act. The functions conferred are not mandatory, are not themselves significant elements of the regulatory scheme, and are not tied to any financial penalties or other funding concerns.

Subsection (1) confirms the Commissioner may inquire into any of the following:

- a reportable incident for a registered provider,
- a series of reportable incidents by one or more of the registered providers, and
- the compliance of one or more registered providers with Division 1 of Part 10 of Chapter 4 (incident management) or Division 2 of Part 2 of Chapter 5 (reportable incidents).

Subsection (2) confirms the Commissioner does not need notice under section 165A-25 or 165A-30 of any reportable incidents in order to carry out an inquiry under subsection 349-10(1). This means the Commissioner may commence an investigation into a reportable incident that came to the attention of the Commissioner in a way other than under these sections.

Subsection (3) confirms the Commissioner may carry out an inquiry as the Commissioner thinks fit.

Subsection (4) confirms the Commissioner may do the following without limiting subsection (3):

- consult with other persons, organisations and governments on matters relating to the inquiry; and

- request information or documents that are relevant to the inquiry from any person; and
- provide opportunities for individuals accessing funded aged care services to participate in the inquiry.

Subsection (5) allows the Commissioner to prepare and publish a report setting out the Commissioner's findings in relation to the inquiry.

Section 349-15–Taking of other action not prevented by this Division

Section 349-15 confirms that nothing in this Division prevents the Commissioner from taking action under the Act in relation to a reportable incident for a registered provider.

Similarly, nothing prevents the Commissioner from taking action under the Act in relation to information or documents given to the Commissioner under this Division, Division 1 of Part 10 of Chapter 4 (incident management), or Division 2 of Part 2 of Chapter 5 (reportable incidents).

Section 349-15 is made under subsection 602(1) of the Act. It is clarificatory in nature.

Division 2–Establishment and functions of the Complaints Commissioner

Section 358-5–Complaints functions of the Complaints Commissioner–requirements for giving written reports to the Minister

Section 358-5 sets out the requirements for the Complaints Commissioner to provide the Minister with written reports relating to complaints and feedback, for the purposes of paragraph 358(m) of the Act. These requirements are that:

- a report must be for a period of 6 months beginning on 1 January or 1 July; and
- the report for a reporting period must contain the matters referred to in section 372-5 of the Rules and any other matters that the Complaints Commissioner considers relevant; and
- the report must be given to the Minister within 3 months after the end of the reporting period.

Division 3–Complaints Commissioner–complaints and feedback

Subdivision A—Preliminary

Section 361-5–Purpose of this Division

Section 361-5 confirms that this Division is made for the purposes of subsection 361(1) of the Act, which relates to how the Complaints Commissioner must deal with complaints.

Subdivision B– How complaints may be made and withdrawn, and how feedback may be given

Section 361-10–How complaints may be made and feedback may be given

Section 361-10 sets out how complaints and feedback may be made and given to the Complaints Commissioner.

Subsection (1) provides that a complainant may make a complaint to the Complaints Commissioner about a registered provider, aged care worker or responsible person acting in a way that is non-compliant with the Act or a registered provider acting in a way that is incompatible with the Statement of Rights.

To remove any doubt, and consistent with section 23 of the Acts Interpretation Act 1901, a complaint may be made about one or more of the listed entities. For example, a complaint may be made about a registered provider and a responsible person of that registered provider. Similarly, a complaint may be made about two or more aged care workers.

Subsection (2) confirms that a person may give the Complaints Commissioner feedback about a registered provider, or a responsible person or aged care worker of the provider.

To remove any doubt, and consistent with section 23 of the Acts Interpretation Act 1901, feedback may be given about one or more of the listed entities. For example, feedback may be given about a registered provider and a responsible person of that registered provider. Similarly, feedback may be given about two or more aged care workers.

Subsection (3) provides that a complaint and feedback may be given orally and in writing.

Subsection (4) provides that complaints and feedback may be given anonymously.

Subsection (5) outlines that where a complaint or feedback is made, and the person requests that their identity, the identity of a person identified in the complaint or feedback, or any other details included be kept confidential, the Complaints Commissioner must take reasonable steps to ensure this occurs.

The note under subsection (5) provides a reference to section 549 of the Act (recipient to take steps to preserve anonymity). This is relevant for complaints or feedback that are disclosures that qualify for protection under section 547 of the Act (whistleblower protections), where the individual making the disclosure requests that the individual, or any other individual named in the request, remain anonymous.

Section 361-15–How complaints may be withdrawn

Section 361-15 provides that where a complaint is made to the Complaints Commissioner, the complainant may withdraw the complaint, either orally or in writing, at any time.

The notes included with section 361-15 make clear that a complainant withdrawing a complaint does not mean that a complaint process will immediately cease, as the Complaints Commissioner must still deal with the complaint under section 361-40. Withdrawal of a complaint is, however, a matter which the Complaints Commissioner may consider in deciding to take no further action or to end a resolution process.

Subdivision C- Processes for dealing with complaints and feedback

Section 361-20–Requirements for processes

Section 361-20 sets out the requirements for the Complaints Commissioner's processes for dealing with complaints and feedback.

Subsection (1) clarifies that the process must involve providing appropriate support and assistance (including access to advocates and language services) to complainants and persons giving feedback, as well as individuals who may be related to the complaints or feedback.

The provision of support to complainants and persons giving feedback, especially those who may have difficulties communicating with the Commission either orally or in writing, is vital to the accessibility of the Commission's complaints and feedback processes.

Subsection (2) confirms that the Complaints Commissioner's processes must include accounting for complaints and feedback that are also disclosures that qualify for protection under section 547 of the Act (whistleblower protections).

Section 361-25–Acknowledging receipt of complaints and feedback

Section 361-25 sets out requirements for acknowledging receipt of complaints and feedback.

Per subsection (1) where a person makes a complaint or gives feedback to the Complaints Commissioner, the Complaints Commissioner must acknowledge receipt within 3 business days of receiving the complaint or feedback.

Subsection (2) clarifies that this will not apply to a complaint or feedback if:

- acknowledgment of the complaint or feedback would contravene a provision of Chapter 7 of the Act (information management);
- the complaint or feedback was made anonymously;
- the complainant or the person who gave the feedback cannot be contacted because of a request for confidentiality under subsection 361-10(5);
- the complainant or the person who gave the feedback requested not to receive an acknowledgement of receipt; or
- for a complaint – where the complaint has been withdrawn.

Section 361-30–Referral of complaints and feedback to other persons or bodies

Section 361-30 sets out the requirements for the Complaints Commissioner to refer complaints and feedback to other persons or bodies under paragraph 358(e) of the Act.

Subsection (2) provides that the Complaints Commissioner must give written notice of the referral to the complainant or person who gave the feedback unless:

- giving written notice of the referral to the complainant or person who gave the feedback would contravene a provision of Chapter 7 of the Act (information management);
- the complaint was made or the feedback was given anonymously;
- the complainant or person who gave the feedback cannot be contacted because of a request for confidentiality under subsection 361-10(5) of the Rules; or
- for a complaint – where the complaint has been withdrawn.

Subsection (3) confirms that subject to Chapter 7 of the Act (information management) and subsection 361-10(5) of the Rules, the Complaints Commissioner must give the other person or body any information or documents that relate to the complaint or feedback that are in the possession or under the control of the Complaints Commissioner.

Section 361-35–Communications with complainant, entity against which complaint made and other persons

Section 361-35 sets out how the Complaints Commissioner must communicate with those involved in the complaints process.

Subsection (1) provides that where a complainant makes a complaint to the Complaints Commissioner, the Complaints Commissioner must communicate regularly with the complainant regarding the progress of dealing with the complaint. Similarly, the Complaints Commissioner must give the complainant a proposed complaints determination (as per section 361-40) and seek their views on the proposed complaints determination.

Subsection (2) clarifies that these communication requirements do not apply where:

- communicating regularly with the complainant or giving the complainant a proposed complaint determination would contravene a provision of Chapter 7 of the Act (information management);
- the complaint was made anonymously;
- the complainant cannot be contacted because of a request for confidentiality;
- where the complaint has been withdrawn; or
- where the complainant has requested not to receive communications about the complaint.

In contacting the complainant, the Commission will take into account any requests received from the complainant regarding how often they wish to be contacted, and in what manner.

Subsection (3) makes clear that the Complaints Commissioner must provide written notice to the entity against which the complaint is made as soon as practicable after the complaint has been made. It is intended that notification under this subsection may occur after the Complaints Commissioner has carried out an initial assessment in relation to the complaint, providing that the initial assessment is completed within a reasonable period.

Subsection (4) states that subsection (3) does not apply where:

- the giving of the notice would contravene a provision of Chapter 7 of the Act (information management); or
- the Complaints Commissioner considers that the giving of the notice will, or is likely to, create a safety, health or well-being risk for the complainant, an individual accessing funded aged care services or any other person; or
- the Complaints Commissioner considers that the giving of the notice will, or is likely to, place the complainant or an individual accessing funded aged care services at risk of intimidation or harassment; or
- the Complaints Commissioner considers that the giving of the notice will or is likely to interfere with the performance of any of the Commissioner's safeguarding functions under paragraphs 349(a), (d) and (e) of the Act.

Subsection (5) provides that where the complaint was made on behalf of an individual accessing funded aged services, the Complaints Commissioner must communicate regularly with the individual, the individual's supporter (if any), and an independent aged care

advocate (if any) where it has been consented to by the individual. This communication is to be communication about progress in dealing with the complaint.

Subsection (6) confirms that subsection (5) does not apply where:

- communicating regularly with the person would contravene a provision of Chapter 7 of the Act (information management);
- the person cannot be contacted because of a request for confidentiality under subsection 361-10(5) of the Rules;
- the complaint has been withdrawn and the Complaints Commissioner has decided to take no further action in relation to the complaint, or to end a resolution process in relation to the complaint;
- the person has requested not to receive communications about the complaint; or
- it is not appropriate to communicate with the person.

The notes under subsection (6) provide examples when it would not be appropriate to communicate with a person. For instance, it would not be appropriate to communicate with a person (as per paragraph (6)(e)) where an individual lacks capacity to receive or understand the communication. Communication to all persons listed under subsection (5) may also not be appropriate where the complaint has been made on behalf of a large number of individuals, not all of whom need to receive regular communications.

Section 361-40–Complaint determinations and seeking feedback

Section 361-40 sets out the requirements for issuing complaints determinations and seeking feedback.

Subsection (1) provides that where a complaint is made to the Complaints Commissioner about the compliance with the Act by a registered provider, responsible person, or aged care worker, or a provider acting in a way that is incompatible with the Statement of Rights, the Complaints Commissioner must by the end of the period prescribed, do the following:

- deal with and resolve a complaint; and
- prepare a written statement i.e. a complaint determination.

The complaint determination must set out what action (if any) the Complaints Commissioner took to deal with and resolve the complaint, and what action (if any) should be taken by another person to deal with and resolve the complaint.

The determination must similarly include information relating to review or reconsideration of decisions made under the scheme.

The Complaints Commissioner must give the complainant a copy of the complaint determination.

Paragraph (2)(a) provides that the default period for resolution and the issuing of the complaints determination is 90 days from the day the complaint is made.

Paragraph (2)(b) provides that the period will be 120 days from the day the complaint is made, where the Complaints Commissioner is satisfied that a longer period is required, and this has been communicated to the complainant.

Paragraph (2)(c) provides that the period will be 120 days, plus one or more additional extension periods of 30 days, where the Complaints Commissioner is satisfied that a longer period is required due to exceptional circumstances, and this has been communicated to the complainant, or where the complaint has agreed to the additional period.

It is intended that the Complaints Commissioner will endeavour to resolve most complaints within 90 days, as per the timeframe provided under paragraph (2)(a). However, it is acknowledged that the complexity of some complaints, together with matters that are outside of the control of the Complaints Commissioner, may result in some complaints taking over 90 days to resolve. In these circumstances, the Complaints Commissioner should take all reasonable steps to advise the complainant at the earliest opportunity of an extension under either paragraph (2)(b) or paragraph (2)(c).

Paragraph (2)(c)(ii) allows for an extension in any circumstance where the complainant agrees to an additional period. This is in recognition that there may be some instances where the complainant wishes to delay the progression of a complaint for personal reasons, and that their complaint should not lapse or be withdrawn merely due to such a requested delay.

Per subsection (3), the Complaints Commissioner must also give a copy of the complaint determination to each person who the Complaints Commissioner has communicated with under subsection 361-35(5) and the entity against which the complaint is made.

Subsection (4) sets out that the Complaints Commissioner must seek feedback from the complainant, other persons who the Complaints Commissioner has communicated with and the entity against which the complaint was made, regarding how the complaint was dealt with and resolved.

Section 361-42–Dealing with complaints—general

Section 361-42 sets out that the Complaints Commissioner must deal with a complaint by either deciding to take no further action (see section 361-50) or deciding to undertake a resolution process in relation to the complaint.

Section 361-45–Dealing with complaints—resolution processes

Section 361-45 sets out the resolution actions the Complaints Commissioner may take in relation to the complaint.

Paragraph (2)(a) provides that the Complaints Commissioner may require the entity against which the complaint is made to attempt to resolve the complaint and report back to the Complaints Commissioner within a specified period.

Paragraph (2)(b) sets out that the Complaints Commissioner may require the entity against which the complaint is made to take other specified action in relation to the complaint within a specified period. Specified actions under this subparagraph may include, but are not limited to, the following, provided the specified action is required for the primary purpose of resolving the complaint:

- requiring a worker to stop doing something and/or to provide an assurance that it will not occur again
- requiring a provider to review or improve certain processes or systems

- requiring a provider or worker to provide an explanation/account to a complainant about what went wrong, or about the cause of a particular issue
- requiring a provider to provide training or resources to their staff on a particular matter related to the complaint.

Paragraph (2)(c) outlines that the Complaints Commissioner may investigate the circumstances giving rise to the complaint, including by collecting information or documents from the entity against which the complaint is made, or attending an approved residential care home or a home or community setting in which funded aged care services are delivered.

Per paragraph (2)(d) the Complaints Commissioner may consider information and documents.

Paragraph (2)(e) confirms that the Complaints Commissioner may discuss the complaint with the complainant, the entity against which the complaint is made, and any other relevant person.

Paragraph (2)(f) outlines that the Complaints Commissioner may facilitate a conciliation process, including by requesting the complainant, the entity against which the complaint is made, and any other relevant person to participate in the process. In a conciliation process a neutral third-party (the conciliator) is agreed to by all parties and assists the parties in resolving their dispute. Any decisions made by the conciliator are not legally binding but rather are intended to assist the parties in finding a mutually acceptable outcome.

Paragraph (2)(g) outlines that the Complaints Commissioner may conduct a restorative engagement process, including by requesting the complainant, the entity against which the complaint is made, and any other relevant person to participate in the process. A restorative engagement process involves all relevant parties coming together to discuss the complaint and to seek to find a mutually acceptable outcome. The Commission can assist in this process by providing a safe environment for all parties involved in the process.

In determining the appropriate complaints resolution process, the Complaints Commissioner will take into account the resources of the provider, insofar as considering the capacity of the provider to engage in a resolution process.

Subsection (3) confirms the Complaints Commissioner may decide to end the resolution process for a reason referred to in section 361-50.

Section 361-50—Dealing with complaints— reasons for taking no further action or ending resolution processes

Section 361-50 sets out the reasons for which the Complaints Commissioner may decide to take no further action in relation to a complaint, or to end a resolution process:

- the complaint has been resolved because the complainant and the relevant entity have agreed on an outcome, and the entity against which the complaint was made has addressed the complaint to the satisfaction of the Complaints Commissioner
- the complaint has been withdrawn
- the Complaints Commissioner refers the complaint to another person or body under paragraph 358(e) of the Act
- the circumstances giving rise to the complaint cannot be determined

- the complainant has been provided with an explanation in relation to the complaint and is satisfied with the explanation
- the complaint is frivolous, vexatious or not raised in good faith
- the complaint is, or has been, the subject of legal proceedings
- the complaint is already being dealt with, or has already been dealt with, under section 361 of the Act or a former complaints scheme
- the complaint is better dealt with, or is already being dealt with, through a different process (for example, through the Commissioner's safeguarding functions or under Chapter 6 of the Act (regulatory mechanisms))
- the circumstances giving rise to the complaint occurred more than one year before the complaint was made, and no longer exist
- the complaint is subject to a coronial inquiry
- an individual accessing funded aged care services who is identified in the complaint does not wish the complaint to be considered by the Complaints Commissioner
- having regard to all the circumstances, no further action is required, or the continuation of the resolution process is not required.

The use of the term 'good faith' in paragraph 361-50(f) refers to an honest belief by the complainant that the non-compliance with the Act or incompatibility with the Statement of Rights to which the complaint relates did occur. In the absence of such good faith, a resolution process may be ended, or no further action taken. A mere mistake of fact is not sufficient to establish a lack of good faith. There must be actual evidence that the complainant did not honestly believe the circumstances of the complaint to be true.

Section 348-5 allows for internal review by the Commissioner to reconsider a decision that was made personally by the Complaints Commissioner, this mechanism facilitates independent decision making where required. It is not anticipated that external review will be required for general complaints decisions. Applications to the ART for reconsidered complaints reviewable decisions would not be suitable for external merits review given the procedural nature of these decisions. This is because review of preliminary or procedural decisions may lead to the proper operation of the administrative decision-making process being unnecessarily frustrated or delayed. Delegates of the Complaints Commissioner have internal review processes in place which are carried out by an independent and distinct business unit established for the purposes of reviewing and reconsidering decisions.

Subdivision D—Reconsideration of decisions to take no further action or to end resolution processes

Section 361-55—Requesting reconsideration of decisions

Section 361-55 sets out how relevant entities may request reconsideration of decisions where the Complaints Commissioner decides to take no further action in relation to a complaint or to end a resolution process.

Per paragraph (1)(a) the complainant may request reconsideration unless the complaint was withdrawn before the decision was made or the reason for the original decision was that the complaint was frivolous, vexatious or not raised in good faith.

Per paragraph (1)(b) the entity against which the complaint was made can also request reconsideration.

Per subsection (2) the request may be made orally or in writing and must identify the reasons for the request. The request must also be made to the Complaints Commissioner within 42 days after the entity making the request receives the complaint determination, or a longer period as determined by the Complaints Commissioner.

Section 361-57–Pertains to withdrawing requests for reconsideration of decisions

Subsection (1) sets out that if an entity requests reconsideration of a decision, the entity may withdraw the request, either orally or in writing at any time.

Subsection (2) provides that if the entity withdraws the request before a reconsideration decision is made under section 361-60, the Complaints Commissioner must end the reconsideration of the decision.

Section 361-60–Reconsideration of decisions

Section 361-60 sets out the process for the Complaints Commissioner to reconsider decisions.

Per subsection (2), where a request is made for reconsideration of a decision the Complaints Commissioner must personally reconsider the decision or enable the decision to be reconsidered by a person:

- whom the Complaints Commissioner has delegated the Complaints Commissioner’s functions and powers under this Division;
- who was not involved in making the decision; and
- who occupies a position that is at least the same level as that occupied by the person who made the decision.

Subsection (3) provides that the Complaints Commissioner must cause the decision to be reconsidered by the Commissioner where a request is made under section 361-55 for reconsideration of a decision that was made personally by the Complaints Commissioner.

Per subsection (4), the person who reconsiders the decision is the internal decision reviewer.

Paragraph (5)(a) provides that after reconsidering the decision the internal decision reviewer can affirm the decision.

Per paragraph (5)(b), the internal decision reviewer may also set the decision aside and make a new decision in relation to the complaint (under section 361-42) or decide to undertake a new resolution process.

Per subsection (6) the decision made by the internal decision reviewer is the reconsideration decision.

Subsection (7) provides that after the internal decision reviewer makes the reconsideration decision, they must provide written notice of the reconsideration decision and the reasons to the entity that requested reconsideration.

Subsection (8) confirms the time period for the written notice to be issued.

Per paragraph (8)(a) the default time period for the written notice to be issued is 60 days from the day the reconsideration request is made.

Subparagraph (8)(b) confirms that the period may also be 60 days plus one or more additional periods, where the Complaints Commissioner is satisfied that the additional period is required and has communicated this to the entity who requested the reconsideration.

Subsection (9) provides that if the internal decision reviewer is a delegate of the Complaints Commissioner, section 588 and subsection 589(2) of the Act apply to the internal decision reviewer in the same way that those provisions would apply to the Complaints Commissioner if the Complaints Commissioner were the internal decision reviewer.

Section 361-65—Period for completing resolution process following reconsideration decision

Section 361-65 sets out the period for completing a resolution process following a reconsideration decision that sets aside the original decision.

Per paragraph (2)(a) the internal decision reviewer must complete the resolution process within 90 days from the day the reconsideration request is made, unless paragraph (2)(b) applies.

Paragraph (2)(b) provides that a 120-day period from the day the reconsideration request is made will apply if the Complaints Commissioner is satisfied that there are reasonable grounds to believe a period of more than 90 days is required and has communicated the grounds to the entity that requested the reconsideration.

Examples of when a period of more than 90 days may be required include where a complaint is particularly complex or where extensive further information is required.

Division 4—Reporting and planning

Section 372-5—Annual report—other matters relating to complaints functions of the Complaints Commissioner

Section 372-5 sets out the other matters relating to complaints functions that the annual report (see section 372 of the Act) must include:

- the total number of complaints received by the Complaints Commissioner in the reporting period about a registered provider (or a responsible person or aged care worker of a provider) being non-compliant with the Act
- the total number of complaints received by the Complaints Commissioner in the reporting period about a registered provider acting in a way that is incompatible with the Statement of Rights.

Per paragraph (b), of the above total the report must include the number of complaints that relate to the following:

- each State or Territory
- each provider registration category
- each registered provider
- each approved residential care home.

Per paragraph (c), of the above total the report must include the number of complaints:

- that have been dealt with by the Complaints Commissioner
- that are ongoing; and
- the number of complaints that have been dealt with by the Complaints Commissioner and are ongoing that relate to each State and Territory.

Per paragraph (d) the report must include a summary of the topics of complaints. Examples of topics of complaints may include, but are not limited to:

- medication administration and management
- personnel numbers/sufficiency
- personal and oral hygiene
- change of clinical status/deterioration
- falls prevention and post-fall management
- lack of consultation/communication
- fees and charges
- consistent client care and coordination
- reimbursements.

Per paragraph (e) the report must include for each topic the number of complaints that relate to the following:

- each provider registration category
- each registered provider
- each approved residential care home.

Per paragraph (f) the report must include a summary of the outcomes of complaints.

Per paragraph (g) the report must include a summary of the feedback received under subsection 361-40(4) of the Rules.

Per paragraph (h) the report must include the average time taken to deal with complaints.

Per paragraph (i) the report must include the percentage of complaints under subsection 361-40(1) where the requirement to issue a complaint determination was complied with within each of the periods mentioned in subsection 361-40(2) of the Rules.

Per paragraph (j), the report must include additional information relating to complaints where subparagraph 361-40(2)(c)(i) applied. This means the report must include a summary of the exceptional circumstances which required additional time for the Complaints Commissioner to resolve the complaint and issue a complaints determination as prescribed under 361-40.

Per paragraph (k) the report must include the number of decisions to take no further action reconsidered under Subdivision D of Division 3. Of the number of decisions to take no further action that were reconsidered, the report must include the number of decisions that were affirmed and the number that were set aside to make a new decision under section 361-42.

Similarly, per paragraph (l), the report must include the number of decisions to end resolution processes reconsidered under Subdivision D of Division 3. Of the number of decisions to end

resolution processes, the report must include the number of decisions that were affirmed and the number that were set aside to undertake a new resolution process under Division 3.

Per paragraph (m) the report must include a summary of activities undertaken by the Complaints Commissioner in performing the complaints functions mentioned in paragraphs 358(f), (g), (h), (i) and (j) of the Act. For clarity these functions relate to:

- promoting a culture for registered providers, responsible persons and aged care workers, of raising concerns, open disclosure and best practice in handling complaints and feedback, including by developing educational material and promoting the use of advocates
- promoting a culture of continuous improvement for registered providers including considering and responding to complaints and feedback
- building the capability of individuals to pursue complaints and give feedback
- building the capability of registered providers to develop a culture of learning and innovation to deliver quality funded aged care services and respond to complaints and feedback
- supporting registered providers to develop and implement effective complaints and feedback management systems.

Chapter 12 – Regulatory mechanisms

Part 1 – Introduction

Section 396-5 – Simplified outline of this Chapter

Section 396-5 provides an outline of the regulatory mechanisms under Chapter 6 of the Act. It provides that Part 2 relates to the register of banning orders under Division 3 of Part 11 of Chapter 6 of the Act and deals with information that must be included in the register, accessing and correcting information included in the register, and publication of the register. It also provides that Part 3 of the Chapter prescribes the method for working out certain amounts in certain circumstances under Division 3 of Part 13 of Chapter 6 of the Act.

Part 2 – Banning orders

The inclusion of the following provisions dealing with banning orders is necessary to support the effective operation of the banning order regime established under the *Aged Care Act 2024*. Banning orders may be made against individuals who have not been involved previously in the delivery of funded aged care services. A banning order may be made where the Commissioner reasonably believes that an individual is unsuitable to be involved in the delivery of funded aged care services. For example, a banning order may be made where the individual is the subject of a NDIS banning order.

These provisions are intended to protect older people by enabling the Aged Care Quality and Safety Commissioner to take timely and proportionate action against individuals or entities whose conduct poses a serious risk to the health, safety or wellbeing of care recipients. These provisions provide procedural detail to support the exercise of banning powers, including requirements for what information is to be included in the register of banning orders, accessing and correcting that information, and publication of information, ensuring transparency and fairness. This approach is broadly consistent with the banning order

framework under the *National Disability Insurance Scheme Act 2013*, which has been effective in preventing unsuitable individuals from participating in the provision of care and support services. Incorporating similar mechanisms into the aged care regulatory framework ensures alignment across care sectors and strengthens safeguards for vulnerable individuals receiving Commonwealth-funded services.

Section 507-5 – Information that must be included in the register of banning orders in relation to individuals

Section 507-5 provides that for the purposes of paragraph 507(1)(i) of the Act, the following information is prescribed in relation to each individual against whom a banning order has been made at any time:

- the State or Territory, suburb or locality, and postcode of the individual's last known place of residence;
- if the Commissioner considers that further information is necessary to identify the individual—further information, including personal information, that the Commissioner considers is sufficient to identify the individual.

Note 1 states that for other information that must be included in the register in relation to each entity against which a banning order has been made at any time, see subsection 507(1) of the Act.

Note 2 states that for the application of subsection 507(1) of the Act to banning orders, see Subsection 507(2) of the Act.

The example provides that for paragraph (b), if 2 individuals, each of whom is or was an aged care worker or responsible person of a registered provider, have the same name, suburb or locality, and postcode, and a banning order is made in relation to one of those individuals, the Commissioner could include information in the register to identify the individual in relation to whom the banning order is made.

Capturing information on location of the individual's last known place of residence is a current practice and is often necessary for the identification of the individual, particularly where 2 or more individuals have the same name. Publication of this information may be necessary to ensure registered providers can quickly and accurately understand if an individual is prohibited or restricted from the delivery of funded aged care services.

This information is captured on the register of banning orders but may not necessarily be published and therefore the capturing of information does not necessarily risk adverse outcomes for the banned individual. Further rules on when information may be published is included in section 507-30.

Section 507-10 – Accessing and correcting information included in the register of banning orders in relation to individuals

Section 507-10 provides for accessing and correcting information included in the register of banning orders in relation to individuals.

Subsection 507-10(1) provides that this Section is made for the purposes of subsection 507(5) of the Act.

Accessing information in the register

Subsection 507-10(2) provides that an individual against whom a banning order has been made may request that the Commissioner provide the individual with access to information (if any) that is included in the register of banning orders in relation to the individual.

The note states that the Commissioner must, in certain circumstances, give an individual access to personal information that the Commissioner holds about the individual (see Australian Privacy Principle 12 in Schedule 1 to the Privacy Act).

Seeking correction of information in the register

Subsection (3) provides that an individual against whom a banning order has been made may request that the Commissioner make a correction to information that is included in the register of banning orders in relation to the individual.

The note states that the Commissioner must, in certain circumstances, take reasonable steps to correct personal information that is wrong or misleading so that the information is accurate, up to date, complete, relevant and not misleading (see Australian Privacy Principle 13 in Schedule 1 to the Privacy Act).

Corrections on the Commissioner's initiative

Subsection (4) provides that if the Commissioner considers that information that is included in the register of banning orders in relation to an individual is inaccurate, out-of-date, incomplete, irrelevant or misleading, the Commissioner may correct the information.

The note states that the Commissioner must, in certain circumstances, take reasonable steps to correct personal information that is wrong or misleading so that the information is accurate, up to date, complete, relevant and not misleading (see Australian Privacy Principle 13 in Schedule 1 to the Privacy Act).

Section 507-15 – Accessing information included in the register of banning orders in relation to entities other than individuals

Section 507-15 provides for accessing information included in the register of banning orders in relation to entities other than individuals.

Subsection (1) provides that this Section is made for the purposes of subsection 507(5) of the Act.

Subsection (2) provides that an entity (other than an individual) against which a banning order has been made may request that the Commissioner provide the entity with access to information (if any) referred to in subsection 507(1) of the Act that is included in the register of banning orders in relation to the entity.

Subsection (3) provides that if the Commissioner receives a request, the Commissioner must provide the entity with access to the requested information.

Section 507-20 – Correcting information included in the register of banning orders in relation to entities other than individuals—corrections sought by entities

Section 507-20 provides for correcting information included in the register of banning orders in relation to entities other than individuals, pursuant to corrections sought by entities.

Subsection (1) provides that this Section is made for the purposes of subsection 507(5) of the Act.

Subsection (2) provides that an entity (other than an individual) may request that the Commissioner make a correction to information that is included in the register of banning orders in relation to the entity.

Subsection (3) provides that if the Commissioner receives a request, the Commissioner must:

- make the requested correction; or
- decide to not make the requested correction.

The note under subsection (3) states that the Commissioner is not required to make a correction or decision on the request unless any further information or documents requested by the Commissioner are provided (see section 589 of the Act).

The Commissioner will consider if the correction is to information that is wrong or misleading when making a decision.

Subsection (4) provides that the Commissioner must notify the entity of a correction or decision made under subsection (3).

Section 507-25 – Correcting information included in the register of banning orders in relation to entities other than individuals—corrections on the Commissioner’s initiative

Section 507-25 provides for correcting information included in the register of banning orders in relation to entities other than individuals, concerning corrections on the Commissioner’s initiative.

Subsection (1) provides that this Section is made for the purposes of subsection 507(5) of the Act.

Subsection (2) provides that this Section applies if:

- the Commissioner becomes aware of a matter; and
- based on the matter, the Commissioner considers that information that is included in the register of banning orders in relation to an entity (other than an individual) requires a correction.

Subsection (3) provides that the Commissioner must give a written notice to the entity:

- setting out the details of the matter and the proposed correction; and
- inviting the entity to give written comments on the matter and the proposed correction within the period specified in the notice.

Subsection (4) provides that the period specified for the purposes of paragraph (3)(b) must not end earlier than 28 days after the day on which the notice is given.

Subsection (5) provides that as soon as practicable after the earlier of:

- when the Commissioner receives comments from the entity; or
- the end of the period specified for the purposes of paragraph (3)(b);
- the Commissioner must consider any comments given by the entity and:
- make the proposed correction; or
- make a different correction; or
- decide not to make a correction.

Subsection (6) provides that the Commissioner must give the entity written notice of a correction or decision made under subsection (5).

Section 507-30 – Publication of register of banning orders

Section 507-30 provides for the publication of the register of banning orders.

Subsection (1) provides that this Section is made for the purposes of paragraph 507(6)(a) of the Act.

Subsection (2) provides that the Commissioner may publish the register of banning orders, in whole or in part, on the Commission's website.

The note under subsection (2) states that for the information that must be included in the register, see Subsection 507(1) of the Act and section ^507-5 of this instrument.

Commissioner may decide not to publish part of register or particular information

Subsection (3) provides that the Commissioner may decide not to publish a part of the register or particular information that is included in the register if the Commissioner is reasonably satisfied that it is not in the public interest to publish that part of the register or that information, taking into account all relevant matters including:

- the interests of individuals whose interests may be affected by publishing that part of the register or that information; and
- the interests of individuals who are accessing, have accessed, or may access, funded aged care services.

In making this decision, the Commissioner may need to consider competing interests. For example, if a banned individual is at risk of domestic violence and this risk is exacerbated by the publication of their location information, this may outweigh the interests of individuals accessing funded aged care services to be able to access the information and the Commissioner may withhold it from the public register. However, where the risk is solely reputational or professional in nature, this is unlikely to outweigh the interests of older people and those who support them to be able to identify if an individual is banned from delivering certain (or all) funded aged care services.

It should be noted that the State or Territory, suburb or locality, and postcode of the individual's last known place of residence is information that is currently published on the register of banning orders made under section 74GI Commission Act. Continuing the publication of this information under the new Act would be a continuation of the status quo. The publication of this information is to ensure registered providers can quickly and accurately understand if an individual is prohibited or restricted from the delivery of funded aged care services.

The publication of the register of banning orders under subsection 507-30(2) is not a reviewable decision. This is consistent with the arrangements under the previous *Aged Care Quality and Safety Commission Rules 2018*. Publishing the identities of individuals who are banned from delivering funded aged care services is a necessary element of ensuring banning orders are an effective safeguarding mechanism. It is also a critical transparency measure, allowing older people and those who support them to assure themselves that individuals involved in their care are suitable.

If an individual considers the banning order was incorrectly applied, they may apply for reconsideration of the decision to make the order under section 559 of the Act, including through to the Administrative Review Tribunal. Individuals may also apply to the Commissioner to vary or revoke a banning order under section 505 of the Act. While decisions are pending on applications to reconsider, vary or revoke a banning order, statements will appear on the register informing readers of these pending processes.

Part 3 – Recoverable amounts

Section 523-5 – Circumstances for waivers – settlements between Commonwealth and debtors – method for working out present value of unpaid amount

Section 523-5 provides that for the purposes of subsection 523(6) of the Act, the method for working out the present value of an unpaid amount mentioned in subsection 523(5) of the Act in relation to a recoverable amount is to use the following formula:

$$\frac{\text{annual repayment}}{\text{interest}} \times \left[1 - \frac{1}{(1 + \text{interest})^{\text{repayment period}}} \right]$$

where:

annual repayment is the amount of the recoverable amount that the System Governor believes would be recovered under Division 2 of Part 13 of Chapter 6 of the Act in a year if subsection 523(4) of the Act did not apply in relation to the recoverable amount.

interest has the same meaning as in subsection 1237AAB(6) of the Social Security Act.

repayment period is the number of years needed to repay the unpaid amount if repayments equal to the annual repayment were made each year.

Chapter 13 – Information Management

Part 1 – Introduction

Section 534-5 – Simplified outline of this Chapter

Section 534-5 provides a simplified outline of Chapter 13. The section explains that Chapter 13 governs matters relating to information management, such as record keeping and information sharing obligations for registered providers and other entities involved in the aged care system, including former registered providers. Chapter 13 also relates to

information the System Governor must publish and information the System Governor and the Commissioner may publish.

Part 2—Record-keeping

Section 543-5—Retention of records by former registered provider

Section 543-5 prescribes that every kind of registered provider is subject to the record retention obligation under paragraph 543(1)(a) of the Act. This means that any entity that ceases to be a registered provider must retain certain records for seven years after cessation, where retention was a condition of registration and the records relate to funded aged care services previously delivered.

Part 3 – Information sharing

Division 1 – Publication by System Governor

Subdivision A—System Governor must publish information about funded aged care services generally

Section 544-5 – Preliminary

Subsection 544-5(1) confirms that this Subdivision is made for the purposes of subsection 544(1) of the Act, which pertains to what the System Governor must publish about funded aged care services generally.

Subsection (2) confirms that the information must be published, as soon as practicably, on a portal or website maintained by the Department.

The ‘Note’ refers to subsection 544(3) of the Act, relating to not publishing certain personal information.

Section 544-10 – Pricing information

Section 544-10 provides that if a registered provider gives a report to the System Governor under the reporting provision of the Act (see section 166) in accordance with section 166-1005 of the Rules (which relates to prices of services) the System Governor must publish the information in that report.

This provision therefore enables the System Governor to publish reports relating to the prices of services. It is intended that this publishing requirement will enhance transparency and empower individuals, their families, and supporters to make informed aged care decisions.

The expanded provisions of section 544-10, in accordance with section 166-1005 of the Rules, will provide a comprehensive picture of service pricing across the in-home aged care sector, enabling better comparisons between providers and helping participants make more informed decisions about their services. By allowing provider service pricing to be uploaded to My Aged Care, it will create a centralised list of comparable prices across all providers, making it easier for users to explore options more efficiently.

Section 544-15 – Approved residential care home—income and expenditure

Section 544-15 relates to what the System Governor must publish about income and expenditure for an approved residential care home of a registered provider. This is important to enhancing oversight and transparency of financial information relating to registered providers.

Paragraph (1)(a) provides the System Governor must publish the provider's income as it relates to the residential care home in a financial year.

Paragraph (1)(b) provides the System Governor must publish expenditure by the provider on the delivery of funded aged care services including labour costs, catering, maintenance, cleaning and laundry and administration.

Per paragraph (1)(c) the System Governor must also publish the provider's profit or loss in relation to the approved residential care home in the financial year.

Subsection (2) clarifies that these requirements do not apply to services that are only delivered under the NATSIFACP or MPSP.

Section 544-20 – Approved residential care home—other information

Section 544-20 relates to what other information the System Governor must publish in relation to an approved residential care home. This increased transparency is intended to support choice by empowering individuals, their families and supporters to make more informed care decisions.

Per paragraph (1)(a), the System Governor must publish information provided in accordance with paragraph 166-810(1)(a) of the Rules. This means that the System Governor must publish information about the kind of feedback and complaints received by the registered provider in a reporting period.

Per paragraph (1)(b), the System Governor must publish information provided in accordance with paragraph 166-810(1)(b) of the Rules. This means that the System Governor must publish information about improvements made by the registered provider in a reporting period relating to quality of care.

Per paragraph (1)(c), the System Governor must publish information provided in accordance with paragraph 166-810(1)(c) of the Rules. This means that the System Governor must publish information about initiatives that the registered provider has implemented in the reporting period to support a diverse and inclusive environment for individuals and aged care workers.

Per paragraph (1)(d), the System Governor must publish information provided in accordance with paragraph 166-810(1)(d) of the Rules. This means that the System Governor must publish information about the representation of different demographic groups in the membership of the governing body of the provider (but, for any group, only if a member of the governing body who is a member of that demographic group consents to that information being published, per subsection 544-20(3)).

Per paragraph (1)(e), the System Governor must publish information relating to the total number of individuals accessing funded aged care services in the approved residential care home.

Per paragraph (1)(f) the System Governor must publish information relating to the occupancy rate of total available beds in the approved residential care home.

Per subsection (1)(g), the System Governor must publish information relating to the number of individuals who commenced accessing funded aged care services in the approved residential care home.

Per paragraph (1)(h), the System Governor must publish information relating to the number of individuals who ceased accessing funded aged care services in the approved residential care home.

Subsection (2) clarifies that these requirements do not apply to funded aged care services delivered only under the NATSIFACP or MPSP.

Subsection (3) confirms that the System Governor must not publish information in accordance with paragraph (1)(d) relating to the demographic group of a member of a governing body of a registered provider unless that member consents to the information being published.

Section 544-25 – Nursing and transition care

Section 544-25 sets out what information the System Governor must publish in relation to a registered provider in the registration category nursing and transition care. It is the policy intent that these publishing requirements assist older people to better understand the operations and financial information of registered providers.

Per paragraph (1)(a) the System Governor must publish information provided in accordance with subsection 166-810(1)(a) of the Rules. This means that the System Governor must publish information about the kind of feedback and complaints received by the registered provider in the reporting period.

Per paragraph (1)(b) the System Governor must publish information provided in accordance with paragraph 166-810(1)(b) of the Rules. This means the System Governor must publish information about improvements made by the registered provider in a reporting period relating to quality of care.

Per paragraph (1)(c) the System Governor must publish information provided in accordance with paragraph 166-810(1)(c) of the Rules. This means the System Governor must publish information about initiatives that the registered provider has implemented in the reporting period to support a diverse and inclusive environment for individuals and aged care workers.

Per paragraph (1)(d) the System Governor must publish information provided in accordance with paragraph 166-810(1)(d) of the Rules. This means the System Governor must publish information about the representation of different demographic groups in the membership of the governing body of the provider (but, for any group, only if a member of the governing body who is a member of that demographic group consents to that information being published, per subsection 544-25(2)).

Per paragraph (1)(e) the System Governor must publish information relating to the total number of individuals to whom the provider delivers funded aged care services under the TCP.

Subsection (2) confirms that the System Governor must not publish information in accordance with paragraph (1)(d) relating to the demographic group of a member of a governing body of a registered provider unless that member consents to the information being published.

Subsection (3) confirms that the above requirements do not apply to funded aged care services delivered only under the NATSIFACP or MPSP.

Subsection (4) confirms that the above requirements in paragraph (1)(c) (relating to diversity initiatives) and paragraph (1)(d) (relating to demographic groups reporting) do not apply to funded aged care services delivered only under the TCP.

Section 544-30 – Approved residential care home—direct care responsibilities

Section 544-30 sets out what the System Governor must publish in relation to an approved residential care home of a registered provider with respect to direct care responsibilities under section 176 of the Act. Section 544-30 replicates the requirements under the former aged care legislative framework.

Paragraph (1)(a) provides that the System Governor must publish information relating to the required combined staff average amount of direct care per individual per day in respect of the approved residential care home for the quarter worked out under subsection 176-20(1).

Paragraph (1)(b) provides that the System Governor must publish information relating to the required registered nurse average amount of direct care per individual per day in respect of the approved residential care home for the quarter worked out under subsection 176-20(2).

Paragraph (1)(c) provides that the System Governor must publish information relating to the average amount of direct care delivered in the approved residential care home by direct care staff members of the registered provider per mainstream counted individual per day during the quarter.

Paragraph (1)(d) provides that the System Governor must publish information relating to the average amount of direct care delivered in the approved residential care home by enrolled nurse staff members of the registered provider per mainstream counted individual per day during the quarter.

Paragraph (1)(e) provides that the System Governor must publish information relating to the average amount of direct care delivered in the approved residential care home by registered nurse staff members of the registered provider per mainstream counted individual per day during the quarter.

The ‘Note’ specifies subsection 544-30(1) relates to Subdivision A of Division 2 of Part 6 of Chapter 5 of the Rules (Delivery of direct care – mainstream providers).

Subsection (2) clarifies that these requirements do not apply to the delivery of funded aged care services delivered only under the NATSIFACP or the MPSP. This is consistent with the requirements linking to subsection 176-20(1) and (2) of the Rules, which do not apply to the delivery of funded aged care services delivered only under the NATSIFACP or the MPSP.

Subsection (3) provides that the System Governor must publish the information about direct care responsibilities in paragraph (1)(a) and (1)(b) as soon as practicable on or after the calculation day for that quarter. For the purposes of direct care responsibilities, the calculation day, for a quarter, means the 15th day of the calendar month before the calendar month in which the quarter begins (see section 5-5).

Subsections (1), (2) and (3) collectively complement rules made under section 176 of the Act that provide for average amounts of direct care that must be provided to each individual accessing funded aged care services at a residential care home. The effect of the subsections is to ensure that, in parallel, information will be published about the required and actual average amount of total and registered nurse direct care provided by direct care staff members, including enrolled nurses and registered nurses, at residential care homes.

The intended outcome is to increase transparency of information about provider requirements in relation to direct care. Public availability of this information will assist individuals and their families to be better informed about the care minutes responsibilities of registered providers, including the average amounts of direct care that are being provided across residential care homes.

Subdivision B-Information that System Governor may publish about particular funded aged cares services

Section 545-20—Additional matters that the System Governor may publish

Section 545-20 sets out additional matters that the System Governor may publish. As per the above requirements, it is the intent that the publishing of this information will increase transparency in aged care.

Per paragraph (a), the System Governor may publish information included in a report referred to in section 166-855 of the Rules i.e. reporting requirements relating to registered nurses.

Per paragraph (b) where the provider had been granted an exemption from section 175 of the Act, which relates to the 24/7 nursing requirements, for a residential care home.

The System Governor may publish:

- the steps the provider has taken to ensure that the clinical care needs of the individuals will be met whilst the exemption is in force
- confirmation that the System Governor is satisfied that those steps are reasonable

Per paragraph (c) the System Governor may publish reports relating to service staff and individuals who have received COVID-19 and Influenza vaccinations (see sections 166-10, 166-15, 166-20 or 166-25 of the Rules).

Per paragraph (d) the System Governor may publish the following information, including the below financial and prudential matters:

- an aged care financial report (see section 166-310 of the Rules)
- a response to a request for further information relating to an aged care financial report (see subsection 166-310(8) of the Rules)
- a financial support statement (see section 166-315 of the Rules)
a response to a request for further information relating to a financial support statement (see subsection 166-315(8) of the Rules)

- a care minutes performance statement (see section 166-335 of the Rules)
- an audit of a care minutes performance statement (see subsection 166-335(6) of the Rules)
- a quarterly financial report (see section 166-340 of the Rules)
- a response to a request for further information relating to a quarterly financial report (see subsection 166-340(11) of the Rules)
- a general purpose financial report (see section 166-345 of the Rules)
- a response to a request for further information relating to a general purpose financial report (see subsection 166-345(10) of the Rules)
- an audit of a general purpose financial report (see section 166-350 of the Rules)
- an annual prudential compliance statement (see section 166-360 of the Rules)
- an audit relating to an annual prudential compliance statement (see 166-385 of the Rules)
- a report relating to governing body statements (see section 166-805 of the Rules)
- a report relating to provider operations reporting (see section 166-810 of the Rules).

Under paragraph (e) the System Governor may publish information included in an annual wellness and reablement report relating to CHSP reporting (see section 166-615 of the Rules).

Per paragraph (f) the System Governor may publish the grade assigned to a provider in a final assessment report relating to an entity's conformance with the Aged Care Quality Standards (see section 110-30 of the Rules). This allows the System Governor to publish this information (including on My Aged Care and Find a Provider) for a residential care home.

Per paragraph (g) the System Governor may publish any information included in an audit relating to an entity's conformance with the Aged Care Quality Standards (see section 110-38 of the Rules). Similar to subsection (f), this allows the System Governor to publish this information (including on My Aged Care) for a provider. The reference to section 110-38 (Final audit reports) ensures the System Governor is able to publish any information included in an audit report for providers delivering residential care, nursing and transition care or personal and care support in the home or community.

Paragraph (h) provides that the System Governor may publish any information relating to a compliance notice given under section 481 or 482 of the Act including:

- the date the compliance notice was sent to the provider;
- brief details of the non-compliance or possible non-compliance;
- action that the provider must take, or refrain from taking, to address the non-compliance or possible non-compliance;
- the period within which the provider must take, or refrain from taking, the action to address the non-compliance or possible non-compliance;
- whether the System Governor or the Commissioner (as applicable) is satisfied that the provider has complied with the compliance notice;
- whether the compliance notice is varied or revoked.

It is the intent that the System Governor may publish this information on My Aged Care, as it relates to the compliance actions the Commission has taken for a provider.

Paragraph (i) provides that the System Governor may publish any information included in an annual activity report relating to MPSP reporting (see section 166-725 of the Rules).

Paragraph (j) similarly provides that the System Governor may publish any information included in an annual statement of financial compliance and income and expenditure relating to MPSP reporting (see section 166-730 of the Rules).

Subsection (k) confirms that the System Governor may publish any information included in a services demographic report relating to MPSP reporting (see section 166-735 of the Rules).

The ‘Note’ specifies section 545-20 relates to subsection 545(2) of the Act, which relates to not publishing certain personal information.

It is the intent that these provisions support and promote transparency for older people, family members and their carers to make informed decisions relating to aged care.

Division 2—Publication by Commissioner

Section 546-5 – Purpose of this Division

Section 546-5 confirms that this Division is made for the purposes of paragraph 546(1)(l) of the Act, which pertains to what the Commissioner may publish about the delivery of funded aged care services in a particular residential care home or home or community setting by a particular registered provider.

Section 546-10 – Matters included in or related to final assessment reports for approved residential care homes

Section 546-10 specifies that the Commissioner may also publish information including, or relating to, the final assessment report of a home assessment of a residential care home, including, but not limited to: the report’s findings, the information considered in reaching those findings, and the grade assigned for conformance with the Aged Care Quality Standards for the registered provider’s delivery of funded aged care services in the approved residential care home.

The publishing of this information is intended to increase the Commission’s transparency and accountability for its regulatory actions, especially for older Australians. Publication of clear audit and assessment information will increase community knowledge of provider performance and allow comparisons between providers, further empowering older Australians to make informed choices about their care. Increased publication of this information will also improve provider accountability, incentivising continuous improvement in the sector more broadly.

Section 546-15 – Matters included in or related to final audit reports

Section 546-15 specifies that the Commissioner may also publish information including, or relating to a final audit report of an entities ability to conform with the Aged Care Quality Standards, including, but not limited to:

- the name of the entity to which the final audit report relates;
- the date of completion of the final audit report;
- a summary of the outcome of the audit including the grade assigned for conformance with the Aged Care Quality Standards (as outlined in the audit methodology);
- to the extent that the audit relates to services delivered in a particular approved residential care home:
 - the name of the approved residential care home; and
 - the date of completion of the home assessment conducted in accordance with subsection 110-26(2); and

- a summary of the outcome of the home assessment, including the grade assigned (as outlined in the audit methodology) for conformance with any of the Aged Care Quality Standards assessed at the approved residential care home.

The ‘Note’ specifies that home assessment outcomes about an approved residential care home in which funded aged care services are delivered by a registered provider may be published before the completion of the final audit report (see section 546-10). This supports transparency through timely access to information about the approved residential care homes, as audits for larger registered providers can take place in the period between invitation and renewal which can be up to 18 months. Registered providers receive and respond to a preliminary assessment report before the final audit is provided (as outlined in sections 110-28 and 110-30), allowing them to address any concerns with the home assessment outcomes before they are published.

It is worth noting that, as per subsection 546(2) of the Act, information published under subsection 546(1) of the Act must not include personal information about an individual who is not a registered provider.

Chapter 14 – Miscellaneous

Part 1 – Introduction

Section 555-5 – Simplified outline of this Chapter

This Chapter provides a table of decisions made by the Commissioner, System Governor and the Pricing Authority, which can be reconsidered and reviewed administratively. Each section is separated into the respective decision makers.

Part 2 – Reconsideration and review of decisions

Part 2 prescribes the specific decisions made under the aged care legislative framework that are subject to reconsideration or review. These provisions identify the relevant decision-makers (the Commissioner, the System Governor, and the Pricing Authority), the types of decisions that may be reviewed, and the entities that can seek reconsideration or review of those decisions. This supports transparency, procedural fairness, and accountability in the administration of the aged care legislative framework.

Section 556-5 – Decisions by the Commissioner

Section 556-5 prescribes decisions made by the Commissioner that are reviewable under table item 31 in subsection 556(1) of the Act. These decisions relate to the register of banning orders, which is maintained to protect the integrity of the aged care workforce and ensure unsuitable individuals are excluded from participation.

Item 1 refers to a decision under subsection 507-20(3) of the Rules not to make a requested correction to information in the register of banning orders in relation to an entity other than individuals. The entity affected by the decision is the subject of the banning order.

Item 2 refers to a decision under subsection 507-25(5) of the Rules not to make a proposed correction, or to make a different correction, to information in the register of banning orders in relation to an entity other than individuals. The entity affected is the subject of the banning order.

Section 557-5 – Decisions by the System Governor

Section 557-5 prescribes decisions made by the System Governor that are reviewable under table item 44 in section 557 of the Act. These decisions cover the range of the System Governor's functions, including approving a person to audit information reported by providers, approving different reporting periods to the financial year, and financial determinations.

Item 1 refers to a decision under subsection 166-335(7) of the Rules to approve a person to audit a registered provider's care minutes performance statement. The entity affected is the registered provider.

Item 2 refers to a decision under subsection 166-350(2) of the Rules to approve a person to audit a registered provider's general purpose financial report. The entity affected is the registered provider.

Item 3 refers to a decision under subsection 166-355(3) of the Rules to determine a 12-month reporting period other than the financial year, for a registered provider. The entity affected is the registered provider.

Item 4 refers to a decision under subsection 166-385(2) of the Rules to approve a person to audit a registered provider's annual prudential compliance statement. The entity affected is the registered provider.

Item 5 refers to a decision under subsection 175-25(1) of the Rules to refuse to grant an exemption from the requirement under section 175(1) of the Act to relating to Registered nurses to a registered provider in relation to a residential care home. The entity affected is the registered provider.

Item 6 refers to a decision under subsection 175-50(1) of the Rules to revoke a registered provider's exemption from the requirement under section 175(1) of the Act to relating to Registered nurses to a registered provider in relation to a residential care home. The entity affected is the registered provider.

Item 7 refers to a decision under paragraph 197-10(1)(a) of the Rules to determine an individual's fortnightly total income amount, fortnightly total essential expenses or fortnightly remaining income amount, for the purpose of the home or community fee reduction supplement. The entities affected are the individual and the registered provider delivering services to them.

Item 8 refers to a decision under paragraph 197-10(1)(b) of the Rules to determine the day a home or community fee reduction supplement determination takes effect. The entities affected are the individual and the registered provider delivering services to them.

Item 9 refers to a decision under paragraph 197-10(1)(c) of the Rules to determine the period for which a home or community fee reduction supplement determination is in effect. The entities affected are the individual and the registered provider delivering services to them.

Item 10 refers to a decision under subsection 197-20(1) of the Rules to vary or revoke a home or community fee reduction supplement determination. The entities affected are the individual and the registered provider delivering services to them.

Item 11 refers to a decision under subsection 211-20(5) of the Rules on an application by a provider to determine an amount for an individual who has the classification level AT High for the classification type short-term for the service group assistive technology. The entities affected are the individual and the registered provider delivering services to them.

Item 12 refers to a decision under subsection 230-30(1) of the Rules to refuse to determine that an approved residential care home is a significantly refurbished home. The entity affected is the registered provider.

Item 13 refers to a decision under subsection 230-35(1) of the Rules to refuse to determine that an approved residential care home of a registered provider is a significantly refurbished home. The entity affected is the registered provider.

Item 14 refers to a decision under paragraph 230-35(5)(a) of the Rules that the System Governor is not satisfied the approved residential care home of a registered provider meets refurbishment requirements. The entity affected is the registered provider.

Item 15 refers to a decision under paragraph 231-17(1)(a) of the Rules to determine an individual's daily total essential expenses, daily remaining income amount, unreduced daily amount of the resident contribution and reduced daily amount of the resident contribution, relating to the residential care fee reduction supplement determinations. The entities affected are the individual and the registered provider delivering services to them.

Item 16 refers to a decision under paragraph 231-17(1)(b) of the Rules to determine the day a residential care fee reduction supplement determination takes effect. The entities affected are the individual and the registered provider delivering services to them.

Item 17 refers to a decision under paragraph 231-17(1)(c) of the Rules to determine the period for which a residential care fee reduction supplement determination is in effect. The entities affected are the individual and the registered provider delivering services to them.

Item 18 refers to a decision under subsection 231-19(1) of the Rules to vary or revoke a residential care fee reduction supplement determination. The entities affected are the individual and the registered provider delivering services to them.

Item 19 refers to a decision under subsection 246A-5(2) of the Rules to determine that a judgment or settlement is to be treated as having taken into account the future costs of delivering funded aged care services to an individual, and the part of the compensation under the judgment or settlement that is to be treated as relating to those future costs. The entity affected is the individual.

Item 20 refers to a decision under subsection 246A-5(3) of the Rules to determine the part of the compensation that is to be treated as relating to the future costs of delivering funded aged care services to an individual. The entity affected is the individual.

Item 21 refers to a decision under paragraph 263-10(3)(b) of the Rules not to approve the proposed transfer of a service delivery branch between registered providers. The entities affected are each registered provider.

Section 558-5—Decisions by the Pricing Authority

Section 558-5 prescribes decisions made by the Pricing Authority that are reviewable under table item 2 in section 558 of the Act.

Item 1 refers to a decision under subsection 290-30(4) of the Rules that the Pricing Authority is not satisfied with the information provided by a registered provider under paragraph 290-30(3)(b). The entity affected is the registered provider.

Part 3—Application fees and fees for services provided by the System Governor, Commissioner and Complaints Commissioner

Section 597-5—Fees—exemptions—fees that must accompany application or request made to System Governor, Commissioner or Complaints Commissioner

Section 597-5 prescribes circumstances for the exemption of fees for certain applications or requests.

Subsection 597-5(1) prescribes for the purposes of subparagraph 597(d)(i) of the Act, the circumstances specified in column 2 of an item are prescribed for the fee specified in column 1 of the item in the table at subsection 597-5(1).

Item 1 prescribes the application fee prescribed in section 104-5 of the Rules for an application made by an entity under section 104 of the Act to be registered as a registered provider. The circumstances for an exemption are that on the day the application is made any of the following apply:

- the entity intends to be registered as a registered provider delivering funded aged care services under the Multi-Purpose Services Program (MPSP) or Transition Care Program (TCP);
- the entity intends that at least 85% of the individuals that the entity is to deliver funded aged care services to will be located in an area classified as MM6 or MM7 under the 2023 Modified Monash Model (remote or very remote areas);
- the entity is a registered provider known as an Aboriginal Community Controlled Organisation.

Item 2 prescribes the application fee set out in section 107-5 of the Rules for an application made by a registered provider under section 107 of the Act to renew the provider's registration. The circumstances for an exemption are that on the day the Commissioner invites the registered provider under section 106 of the Act to renew the provider's registration any of the following apply:

- the entity is a registered provider delivering funded aged care services under MPSP or TCP;

- all of the individuals the entity is delivering funded aged care services to are located in an area with a 2023 MM category known as MM5, MM 6 or MM 7;
- the Commissioner considers, based on the information held by the Commissioner as at that day, that the provider is in the smallest 10% of all registered providers based on the number of individuals to whom funded aged care services are delivered by the provider.

Item 3 prescribes the application fee prescribed in section 111-5 of the Rules for an application made by an entity under section 111 of the Act to approve a residential care home in relation to the entity. The circumstances for an exemption are that on the day the application is made any of the following apply:

- the entity is, or intends to be, registered as a registered provider delivering funded aged care services under the MPSP or TCP;
- the entity is, or intends to be, registered as a registered provider and 85% of the individuals the entity is delivering, or intends to deliver, funded aged care services to, are, or will be, located in an area with a 2023 MM category known as MM 6 or MM 7;
- the entity is known as an Aboriginal Community Controlled Organisation.

Items 4 prescribes the application fee prescribed in section 124-5 of the Rules for an application made by a registered provider under section 124 of the Act to vary the provider's registration. The circumstances for an exemption are that on the day the application is made any of the following apply:

- the entity is a registered provider delivering funded aged care services under the MPSP or TCP;
- 85% of the individuals the entity is delivering, or intends to deliver, funded aged care services to, are, or will be, located in an area with a 2023 MM category known as MM 6 or MM 7;
- the registered provider is known as an Aboriginal Community Controlled Organisation.

Item 5 prescribes the application fee prescribed in section 124-10 of the Rules for an application made by a registered provider under section 124 of the Act to vary the provider's registration. The circumstances for an exemption are that on the day the application is made any of the following apply:

- the registered provider is delivering funded aged care services under the MPSP or TCP;
- 85% of the individuals the registered provider is delivering funded aged care services to are located in an area with a 2023 MM category known as MM 6 or MM 7;
- the registered provider is known as an Aboriginal Community Controlled Organisation

Cost recovery by the Commissioner aligns with the Government's overarching Cost Recovery Policy that, where appropriate, non-government recipients of specific government activities should be charged some or all of the costs of those activities. The Cost Recovery Policy also notes that if the same cost recovered activity is provided to both government and non-government stakeholders, charges should be set on the same basis for all stakeholders. The objective of regulatory charging activities (fees) is to ensure the efficiency,

productivity and responsiveness of the registration, renewal and variations processes, and the quality of applications submitted for decision. The fees and exemptions in these provisions were consulted on between March and May 2025 and are reflected in the cost recovery implementation statement (CRIS) for activities of the Commissioner under the Act. Charging models and fees levels will be reviewed annually before the new financial year begins and changes reflected in the CRIS before they can commence. Any change will also be reflected in these Rules. Further information is available at the Aged Care Quality and Safety Commission website which in 2025 could be found here: <http://www.agedcarequality.gov.au>.

As noted in Subdivision G of Division 2 of Part 2 of Chapter 3 of the Rules—Fees payable for an audit, there are exemptions and reduced fees that represent a 50% or 100% reduction in fees payable in connection with audits for registration, renewal and variation for providers who meet certain eligibility criteria. These exemptions and reduced fees aim to support providers to enter and operate in regional, rural and remote markets, and increase the number of First Nations organisations who are registered providers in the aged care sector, as well as supporting providers that are likely to face financial viability challenges to remain in the market.

The MPSP and the TCP are specialist aged care programs that are co-funded by the Australian Government and state and territory governments and delivered by state and territory governments within a closed market. Charging for activities associated with these programs would represent an intra- or inter-government charge and, as such, these programs are exempt from charging in accordance with the Government’s Charging Framework and Cost Recovery Policy. As a result, state and territory governments will not be charged fees for any registration, renewal, variation or audit charge point that solely relates to the provision of MPSP and TCP.

Section 597-10—Fees—refunds—fees that must accompany application or request made to System Governor, Commissioner or Complaints Commissioner

Subsection 597-10(1) prescribes that for the purposes of subparagraph 597(d)(ii) of the Act, the circumstances in subsections 597-10(2) and (3) are prescribed for the fees for an application in subsection 597-10(5).

Circumstances for a full refund

Subsection 597-10(2) prescribes the circumstances in which a fee specified in subsection 597-10(5) may be refunded in whole in relation to an application and an entity are that:

- either or both of the following apply:
 - the entity makes the application in a form other than the approved form; or
 - the entity fails to include information in the application that is required under the Act to be included; and
- the entity pays the applicable fee in relation to the application.

Circumstances for partial refund

Subsection 597-10(3) prescribes the circumstances in which a fee specified in subsection 597-10(5) may be refunded in part in relation to an application and an entity is that both of the following apply:

- the entity makes the application;

- the entity pays an amount which exceeds the applicable fee in relation to the application.

Subsection 597-10(4) prescribes that if subsection 597-10(3) applies in relation to an application and an entity, the amount by which the amount referred to in paragraph 597-10(3)(b) exceeds the applicable fee may be refunded.

Fees for which circumstances apply

Subsection 597-10(5) prescribes that for the purposes of subsection 597-10(2) and 597-10(3), the fees are the following:

- for an application made under section 104 of the Act—the application fee prescribed in section 104-5 of the Rules;
- for an application made under section 107 of the Act—the application fee prescribed in section 107-5 of the Rules;
- for an application made under section 111 of the Act—the application fee prescribed in section 111-5 of the Rules;
- for an application made under section 124 of the Act—the application fee prescribed in section 124-5 of the Rules;
- for an application made under section 124 of the Act—the application fee prescribed in section 124-10 of the Rules.

Statement of Compatibility with Human Rights

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

Aged Care Rules 2025

The *Aged Care Rules 2025* (the Rules), a disallowable 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 Rules

Chapter 1 – Introduction

Chapter 1 of the Rules is introductory and includes definitions and key concepts. This chapter also contains the service list which prescribes the included and excluded funded aged care services. Chapter 1 includes existing features of the aged care system such as the Aged Care Code of Conduct and the strengthened Aged Care Quality Standards. This chapter also details requirements about reportable incidents, restrictive practices, and supporters.

Chapter 2 – Entry to the Commonwealth aged care system

Chapter 2 of the Rules deals with entry into the aged care system. This includes eligibility of individuals for entry, classification and prioritisation. It also details place allocation to individuals and the allocation of places to registered providers for certain specialist aged care programs.

Chapter 3 – Provider registration

Chapter 3 of the Rules covers registration of providers and the residential care home approval process as well as variations, suspensions and revocations of registration. Chapter 3 also prescribes for the provider register and its accompanying obligations.

Chapter 4 – Conditions on provider registration

Chapter 4 of the Rules prescribes conditions on provider registration, such as conditions relating to Rights, Principles, the Aged Care Code of Conduct, the strengthened Aged Care Quality Standards and continuous improvement requirements. Chapter 4 prescribes conditions relating to financial matters, aged care workforce and worker requirements.

Chapter 4 also details information and access requirements for registered providers. It prescribes personal information and record keeping requirements, and the way information must be kept and retained and provided by registered providers. These include the requirement to keep and retain information provided to an individual, to keep records of information about various matters, including in relation to vaccinations, complaints and feedback, prudential and financial requirements, and provider governance, and requirements for the provision of information to individuals. It also deals with conditions relating to access by supporters.

Chapter 4 outlines governance requirements including membership of governing bodies and advisory body requirements. The chapter details requirements about the use, documentation and principles surrounding restrictive practices in approved residential care homes. Lastly, chapter 4 prescribes the management of incidents and complaints.

Chapter 5 – Registered provider, responsible person and aged care worker obligations

Chapter 5 of the Rules details obligations for registered providers, responsible persons and aged care workers. It prescribes obligations relating to reporting, notifications and information and a provider's obligation regarding notification of change in circumstances. Chapter 5 also prescribes obligations surrounding a change of circumstances for responsible persons, obligations relating to suitability of responsible persons and obligations relating to aged care workers, and deals with registered nurses and the delivery of direct care. Chapter 5 also covers requirements for cooperation by registered providers with the Pricing Authority.

Chapter 6 – Obligations of operators of aged care digital platforms

Chapter 6 of the Rules deals with obligations of operators of aged care digital platforms. It prescribes the notifying of the operation of digital platforms to the Commissioner and details other obligations such as managing complaints and reportable incidents, reporting requirements (including to the Commissioner), record keeping requirements and information disclosure.

Chapter 7 – Funding of aged care services—Commonwealth

contributions

Chapter 7 of the Rules deals with the funding of aged care services and in particular, details Commonwealth contributions. Chapter 7 details subsidy arrangements for aged care services for both home care and residential care subsidies.

Chapter 7 provides for subsidies for home support, assistive technology and home modifications. It also provides for instances of fee reduction supplement for home support, assistive technology and home modifications.

Chapter 7 details arrangements for unspent Commonwealth portions and home care account funds. It deals with reduction amounts, subsidy for certain specialist aged care programs and claims and payments and grants provisions.

Chapter 8 – Funding of aged care services—individual fees and contributions

Chapter 8 of the Rules deals with the funding of aged care services, regarding individual fees and contributions. Chapter 8 provides for fees and contributions payable in a home or community setting including individual contributions and unspent funds.

Chapter 8 also provides for an approved residential care home including: contributions for delivery of funded aged care services in ongoing residential care, the maximum daily amount of resident contribution, the hotelling contribution and non-clinical care contribution, the fees for reserving a bed and for ongoing and short-term care. Chapter 8 also prescribes the higher everyday living fee.

Chapter 8 prescribes other matters including refunds paid in advance, resident respite fees, extra service fees and additional service fees. Chapter 8 also deals with fees and contributions for specialist aged care programs.

Chapter 9 – Funding of aged care services—accommodation payments and accommodation contributions etc.

Chapter 9 of the Rules details funding arrangements of aged care services regarding accommodation payments and contributions. Chapter 9 details how accommodation bonds and charges are handled. It provides details regarding maximum accommodation payment amounts and publication of certain amounts by the System Governor, accommodation agreements and the charging of accommodation payments and contributions. Chapter 9 also prescribes Rules relating to the handling of refundable deposits.

Chapter 10 – Funding of aged care services—means testing

Chapter 10 of the Rules outlines funding arrangements of funded aged care and specifically details means testing arrangements for individuals accessing or seeking to access funded aged care services. Chapter 10 specifies how calculations are made to determine an individual's contributions based on their circumstances and assets.

Chapter 11 – Governance of the aged care system

Chapter 11 of the Rules deals with governance of the aged care system. Chapter 11 outlines requirements for identity cards that are issued by the System Governor for approved needs assessors. It also sets out how the Commissioner may deal with reportable incidents.

Chapter 11 establishes a scheme for dealing with complaints and feedback and prescribes requirements for the Complaints Commissioner to give written reports to the Minister in relation to complaints and feedback. Chapter 11 also provides that the Commissioner can reconsider decisions made by the Complaints Commissioner.

Chapter 12 – Regulatory mechanisms

Chapter 12 of the Rules relates to regulatory mechanisms, providing for arrangements relating to banning orders. It details requirements surrounding an individual's information required to be included on Banning Registers, information correction processes, and the publication of the Banning Order Register. Chapter 12 also provides for circumstances regarding recoverable amounts.

Chapter 13 – Information management

Chapter 13 of the Rules relates to information management and prescribes requirements for record keeping and information sharing. Chapter 13 provides record retention requirements for former registered providers. This chapter prescribes information sharing requirements for the System Governor and Commissioner where appropriate and necessary. Chapter 13 details requirements for the Commissioner to publish information regarding matters included in, or related to, final assessment reports for approved residential care homes and matters included in, or related to, final audit reports.

Chapter 14 – Miscellaneous

Chapter 14 of the Rules provides pathways for the reconsideration of reviewable decisions by the Complaints Commissioner, the System Governor and the Pricing Authority. These include a list all reviewable decisions contained within the Rules.

Chapter 14 also provides circumstances for the exemption of fees for certain applications or requests.

Human rights implications

The Rules engage the following human rights:

- the right to an adequate standard of living in article 11(1) of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) and article 28(1) of the *Convention on the Rights of Persons with Disabilities* (CRPD);
- the right to health in article 12 of the ICESCR and article 25 of the CRPD;
- the right to protection from exploitation, violence and abuse in article 16(1) of the CRPD;
- the right to social security in article 9 of the ICESCR and article 28(2) of CRPD;
- the right not to be subjected to torture, or to cruel, inhuman or degrading treatment or punishment in article 7 of the *International Covenant on Civil and Political Rights* (ICCPR) and article 15 of the CRPD;
- the right to privacy in article 17 of the ICCPR and article 22 of the CRPD;
- the right to freedom of opinion and expression in articles 19 and 20 of the ICCPR;
- the right to work and rights at work in articles 4 and 6 of the ICESCR;
- the right to security of the person and freedom from arbitrary or unlawful detention in article 9 of the ICCPR and article 14 of the CRPD;
- the right to self-determination in article 1 of the ICCPR and article 1 of the ICESCR;
- the right to equality and non-discrimination in articles 2, 16 and 26 of the ICCPR, article 2(2) of the ICESCR;
- the right to equal recognition before the law in article 12(2) of the CRPD;
- the right to access information in article 19(2) of the ICCPR and article 21 of the CRPD;
- the right the protection of a person's physical and mental integrity in article 17 of the CRPD.
- Right to enjoy and benefit from culture in article 27 of the ICCRP and in article 15 ICESCR

Right to an adequate standard of living

The right to an adequate standard of living, including adequate food, water and housing, and to the continuous improvement of living conditions is contained in article 11(1) of ICESCR. Article 28(1) of the CRPD also requires countries to take appropriate measures to ensure an adequate standard of living and social protection for persons with disabilities, including clean water services, access for older persons with disabilities to social protection programs, appropriate and affordable services, devices and other assistance and public housing programs.

The Rules promote the right to an adequate standard of living through subsidised provision of funded aged care services on the basis of need.

Division 2 Part 2 of Chapter 2 of the Rules provides the requirements for aged care needs assessment. Aged care needs assessments ensure an individual is assessed for specific types of aged care services that will meet their needs.

Individuals will be assessed against the eligibility criteria in sections 66 to 68 of the Act as well as the criteria prescribed in Division 3, Part 2, Chapter 2 of the Rules, and, if eligible, approved for services depending on their needs. Part 3 of Chapter 1 of the Rules contains the aged care service list which specifies each service that may be funded under the Act.

A number of these funded aged care services are directed at ensuring an individual has an adequate standard of living, including hoarding and squalor assistance, accommodation (including meals and bedding), assistance with cleaning and gardening, meal preparation and home modifications. Therefore, ensuring access to these funded aged care services promotes the right to an adequate standard of living.

Part 3 of Chapter 2 of the Rules sets out the requirements for classification, which follows the assessment of an individual's need for aged care services. These classification processes include the new Support at Home classification system for home support, the Assistive Technology and Home Modifications scheme and the AN-ACC system for residential care. Classification assessment considers the needs of the individual and assesses those against set criteria, which leads to the assignation of a classification level. In Part 2 of Chapter 7 of the Rules, the classification level is linked to an amount for person-centred subsidy, which is then available for the delivery of the funded aged care services approved for the individual.

The calculation method for person-centred subsidy for the home support service group is based on the needs of the individual in line with an individual's classification level (section 194-5 of the Rules for ongoing and section 194-10 of the Rules for short-term). The Rules provide for two short-term pathways that promote the right to an adequate standard of living (section 81-15 of the Rules for classification and section 194-10 of the Rules for person-centred subsidy). The end-of-life pathway will provide a higher level of funding for individuals who have been diagnosed with less than three months to live and would prefer to die in their own homes, in recognition of the increased need for services and support during this time to ensure a higher standard of living. The restorative care pathway will also provide additional funding to deliver multi-disciplinary allied health programs for up to 16 weeks to ensure a higher standard of living. As such, the new arrangements for calculation of aged care subsidy promote the rights of those individuals to an adequate standard of living.

The arrangements will also provide for subsidy to be paid in respect of registered providers who deliver assistive technology (Part 3 of Chapter 7 of the Rules) and home modifications (Part 4 of Chapter 7 of the Rules) funded aged care services to individuals, including those with a disability and with progressive conditions, to ensure they have a higher standard of living in their home.

The arrangements for calculating person-centred and provider-based subsidy for residential care based on an individual's classification will better match the amount of subsidy paid for delivery of funded aged care services to the real costs of meeting an individual's needs. For residential care services (not delivered under a specialist aged care program), the subsidy calculation methods reflect both the characteristics of the individual as per their assigned

classification level (person-centred subsidy in sections 229-5 and 229-10 of the Rules) and the characteristics of the residential care home where the care is delivered (provider-based subsidy in section 238-5 of the Rules). The Rules also outline the accommodation supplement (section 230-10 of the Rules) and the transitional accommodation supplement (section 231-60 of the Rules) which provide for higher subsidies to be paid in respect of the costs of aged care accommodation in ongoing residential care for individuals with lower means. This ensures that providers receive appropriate subsidies to provide eligible individuals with a high standard of living and care.

As such, classification and the calculation of subsidy promotes the rights of individuals accessing funded aged care services to an adequate standard of living.

Additionally, while contributions may be charged to individuals to pay for the cost of funded aged care services, Chapter 10 of the Rules outlines how means testing is to be applied to those contributions. To ensure sustainability of the system, Australians should make a means tested contribution to the cost of their care and means testing for home support, assistive technology and home modifications service groups makes this fairer. Over the next 40 years, the number of people aged over 65 is expected to more than double, and the number over 85 is set to more than triple. Means testing for home support, assistive technology and home modifications service groups ensures people make a fair contribution to the cost of their aged care, where they can afford to do so, particularly when the number of people needing aged care is growing.

Means testing for residential care will ensure that those with the means are asked to make a fair contribution to their care. As a result, the hotelling supplement will be means tested to ensure the government funding is targeted to residents in the greatest financial need and to ensure that these residents receive funded aged care services that support an adequate standard of living. The current means tested care fee will be replaced by a means tested contribution towards non-clinical care. The right to an adequate standard of living is also ensured by the fact that individuals will make contribution to non-clinical care, but not contributions to clinical care costs as clinical care costs are fully subsidised.

The UN Committee on Economic Social and Cultural Rights (UN Committee) has stated all persons should possess a degree of security of tenure which guarantees legal protection against forced eviction. The Rules prescribe ‘security of tenure’ for individuals in approved residential care homes (section 149-55 of the Rules) and ‘continuity of funded aged care services’ in a home or community setting (section 149-5 of the Rules). Security of tenure refers to the guiding principle that an approved residential care home is an individual’s place of residence and that this should be a paramount consideration in any action taken by a provider which would disrupt their living arrangements. This will ensure that in the limited circumstances where an individual may be required to leave an approved residential care home, there are requirements for the provider to find affordable, alternative suitable services which continue to meet the needs of the individual. Similarly, ‘continuity of funded aged care services’ refers to the guiding principle that where a provider elects to discontinue delivery of services to an individual, there are requirements for the provider to ensure a seamless transition to a new provider to ensure that disruption to the individual’s care does not arise.

Part 6 of Chapter 1 of the Rules provides for the Aged Care Quality Standards (Quality Standards). The Quality Standards focus on outcomes for individuals and reflect the level of care and services the community can expect from organisations that provide

Commonwealth subsidised aged care services. Standard 3 relates to care and services and includes a number of outcomes that ensure the right to an adequate standard of living is upheld by registered providers and aged care workers who deliver funded aged care services. Standard 4 relates to the environment and sets expectations around how and where funded aged care services are delivered. Standard 6 also sets out expectations for the provision of food and nutrition for individuals receiving funded aged care services.

Right to Health

The right to health is contained under article 12 of the ICESCR and article 25 of the CRPD. These articles refer to the right of individuals, including persons with disability, to the highest attainable standard of physical and mental health. The UN Committee has stated it includes the right to control one's health and body and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment, and experimentation.

The UN Committee has stated that the right to health is not a right for each individual to be healthy, but is a right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

The Rules promote the right to health by providing for a system of funded aged care services for individuals on the basis of need. All individuals will be able to seek access to funded aged care services, including services which seek to promote and protect the individual's physical and mental health, as well as their lifestyle and wellbeing. Part 3 of Chapter 1 of the Rules contains the aged care service list which specifies each service that may be funded under the Act. The provision of funded aged care services, in both approved residential care homes and a home or community setting, will ensure individuals are able to access health facilities and goods, including nursing and personal care services, essential medications, therapeutic and allied health services and leisure and interest activities.

Section 56-5 of the Rules provides for classes of people who may apply for an aged care needs assessment on behalf of an individual who is accessing or seeking to access funded aged care. This allows for individuals who may not be able to apply on their own, or are not comfortable to apply on their own, to nominate another person to apply on their behalf. Sections 64-10 and 64-15 of the Rules also allow for reassessments in certain circumstances on the basis of information provided to the system governor in which provide expedited access to services when an individual's needs change.

In addition, the arrangements for calculating subsidy (Part 2 of Chapter 7 of the Rules), in particular the classification system (Part 3 of Chapter 2 of the Rules), will take into account the real cost of meeting an individual's need in the delivery of funded aged care services to them. The process for working out an individual's classification for certain services will look at the individual's specific characteristics to determine what level of subsidy should be paid to deliver funded aged care services to meet a person's needs.

The new end-of-life classification level prescribed in the Rules at section 81-15 will provide greater assistance for older people who have been diagnosed with less than three months to live and would prefer to pass away in their own homes, in recognition of the increased need for services to support their health during this time. The restorative care pathway classification level at section 81-15 in the Rules, and the transition care classification levels prescribed in the Rules at sections 81-17, 81-27 and 81-35 will also provide additional

funding to deliver multi-disciplinary allied health programs to support individuals to achieve a higher standard of health following a decline in their condition or hospital episode. The provision of care management as a funded aged care service will also ensure a targeted response to an individual's health needs through intensive care planning and service coordination (prescribed in the Rules under section 8-25).

The Rules also promote the right to health by providing greater protections in respect of the physical and mental health of individuals, including persons with disability, in accessing funded aged care services in approved residential care homes or in a home or community setting.

Part 10 of Chapter 4 of the Rules establishes incident management and reporting requirements in relation to occurred, alleged and suspected instances of harm, abuse and neglect. It provides for more robust requirements for governance systems to ensure better reporting, management and prevention of incidents in approved residential care homes and in home and community settings. The Rules also promotes the right to health by providing the Commissioner with additional powers and functions (section 157-20 of the Rules) to proportionately respond to incidents that have caused harm, or potentially caused harm, and therefore ensure the ongoing health, safety and wellbeing of individuals accessing funded aged care services.

The Rules promote the right to health by providing greater protections to the physical and mental health of individuals accessing funded aged care services. The Aged Care Code of Conduct (Code) set out in section 14-5 of the Rules and associated conditions for registered providers, and further obligations on responsible persons and aged care workers of a registered provider, further promotes the right to health by strengthening regulation of inappropriate conduct by those engaged in delivering funded aged care services. This is particularly the case where a registered provider, responsible person or aged care worker's conduct causes an adverse impact on an individual's physical or mental health. The Rules also introduce a system of worker suitability and worker screening arrangements (Subdivision B of Part 6 of Chapter 4) to safeguard against the engagement of unsuitable people who may present a risk to the physical or mental health of individuals accessing funded aged care services.

The Rules also provide for strengthened regulation of restrictive practices (section 6-15 and 6-20 of the Rules) and specify that the practice must only be used as a last resort, in circumstances where consent is provided, and where the use will prevent harm to the individual and others. This will provide greater protections to the physical and mental health of individuals accessing funded aged care services. Restrictive practices may include, for example, circumstances where mechanical restraints, such as bed rails, are used to reduce the risk of an individual falling out of their bed overnight. The Rules also include requirements for the use of restrictive practices in Division 2 of Part 9 of Chapter 4 of the Rules. It provides for restrictive practices only being used in limited necessary circumstances as a last resort (section 162-15 of the Rules). This promotes the right to health by allowing for interventions that reduce the risk of harm to individuals and others in an approved residential care home.

The Rules also require registered providers to ensure that at least one registered nurse (RN) is on site and on duty at all times (that is, 24 hours each day, 7 days each week) at each approved residential care home operated by them. This promotes the right to health

by explicitly requiring and strengthening the obligation for quality clinical health services to be made available to individuals accessing funded aged care services at an approved residential care home at all times (prescribed in Division 1 of Part 6 of Chapter 5 of the Rules).

The Rules engage the right to health by providing for exemptions from 24/7 RN responsibility as well to balance this right with the operational realities of some registered providers. While the Rules provide for an exemption framework from the 24/7 RN responsibility, the impact on the right to health of an exemption being granted is appropriately mitigated by providing for robust criteria that limits the circumstances in which an exemption may be granted. Further, an exemption can only be granted where the System Governor is satisfied that the registered provider has taken reasonable steps to ensure the clinical care needs of individuals in the approved residential care home will be met during the period the exemption is in force. The exemption framework is therefore an appropriate and proportionate limitation. It recognises the difficulties registered providers of approved residential care homes in rural, regional and remote areas may face in accessing sufficient staff of registered nurses to consistently meet the 24/7 RN responsibility. At the same time, it ensures that the clinical care needs of individuals in an approved residential care home facility are still being met even where a registered provider is unable to meet the 24/7 RN responsibility in respect of particular approved residential care homes.

The Rules will promote the right to health through the reporting and information publication arrangements for the 24/7 RN responsibility. This will provide transparency about any exemptions from the responsibility, to empower current and prospective individuals accessing funded aged care and their families to make informed choices about their care. Providing access to this information will help individuals to choose a registered provider that is right for them, encouraging a holistic approach to care and support better health outcomes.

Right to protection from exploitation, violence and abuse

The right to protection from exploitation, violence and abuse is recognised in articles 7 and 9 of the ICCPR, and articles 16 and 17 of the CRPD. These provisions affirm that all people are entitled to live free from exploitation, abuse, neglect, and cruel, inhuman or degrading treatment, and that governments have positive obligations to put in place safeguards for vulnerable groups, including older people and people with disability.

The Rules promote this right by establishing clear obligations on registered providers to prevent, identify and respond to incidents of abuse, neglect and exploitation within aged care. Providers are required to have systems in place for safeguarding, incident management and reporting, and to ensure that workers are trained to recognise and respond appropriately to risks of harm. The Rules also strengthen the oversight role of the Commission and the Complaints Commissioner, providing avenues for complaints and regulatory action where individuals are subject to mistreatment.

The Rules also provide that individuals accessing funded aged care services have a right to have quality and safe services delivered to them consistently with the requirements imposed on providers under the Rules through the Quality Indicators (Subdivision B of Division 3 of Part 2 of Chapter 5 of the Rules). This includes strict requirements regarding the management of Reportable incidents (section 165A5 of the Rules) and the use of restrictive practices (section 162-10 of the Rules). The Rules also recognise the right

an individual has to make complaints about the delivery of their funded aged care services without fear of reprisal (Part 10 of Chapter 4 of the Rules).

The Rules provide for a framework for screening of workers and imposing banning orders for both registered providers and individuals. This further promotes this right by restricting or prohibiting unsuitable providers, aged care workers and responsible persons from working or otherwise being involved in the delivery of funded aged care services (Part 2 of Chapter 12 of the Rules).

The Rules promote this right by requiring registered providers that deliver services in a home or community setting to respond to and manage incidents, and to implement appropriate measures to facilitate appropriate incident management and response. The actions required of registered providers under the Rules includes the provision of support and assistance to ensure the safety, health and well being of persons affected by reportable incidents, which may involve instances of hostility, exploitation, violence or abuse.

The Rules identify types of reportable incidents (Division 2 of Part 2 of Chapter 5 of the Rules) including unreasonable use of force, unlawful sexual contact or inappropriate sexual conduct, neglect, psychological or emotional abuse, unexpected death, stealing or financial coercion by a staff member, inappropriate use of restrictive practices, and unexplained absence from care to be reported to the Commission. Registered providers of residential care are required to notify the Commissioner about incidents of unlawful sexual contact, or inappropriate sexual conduct, within 24 hours as per the existing priority 1 reporting requirements under the Serious Incident Response Scheme (SIRS), as set out in section 165A-25 of the Rules.

The requirements relating to incident management and reportable incidents, and the additional compliance and enforcement powers the Act conferred on the Commissioner, implement the commitment for effective legislation to ensure that such instances of exploitation, violence and abuse are identified, investigated and, where appropriate, prosecuted.

Additionally, section 162-35 of the Rules acknowledges there may be limited situations where it is appropriate to use restrictive practices to ensure the safety of the individual and others - such as staff and volunteers, or other individuals accessing funded aged care services. Where restrictive practices are used, providers must ensure they only use them as a last resort and following the trialling and documenting of alternative behaviour supports, unless the use of a restrictive practice is necessary in an emergency. If a restrictive practice is required to be continued after an emergency has passed, registered providers must comply with all legislative requirements relating to the use of restrictive practices, including obtaining informed consent for ongoing use of a restrictive practice. By permitting the use of restrictive practices in limited situations and with the appropriate safeguards, the Rules effectively balance the rights of individuals receiving funded aged care services with the rights of the aged care workers and responsible persons of registered providers to also be free from violence, exploitation and abuse in their workplace.

It is expected that registered providers will be actively engaged in an individual's behaviour support planning and that this will reduce any occurrence of emergencies. This should include consideration of any escalation points for any changed behaviours and how best to manage behaviours to prevent an emergency in the care planning for individuals.

By embedding safeguards around the use of restrictive practices, ensuring that funded aged care services are delivered in a manner that respects dignity and safety, and requiring timely reporting and response to serious incidents, the Rules actively reduce the risk of violence, exploitation and abuse in aged care settings.

Accordingly, the Rules promote the right to protection from exploitation, violence and abuse because they promote the safety and security of older people, as well as aged care workers and responsible persons, and any limits on rights (such as the regulated use of restrictive practices) are narrowly tailored, for a legitimate objective, and subject to robust oversight and review.

Right to Social Security

The right to social security, including social insurance, is contained in article 9 of the ICESCR. Article 28(2) of the CRPD also recognises the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability.

The UN Committee has stated that the right to social security is of central importance in guaranteeing human dignity for all persons when they are faced with circumstances that deprive them of their capacity to fully realise their rights under the ICESCR.

The UN Committee has stated that the right to social security, through its redistributive character, plays an important role in poverty reduction and alleviation. It has also stated that social security prevents social exclusion and promotes social inclusion.

The Rules promote and balance the right of those receiving care to social security by subsidising funded aged care services based on need. This includes ensuring higher subsidies are paid in relation to services for, and lower contributions are collected from, individuals with low means or those suffering financial hardship.

The AN-ACC funding model will link calculation of a variable amount of residential aged care subsidy to each care recipient's AN-ACC classification level. It will also link calculation of a fixed amount of subsidy to the characteristics of approved residential aged care homes. This fixed component will be the same for all residents at an approved residential care service and will be higher for services in remote locations and certain specialist services, in recognition of higher fixed operating costs.

The arrangements for calculation of person-centred subsidy align the amount of subsidy paid for provision of funded aged care services to the real costs of meeting an individual's needs. For approved residential care services, the calculation method will reflect both the individual characteristics of the eligible individual and the characteristics of the approved residential care home where the individual receives care.

The calculation method for subsidy for a home or community setting will similarly be based on an individual's classification level that is determined through an assessment of an individual's needs. As such, the arrangements for the calculation of person-centred subsidy and provider-based subsidy promote the right to social security by providing a minimum essential level of aged care-related benefits to all eligible individuals, enabling them to acquire essential health care and personal care, including nursing and allied health services, housing and accommodation, domestic assistance and home maintenance and meals and nutrition.

Right not to be subjected to torture, or to cruel, inhuman or degrading treatment or punishment

The right not to be subjected to torture or to cruel, inhuman or degrading treatment is contained in article 15 of the CRPD and article 7 of the ICCPR, which also notes that no one shall be subjected without their free consent to medical or scientific experimentation. For an act to be prohibited as torture, it must involve severe pain and suffering, it must be intentionally inflicted, and it must be inflicted for a purpose referred to in the definition in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). Conduct not meeting the threshold of torture may be regarded as cruel, inhuman or degrading treatment or punishment (ill treatment).

While ill treatment is not defined in the ICCPR or CAT, the UN treaty bodies responsible for overseeing the implementation of these treaties have provided guidance on the sort of treatment that is prohibited. An example of cruel, inhuman or degrading treatment includes acts carried out by police using excessive force, such as using restraints where they are not required.

The Rules promote this right by requiring providers to identify, manage and resolve incidents involving harm, abuse or neglect of individuals accessing funded aged care services, including individuals with a disability. The reporting, incident management and follow-up actions that are required in the Instrument are designed to improve the quality and safety of the care provided and to reduce the risk of such incidents occurring. Part 7 of Chapter 1 of the Rules specifically outlines what constitutes a reportable incident, ensuring clear expectations are set as to what is unreasonable, unlawful or abusive behaviour and therefore unacceptable.

Part 6 of Chapter 1 of the Rules provides for the Aged Care Quality Standards (Quality Standards). The Quality Standards focus on outcomes for individuals and reflect the level of care and services the community can expect from organisations that provide Commonwealth subsidised aged care services. Outcome 1.2 of the Standards require that the provider delivers funded aged care services in a way that is free from all forms of discrimination, abuse and neglect. Outcomes also set expectations for how incidents, complaints and feedback are handled by registered providers to ensure that where there are instances of unacceptable behaviour, these will be raised and responded to quickly and efficiently.

Under section 164 of the Act, a registered provider has an obligation to manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an incident management system. Regardless of whether a reportable incident is an alleged, suspected or a known occurrence, these incidents are reportable incidents for the purposes of the Rules. The Rules set out further detail regarding requirements around incident management and reportable incidents to strengthen measures to prevent infringements on the quality of care provided to individuals accessing funded aged care services. This promotes article 15 of the CRPD and article 7 of the ICCPR by ensuring that individuals, including persons with a disability, who are subjected to cruel, inhuman or degrading treatment have the incident promptly reported and impartially examined by the relevant authorities. Further, the Rules extend protections for people who report abuse or neglect in relation to reportable incidents occurring in connection with the delivery of funded aged care services by a registered provider (section 165-15). This is designed to ensure those who witness

or suspect that cruel, inhuman or degrading treatment is occurring do not face repercussions, such as civil or criminal liability, for reporting the incidents. This also promotes article 15 of the CRPD and article 7 of the ICCPR by ensuring that persons are not prevented or discouraged from reporting ill treatment and therefore allowing such treatment to continue without investigation or remedial action.

The Rules also promote this right by addressing issues with the restrictive practices consent arrangements to ensure that where the pre-conditions for the use of restrictive practices are met, in all circumstances there will be an appropriate person or body from whom the registered provider must first obtain informed consent before restrictive practices are used (section 6-15). This is because, without clear arrangements on who can consent, there is a heightened risk that restrictive practices will be used without consent from a person who is authorised to provide that consent. Section 6-20 of the Rules details clear arrangements for an appropriate person to be approached to provide consent to the use of a restrictive practice where the care recipient does not have the capacity to consent themselves. Providing clarity on who the registered provider may seek informed consent from will ensure that appropriate consideration is given to the personal rights and liberties of individuals accessing funded aged care services prior to determining whether restrictive practices should be used.

The Rules ensure the strong regulation of restrictive practices and promotes this right by taking steps to reduce the instances of inappropriate use of restrictive practices occurring in aged care.

Right to Privacy

Article 17 of the ICCPR provides that no one shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour or reputation, and that everyone has the right to the protection of the law against such interference or attacks. Article 22 of the CRPD outlines a similar right. Although the United Nations Human Rights Committee (Human Rights Committee) has not defined ‘privacy’, it should be understood as to comprise freedom from unwarranted and unreasonable intrusions into activities that society recognises as falling within the sphere of individual autonomy.

The right to privacy under article 17 can be permissibly limited to achieve a legitimate objective and where the limitations are lawful and not arbitrary. The term ‘unlawful’ in article 17 of the ICCPR means that no interference can take place except as authorised under domestic law. Additionally, the term ‘arbitrary’ in article 17(1) of the ICCPR means that any interference with privacy must be in accordance with the provisions, aims and objectives of the ICCPR and should be reasonable in the particular circumstances. The Human Rights Committee has interpreted ‘reasonableness’ to mean that any limitation must be proportionate and necessary in the circumstances.

Chapter 5 of the Rules limits the right to privacy by outlining the details of what type of information registered providers are to collect and record about various matters, including in relation to vaccinations, complaints and feedback, prudential and financial requirements, and provider governance. This limitation is necessary, reasonable and proportionate to achieve the legitimate objective of the aged care legislation to promote accountability, transparency, and enable proper scrutiny of the registered provider’s operations.

Similarly, the Rules prescribe worker screening recordkeeping requirements (see Chapter 4, Part 6, Subdivision B and Part 6, Subdivision P), including requiring providers to keep records of personal information, evidence of qualifications, as well as an aged care or NDIS clearance decision. The right to privacy under Article 17 can be permissibly limited to achieve a legitimate objective and where the limitations are lawful and not arbitrary. The objective of these recordkeeping provisions, as explained above, is to ensure the safety of funded aged care services, as well as to ensure responsible persons and aged care workers are suitable to be involved in the delivery of funded aged care services. This is a legitimate objective that falls within the permissible purposes of protecting the rights of those accessing care and protecting public health.

The Rules provide details for what information the Commissioner needs to maintain in the provider register (see section 141-10), as well as corrections of the provider register (see section 141-25) and publication of the provider register (see section 141-30). Similarly, Part 2 of Chapter 12 of the Rules prescribes the details and requirements for the Commissioner in relation to maintaining, correcting and publishing the register of banning orders. Including provision for correction of information in both registers is consistent with an individual's ability under Australian Privacy Principle 13 to request correction of their personal information, as well as making the register wholly or partly publicly available, or specified information in the register publicly available.

Chapter 1 Part 7 of the Rules limits the right to privacy by detailing the information that registered providers are required to collect about reportable incidents and restrictive practices. The Act then requires disclosure of a subset of that information about reportable incidents in notifications to the Commissioner under the Serious Incident Management Scheme (SIRS).

Additionally, the Rules at section 154-150 prescribe that providers must store this information for a period of seven years. Where incidents result in civil or criminal proceedings, this retention period ensures that evidence is preserved for a sufficient duration, given the time such proceedings typically take. This supports the right to an effective remedy under article 2(3) of the ICCPR by ensuring that evidence is available to facilitate justice and uphold the right to a fair hearing for individuals subjected to abuse or neglect.

The personal information that may be collected through the SIRS is to be used by the Commission to identify where restrictive practices are inconsistently applied. This in turn further promotes the right to health, the right not to be subjected to cruel, inhuman or degrading treatment, and the right to protection from exploitation, violence and abuse by reducing in instance of abuse and neglect of vulnerable older Australians. The Commissioner will also use the information received through notifications, complaints, reports of serious incidents, investigations and monitoring to intervene in circumstances to protect individuals from the misuse of restrictive practices.

The objective of these Rules is to ensure appropriate actions are taken to address and prevent incidents, including serious incidents, from occurring. This is a legitimate objective that falls within the permissible purposes of protecting the rights and reputations of individuals and safeguarding public health.

Further, any personal information acquired by the Commissioner for the purpose of the SIRS is protected information under the Act. Personal information acquired under or for the purposes of the SIRS by the Commissioner is subject to the protected information provisions under the Act, as well as the general protections relating to the collection, use and disclosure of personal information (including sensitive information) under the *Privacy Act 1988*. This is a legitimate objective that falls within the permissible purposes of protecting the rights and reputations of people and protecting public health.

Right to freedom of opinion and expression

Article 19 of the ICCPR provides that everyone shall have the right to hold opinions without interference and the right to freedom of expression, including the freedom to seek, receive and impart information and ideas of all kinds. This right extends to a right to seek, receive and impart information and the Human Rights Committee in its General Comment 34 has outlined that article 19(2) embraces a right of access to information held by public bodies, regardless of the form in which the information is stored, its source and the date of production.

Under article 19(3), to constitute a permissible limitation on article 19(2), this interference must be according to law and necessary (that is, reasonable, necessary and proportionate) for one of the purposes set out in article 19(3). Article 19(3) of the ICCPR provides that this right may be subject to certain restrictions by law that are necessary for the respect of the rights and reputation of others, the protection of national security, public order or public health or morals.

The Rules provide that individuals accessing, or seeking to access, funded aged care services have the right to express opinions about the funded aged care services they access and be heard. Individuals also have the right to make complaints using an accessible mechanism, without fear of reprisal, about the delivery of funded aged care services provided to them; and have those complaints dealt with fairly and promptly.

Division 2 Part 10 of Chapter 4 of the Rules both promotes and limits the right to freedom of opinion and expression by requiring providers to have both a complaints and feedback management system, as well as a system for handling whistleblower disclosures. Section 165-15 of the Rules ensures the right to freedom of expression in relation to complaints and feedback is not hindered due to threats or reprisals from others. Section 165-20 of the Rules promotes the right in article 19(2) by requiring providers to explain that the provider will not victimise or discriminate against anyone making a complaint or giving feedback to the complaints Commissioner. The Rules serve to protect an individual from being subject to persecution, retribution or personal detriment, thus promoting the right to freedom of expression.

Division 4 Part 3 of Chapter 11 of the Rules provides for how an individual can make complaints or give feedback to the Complaints Commissioner. An individual may make a complaint to the Complaints Commissioner about a registered provider, responsible person, or aged care worker's compliance with the Act, or about a registered provider acting in a way that is incompatible with the Statement of Rights (subsection 361-10(1) of the Rules). An individual may also give feedback about a registered provider, responsible person or aged care worker of the provider (subsection 361-10(2) of the Rules). This Division also sets out the relevant process and procedure for dealing with complaints and feedback and resolving

them. These provisions ensure that an individual can express opinions about the funded aged care services they receive, and sets out the appropriate mechanism for doing so. It also guarantees that the individual's complaint will be dealt with and resolved as required according to a transparent process.

Right to work and rights at work

Article 6(1) of the ICESCR protects the right to work, which includes 'the right of everyone to the opportunity to gain [their] living by work which [they] freely [choose or accept]'. The UN Committee on Economic Social and Cultural Rights has stated that the right in article 6(1) includes the right not to be unjustly deprived of work, and that this includes security against unfair dismissal.

Under article 4 of the ICESCR, limitations to the right to work are permitted in so far as they are compatible with the nature of the right and 'solely for the purpose of promoting the general welfare in a democratic society'. The UN Committee has stated that such limitations must be proportionate and the least restrictive alternative where several types of limitations are available.

Part 2 of Chapter 12 of the Rules provide procedural detail to support the exercise of banning powers, including requirements for what information is to be included in the register of banning orders, accessing and correcting that information, and publication of information, ensuring transparency and fairness. These support the effective operation of the banning order regime established under the Act. Together these provisions place reasonable limits on the right to work by providing that the Commissioner may make a banning order prohibiting or restricting a former, prospective or current aged care worker, or responsible person, of a registered provider, from being involved in delivering all or specified types of funded aged care services or engaging in specified activities of the provider. These powers are reasonable and proportionate to ensure the health, safety and wellbeing of those accessing funded aged care services.

It is intended that the power to make a banning order will only be exercised in the most serious circumstances. Part 2 of Chapter 12 of the Rules also contains important safeguards for the rights of an individual who is subject to a banning order by ensuring the individual is able to request access to the banning order or vary their information.

Division 1 of Part 6 of Chapter 4 of the Rules also provides further detail, for the purposes of section 152 of the Act, regarding requirements for aged care workers employed by registered providers providing funded aged care services. These requirements include restrictions on when a registered provider is able to employ an aged care worker, and what those aged care workers must do. These provisions are reasonable, necessary and proportionate limitations on the right to work are in place which aim to protect vulnerable individuals accessing funded aged care services from misconduct and abuse.

Right to security of the person and freedom from arbitrary detention

Article 9 of the ICCPR and article 14 of the CRPD provide for the right to personal liberty, which requires that an individual not be subjected to arrest and detention, except as provided for by law, and provided that the law itself and the manner of its execution are not arbitrary.

The Rules support the right to liberty through providing for adequate safeguards to be put in place to ensure that the use of restrictive practices which may, in some circumstances, amount to detention, are not exercised in an arbitrary manner.

Section 17-5 of the Rules supplements the definition of restrictive practices in the Act by detailing the kinds of practices or interventions that are restrictive practices. Part 9 or Chapter 4 then sets out extensive requirements relating to the use of those practices or interventions. Notably, restrictive practices must only be used as a last resort to protect the individual and others from harm, the practices or interventions must be proportionate to the risk of harm and must be used in the least restrictive form and for the shortest time possible.

The Rules further require that a restrictive practice must only be used if informed consent to the use of the restrictive practice had been obtained from the individual or a third party where the individual lacks capacity to consent themselves (referred to as restrictive practices substitute decision-maker). Section 6-20 of the Rules sets out an exhaustive list of persons who may be appointed or nominated as restrictive substitute decision-makers, which provides further safeguards from unauthorised use of restrictive practices where an individual lacks capacity to provide consent.

The requirement to obtain consent, coupled with clearly defined parameters as to when and how restrictive practices may be used, will prevent the arbitrary use of those practices and ensure individuals are not unnecessarily deprived of their security and freedom. The Rules appropriately balance the right to freedom from arbitrary detention with the individual's safety and wellbeing and the right of aged care workers to a safe workplace.

Right to self-determination

Article 1(1) of the ICCPR recognises the right to self-determination and provides that all peoples have the right of self-determination. By virtue of that right, individuals should be able to freely determine their political status and freely pursue their economic, social and cultural development. Article 1(1) of the ICESCR also outlines this right. The UN Committee on the Elimination of Racial Discrimination has stated that the right to self-determination involves 'the rights of all peoples to pursue freely their economic, social and cultural development without outside interference'

The Rules promote the right to self-determination by requiring funded aged care services to be person-centred, respectful of individual choice, and responsive to the needs and preferences of diverse groups, including people from culturally and linguistically diverse backgrounds, people with disability, people of faith, and LGBTIQ+ people. Individuals are supported to express their wishes, to participate in decision-making about their care, and to have their identity and preferences respected. The Rules also strengthen accountability and transparency, giving people access to information for complaint mechanisms so that they can exercise greater control over the services they receive.

To the extent that the Rules may place limits on self-determination, such as where regulatory requirements constrain the range of available service models or mandate minimum safety and quality standards, those limits are directed to the legitimate objective of protecting health, safety and wellbeing. The Rules strike a balance between individual autonomy and collective safeguards by ensuring that any limits are proportionate, evidence-based and accompanied by oversight.

The right to self-determination is supported by the explicit inclusion of services in the service type *social support and community engagement* in the service list, which is set out in Chapter 1 of the Rules, and which encourages and promotes the free pursuit of social and cultural development without interference. The right is also promoted by the service list which specifically provides for access to Aboriginal and Torres Strait Islander health care workers, promoting the engagement of Aboriginal and Torres Strait Islander individuals with workers specialising in their cultural heritage and experience.

Part 6 of Chapter 1 of the Rules provides for Quality Standards. The Quality Standards focus on outcomes for individuals and reflect the level of care and services the community can expect from organisations that provide funded aged care services. Outcome 1.3 of the Quality Standards provides that registered providers must support individuals to exercise choice and make decisions about their care, providing them with support to do these things if they want or need it. It also recognises that a key part of self-determination is that individuals must be supported to exercise dignity of risk to achieve their goals and maintain independence and quality of life. Outcome 2.1 requires that the registered provider must engage in meaningful and active partnerships with individuals to inform organisational priorities and continuous improvement.

The right to self-determination has particular importance for Aboriginal and Torres Strait Islander peoples, and is recognised in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). This right includes the ability of First Nations peoples to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while also participating fully in their communities. The Rules support this right by embedding cultural safety in aged care, promoting governance and service models designed and delivered by Aboriginal and Torres Strait Islander organisations, and recognising the importance of connection to Country, and community in decision-making about aged care services. For example, Outcome 3.2 of the Quality Standards requires that funded aged care services are delivered in a way that is culturally safe and culturally appropriate for individuals with specific needs and diverse backgrounds.

These measures promote the right to self-determination for Aboriginal and Torres Strait Islander peoples, acknowledging that such people must be able to exercise meaningful control over their affairs and preserve their group identity and culture. Under the Rules, specialist Aboriginal or Torres Strait Islander programs are explicitly defined as programs to deliver funded aged care services that are culturally safe for, and tailored to meet the needs of, the Aboriginal or Torres Strait Islander persons to whom funded aged care services are being delivered in the approved residential care home. This definition promotes the right to self-determination through giving agency to Aboriginal and Torres Strait Islander people.

Accordingly, the Rules are compatible with the right to self-determination because they promote dignity, choice and participation for people receiving funded aged care services, and any limits on the right are reasonable, necessary and proportionate.

Right to equality and non-discrimination

The rights to equality and non-discrimination are contained in articles 2 and 26 of the ICCPR and article 2(2) of the ICESCR. The rights to equality and non-discrimination provide that all persons are equal before the law and entitled, without any discrimination, to the equal protection of the law. Non-discrimination is an integral part of the principle of equality.

It ensures that no one is denied their rights because of factors such as race, colour, sex, language, religion, political or other opinion, national or social origin, property or birth.

The Human Rights Committee has recognised that 'not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the Covenant'.

The Rules promote the right to equality and non-discrimination by providing that the aged care system must be accessible and responsive to the diverse needs of individuals accessing, or seeking to access funded aged care services. In particular, the Rules include the following:

- The Quality Standards which set clear expectations of the quality of services all individuals receiving funded aged care services should receive (Part 6 of Chapter 1)
- Means testing-based contributions to ensure that those who have lower means pay less for their aged care (Part 2 of Chapter 10)
- Specific funding for registered providers in regional and remote areas to ensure services are available to those in these geographical locations (Chapter 7)
- Whistleblower protections, including protections against victimisation (section 165-40)
- The roles of the System Governor, Commissioner and Complaints Commissioner, including their education, training and complaints functions (Chapter 11).

These provisions empower individuals accessing funded aged care services, and offer a range of supports to ensure that all persons can equally participate in the aged care system, and therefore exercise the rights engaged and promoted by this instrument. This includes individuals from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander persons, individuals with a disability, and persons of any gender, sex or religion.

Further, the Rules ensure that the provisions that relate to complaints management by both registered providers (Chapter 4) and the Complaints Commissioner (Chapter 11) prohibit the victimisation of an individual as a result of their complaint or feedback. These protections encourage older people, their families and workers to make complaints so that incidents of discrimination are reported on and remedied. This also ensures that the remedies provided for unlawful discrimination under this instrument are not undermined.

Division 2 of Part 10 of Chapter 4 provides for the implementation and maintenance of a complaints and feedback management system, managing complaints and feedback and implementing and maintaining a whistleblower system and maintaining a whistleblower policy. It also provides for managing disclosures that qualify for protection under section 547 of the Act (whistleblower protections). This provision provides that it is an offence for a person to cause, or threaten to cause, detriment to another person in relation to a complaint under this instrument. The provision enhances compliance with the right to remedy under article 2(3)(a) of the ICCPR by addressing barriers to seeking a remedy and providing a disincentive for undermining the remedy process. The creation of the offence is proportionate to the objective of upholding the remedy process. The above requirements serve to support the right to equality and non-discrimination.

Section 165-35 of the Rules requires registered providers to take reasonable steps to ensure that the person who made a complaint or gave the feedback, or on whose behalf the complaint was made or the feedback was given, is not adversely affected as a result, and that no older person who is affected by an issue raised in the complaint or feedback suffers any detriment, victimisation or reprisal as a result.

Right to equal recognition before the law

Article 12 of the CRPD reaffirms that persons with disability have the right to recognition everywhere as persons before the law and shall enjoy legal capacity on an equal basis with others, with appropriate measures being taken to provide access and support in exercising their legal capacity, including appropriate safeguards. The article also provides that persons with disability should be ensured equal rights to, among other things, control their financial affairs and not be arbitrarily deprived of their property. Similarly, article 16 of the ICCPR states that everyone shall have the right to recognition everywhere as a person before the law, and article 26 of the ICCPR states that all persons are equal before the law and are entitled, without any discrimination on any grounds, to the equal protection of the law, including protection from discrimination. The UN Committee on the Rights of Persons with Disabilities has confirmed that there can be no derogation from article 12, which describes the content of the general right to equality before the law under the ICCPR.

The Rules affirm these rights by avoiding language or framing which would unnecessarily limit or restrict people with disability, their families or carers under the Rules. The rights articulated in article 12 of the CRPD are directly supported through the operation of the Rules by facilitating funding for funded aged care services, including provisions which facilitate advocacy supports which may assist individuals who are accessing funded aged care services to understand and advocate for their rights (see section 156-5 regarding access to individuals).

Standard 1 on the Quality Standards reflects requires providers to demonstrate they understand and value individuals, including their identity, culture, ability, diversity, beliefs and life experiences. This reflects that the Commonwealth aged care system will be accessible, and offer culturally safe, culturally appropriate, trauma-aware and healing-informed funded aged care services, if required by an individual and based on the needs of the individual, regardless of the individual's location, background and life experiences.

In relation to restrictive practices, where the individual cannot provide informed consent, the Rules provide for a substitute decision-maker to be appointed in accordance with any applicable state or territory laws, and in the absence of such laws in accordance with the Commonwealth hierarchy. Requiring consent for these practices, from either the individual or a substitute decision-maker (who is not a health practitioner or engaged by the provider) is a critical transparency check on the potential for their inappropriate use (section 6-20).

The exercise of legal capacity is promoted in the Rules by the fundamental premise that an individual receiving or seeking to access aged care is presumed to have legal capacity. This includes a right for a person to exercise their legal capacity by recognising the role of both formal and informal support networks to support a person to exercise that legal capacity as the person interacts with the aged care system, including the restrictive practices substitute decision-maker framework. It is recognised that an individual's capacity to make

decisions can be fluid. However, in a care setting health practitioners will have knowledge about the individual's health conditions and be able to make a professional assessment about an individual's capacity to make an informed decision about the use of restrictive practices.

The Rules also promote these rights by providing that persons with disability, who are accessing funded aged care services, have access to remedy, and can make a complaint to the Complaints Commissioner if they feel that their rights under the Rules have not been upheld. This is specifically provided for in the functions of the Complaints Commissioner (Division 3, Part 2, Chapter 11). Individuals who raise matters relating to their rights and the care they are receiving are also protected under whistleblower arrangements and anti-victimisation provisions to ensure that no adverse action occurs as a result of raising concerns. There are multiple avenues for individuals to raise whistleblower complaints and they may do so anonymously. Section 361-20 of the Rules requires that the Complaints Commissioner's processes for dealing with complaints and feedback includes providing appropriate support and assistance (including access to advocates and language services). This ensures that older people, their families and aged care workers are encouraged and supported to raise concerns with the Commission and be recognised equally before the law.

Consistent with the right to equal recognition, the Rules also provide rights and processes for review of decisions (Part 2, Chapter 14 of the Rules). Reviewable decisions under the legislation promote a framework for individuals accessing funded aged care services, providers and entities to challenge administrative decisions and determinations under the Rules. Section 556-5 of the Rules lists decisions made by the Commissioner, section 557-5 of the Rules lists decisions made by the System Governor, and section 558-5 lists decisions made by the Pricing Authority that are subject to reconsideration and review. Each group of decisions function to facilitate equal recognition between individuals, providers and entities as 'affected entities'. This promotes article 12 of the CRPD as the provisions ensure appropriate safeguards are in place for administrative challenges. This aims to eliminate the potential for administrative decisions to be made arbitrarily or unequally according to Australian administrative law. Articles 16 and 26 of the ICCPR are promoted as each person is treated equally and benefit equally according to the administrative protections.

The respective articles in both the CRPD and ICCPR are similarly promoted through Part 3 of Chapter 11 and Part 2 of Chapter 14 of the Rules which provide a framework for the reconsideration of reviewable decisions. This framework ensures entities, including individuals accessing funded aged care services who are affected by a reviewable decision, have equal protections within the Rules. The Rules provide that written notice of an individual's review rights must be given when a reviewable decision is made, as well as details of how to request a review.

Right to access information

The right to access information is contained in article 19(2) of the ICCPR, which provides that everyone has the right to freedom of expression and that right includes the freedom to seek and receive information of all kinds, either orally or in writing. Article 21 of the CRPD provides a similar right for persons with disabilities, in that appropriate measures should be taken to ensure people with disabilities can exercise their right to freedom of expression and opinion, including being provided with information in accessible formats, in a timely manner, without additional cost.

The Rules promote the right to access information as Part 6 of Chapter 1 of the Rules provides for the Quality Standards. The Quality Standards focus on outcomes for individuals and reflect the level of care and services the community can expect from organisations that provide Commonwealth subsidised aged care services. Standard 2 includes that registered providers must ensure that information recorded about an individual is able to be accessed and understood by the individual, supporters of the individual, aged care workers, registered health practitioners, allied health professionals, allied health assistants and others involved in the individual's care. This is strengthened by the link between the Quality Standards in the Rules and section 155 of the Act (provision of information to individuals) which sets out conditions applicable to registered providers to allow access to records and information to individuals and explain those records and information to those individuals.

Part 3 of Chapter 13 of the Rules also promotes the right to access information by prescribing details about the System Governor's requirement to publish information about funded aged care services and the registered providers delivering those services. This includes information about the quality of funded aged care services, pricing information, the income and expenditure of approved residential care homes of registered providers, and about direct care responsibilities, in a way that is easily accessible to the public. This information will be made publicly available, which will provide individuals accessing funded aged care services, who may have impediments to their full and effective participation in society, and their families with clear, timely and meaningful information about funded aged care services and registered providers.

Information published by the System Governor in relation to registered providers provides individuals, who may have impediments to their full and effective participation in society and their families with clear, timely and meaningful information about registered providers and their services. This information about registered providers published publicly will assist current and prospective individuals seeking to access funded aged care to make better and more informed decisions about aged care. It is intended that this information will be made available in one location and at no cost to care recipients or their families who may wish to access the information.

Chapter 4 of the Rules provides further detail in relation to conditions that apply to a registered provider's registration, and includes requirements around sharing information with individuals. For example, Division 2 of Part 7 provides for kinds of information that must be provided to individuals, and includes that the information must not just be provided, but explained to the individual. Subdivision D of Division 3 of Part 4 also sets out requirements for when a registered provider and an individual must enter into a care and services plan, and how this plan must be developed with the individual. This promotes this right by ensuring that providers work closely with individuals to establish the care and services they need.

Right to the protection of a person's physical and mental integrity

Article 17 of the CRPD provides that every person with disabilities has a right to respect for their physical and mental integrity on an equal basis with others. The objects and guiding principles of this instrument recognise the rights of people with disabilities to full and effective participation and inclusion in society. The Rules achieve this by providing authority to fund supports and services designed to support individuals' social and economic participation, ability to exercise choice and control in all matters that affect their lives, access

to meaningful employment, education and development and participation in society on an equal basis to other members of Australian society.

The Rules promote this right by establishing obligations on approved providers to deliver safe and high-quality funded aged care that supports the physical, mental and emotional wellbeing of individuals. The Rules require registered providers to respect the dignity, privacy and choices of individuals, and to ensure that services are delivered in a way that upholds their autonomy. The Rules also regulate the use of restrictive practices, permitting them only as a measure of last resort, under clearly defined conditions, and subject to appropriate safeguards and oversight. These requirements are directed to preventing harm and ensuring that the integrity of individuals is protected.

To the extent that the Rules may limit the right to physical and mental integrity – for example, by allowing restrictive practices in exceptional circumstances – such limitations are reasonable, necessary and proportionate to the legitimate objective of protecting the health and safety of individuals. The Rules require registered providers to consider alternative strategies before using restrictive practices, to obtain consent or appropriate authorisation where possible, and to ensure that any use is documented, monitored, and regularly reviewed. These safeguards minimise the impact on rights and ensure accountability.

The Quality Standards, which are set out in Part 6 of Chapter 1 of the Rules, also promotes this right. The Quality Standards focus on outcomes for individuals and reflect the level of care and services the community can expect from organisations that provide Commonwealth subsidised aged care services. Standard 1 relates to the individual, and emphasises the importance of person-centred care, and requires providers to demonstrate the provider understands and values individuals, including their identity, culture, ability, diversity, beliefs and life experiences.

Accordingly, the Rules are compatible with the right to protection of physical and mental integrity because they promote the right and, to the extent that they limit it, those limitations are for legitimate objective and are accompanied by appropriate safeguards.

Right to enjoy and benefit from culture

Article 27 of the ICCPR protects the rights of individuals belonging to ethnic, religious and linguistic minorities within a country to enjoy their own culture, practise their own religion and use their own language. These rights are particular to members of such minorities, who also enjoy the other rights guaranteed in the human rights treaties. Article 15 of ICESCR protects the right of all persons to take part in cultural life and to enjoy the benefits of scientific progress and its applications.

The Rules support the right to enjoy and benefit from culture by providing a definition of diverse cultural activities (section 5-5 of the Rules). The Quality Standards (Part 6 of Chapter 1 of the Rules) also embeds the requirement for registered providers to show an understanding of a person's identity, culture and beliefs. The Quality Standards also require registered providers to ensure that funded aged care services are delivered in a way that is culturally safe and culturally appropriate for individuals with specific needs and diverse backgrounds. This promotes the right to benefit and enjoy culture by ensuring that the needs of diverse individuals are catered for.

The Rules support this right through providing funding for individuals to engage in their religious, cultural or social activities under the service list provided under Chapter 1 of the Rules. The Rules also support cultural and religious engagement through providing and arranging access and transport to any religious, social and cultural activities specified in the individual's care and services plan (section 8-80 of Division 2 of Part 3 of Chapter 1 of the Rules) and through assistance in attending cultural and community events. Section 8-90 of Division 2 of Part 3 of Chapter 1 of the Rules, allows for access to transport mechanisms to connect the individual with their usual activities, including cultural and religious activities.

The Rules also provide for access to translation services for individual and meal requirements designed to support cultural and religious needs and preferences. Translational services for individuals ensure individuals understand information provided to them about the aged care system. All accessible forms are able to be translated to the relevant language. Meal requirements under section 148-20 of the Rules relates to nutritional requirements and prescribes that nutrition provided through funded aged care services must be religiously and culturally appropriate for an individual.

This right is also supported by the Rules providing for the funding of and delivery of aged care services through specialist aged care programs, which promote and support culturally safe care that is tailored to Aboriginal and Torres Strait Islander peoples (section 5-5 of the Rules). Specialist residential care homes give choice and control to Aboriginal and Torres Strait Islander communities and provide for the celebration of culture and religion in a manner in which they deem fit for their own community.

The Rules allow for days of leave for an individual from approved residential care homes which allow for an individual receiving funded aged care services to participate in cultural, religious and social activities without being penalised for absence.

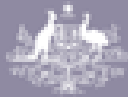
The right to benefit from and enjoy culture may be limited in some circumstances such as a national emergency wherein individuals may be limited in public gathers and general activities. This is rational and proportionate when there are public safety concerns and limiting freedom of movement for an individual means the overall safety of the general population and the protection of other rights such as the right to health.

Conclusion

The Rules are compatible with human rights as they promote a number of human rights, particularly the rights of individuals accessing funded aged care services to social security, an adequate standard of living and the highest attainable standard of health. The Rules strengthen the protections for individuals by implementing measures to ensure greater protections from exploitation, violence, abuse and cruel, inhuman or degrading treatment. While the Rules limit certain human rights, such as the right to privacy, these rights are limited in pursuit of the permissible legitimate objectives of the Rules, and in a way that is reasonable, necessary and proportionate in the particular circumstances to achieving those objectives.

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.

Contents

Executive summary	45
Contents	47
Background	48
1. Policy problem	51
2. Need for Government action	63
3. Policy options considered	70
4. Net benefit of each option	78
5. Consultation	83
6. Preferred option and implementation	88
7. Evaluation	95
Appendix A – Measuring the change in care minutes	99
Appendix B – Measuring the change in subsidy payments	102
Appendix C – Assurance costs	105
Appendix D – Glossary of terms	108
Appendix E – Abbreviations	112

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 2014¹ made through the Aged Care Legislation Amendment (Care Minutes Responsibilities) Principles 2023².

Under the care minutes responsibility, registered residential aged care providers (providers)³ 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-ACC⁴ 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.

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

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

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

⁴ 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 program⁵ 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 included⁶. The department also provides support for providers to comply with their care minute responsibility⁷.

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 bulletin⁸. The department provides data on care minutes compliance to the ACQSC quarterly to support its regulatory work.

Care minutes transparency

Star Ratings⁹ 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

⁵ DoHDA, 23 June 2025, Accessed 4 July 2025.

⁶ 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.

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

⁸ 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.

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

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.

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 Care¹⁰ website through the Find a Provider¹¹ 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 report¹² 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 website¹³ since the commencement of the care minutes responsibility and provider level care minutes metrics have also been published on the department's website¹⁴ 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 website¹⁵ 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.

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

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

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

¹³ 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.

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

¹⁵ 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)¹⁶ 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 important¹⁷. This finding is also supported by academic evidence which concludes that higher RN staffing results in better quality of care¹⁸. 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 performance against their care minutes targets was measured and published as part of the Staffing Rating for Star Ratings.

¹⁶ 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.

¹⁷ 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.

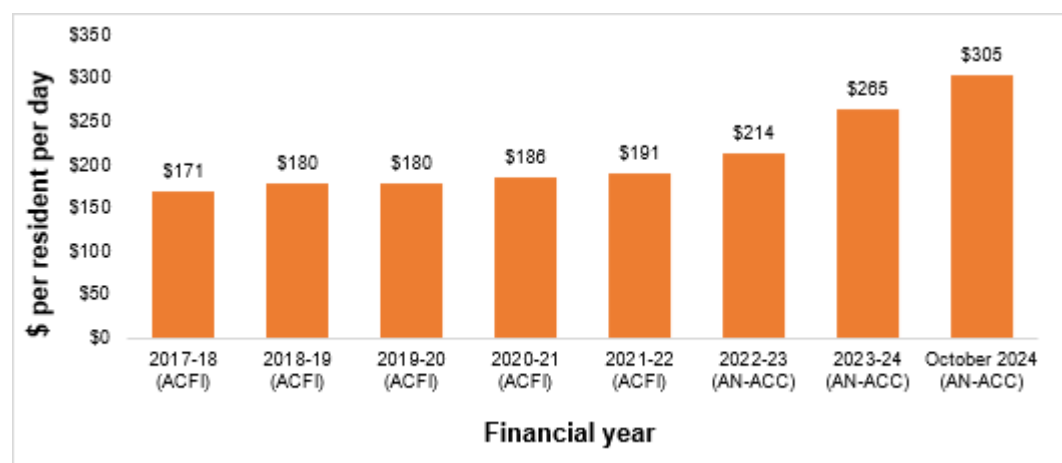
¹⁸ Dellefield, ME, Castle, NG, McGilton, KS, et al, 2015, The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review (2008-2014), *Nursing Economics*, 2015, 33 (2), p. 116, 95-108.

- 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.
- 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 minutes¹⁹.

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

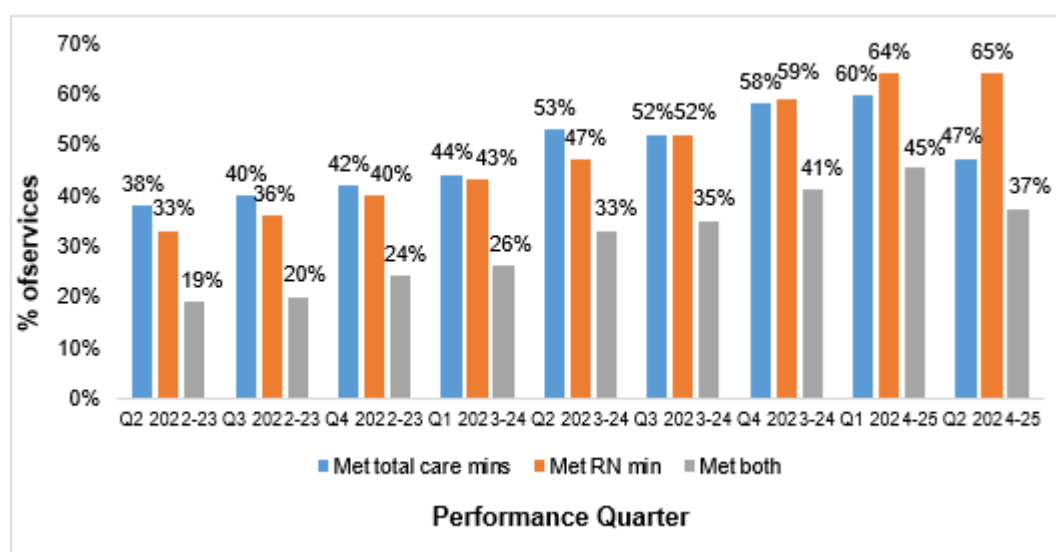
¹⁹ Aged care providers report direct care hours delivered by RNs, ENs and PCWs/AINs together with occupied bed days in the Quarterly Financial Report (QFR). This data is checked for reasonableness by the department upon submission, and is either accepted, or the provider is contacted and asked to check 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).

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 Study²⁰ 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 compliance in these regional and remote areas. For example, to make these areas more

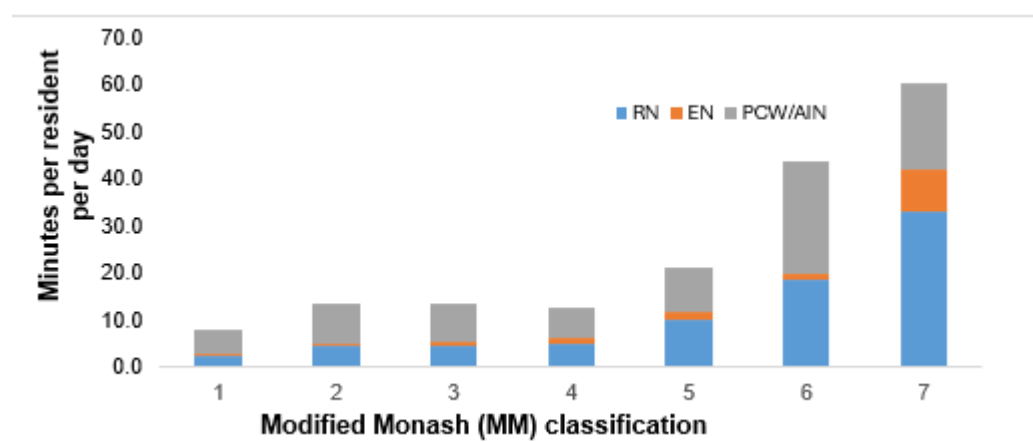
²⁰ National Skills Commission, 2021, Care Workforce Labour Market Study, Accessed 6 July 2025.

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 model²¹ 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.

²¹ 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)

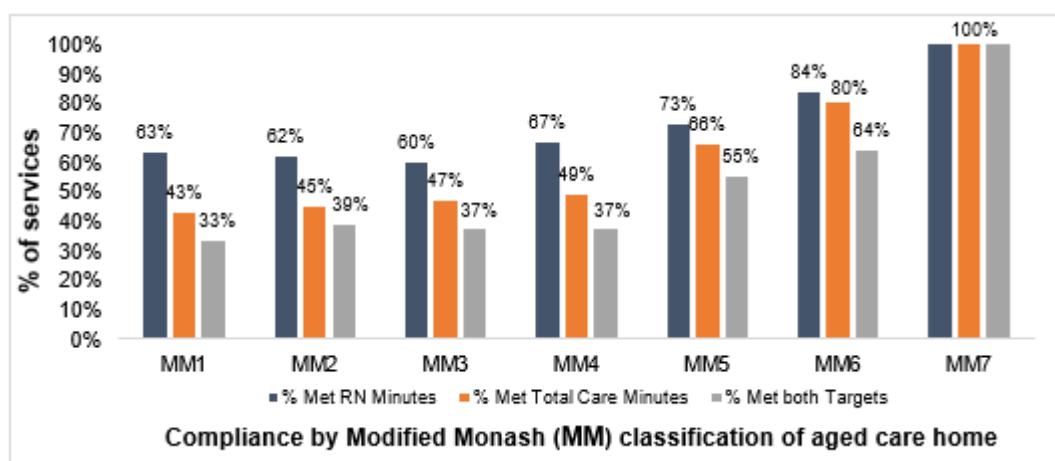
Modified Monash (MM) Model	Total	For-profit	Not-for-profit	Government
MM1: Metropolitan areas	1,543	712	809	22
MM2: Regional centres	194	59	111	24
MM3: Large rural towns	219	50	160	9
MM4: Medium rural towns	174	31	108	35
MM5: Small rural towns	297	27	162	108
MM6: Remote communities	25	0	19	6
MM7: Very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

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.

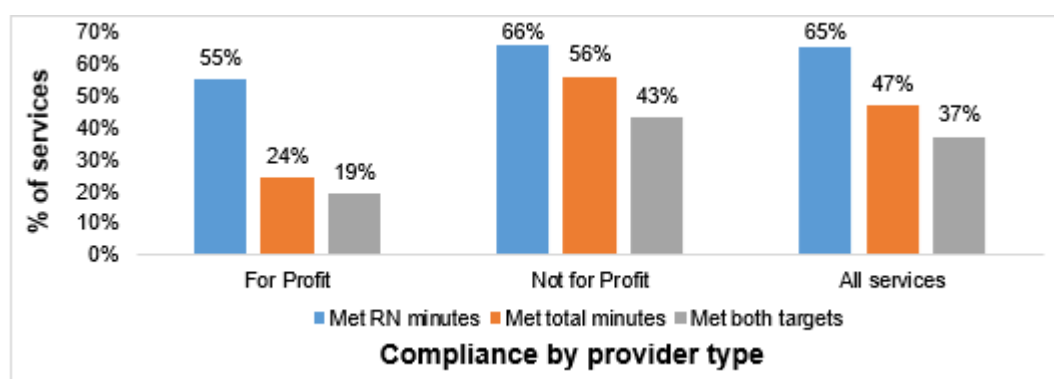
For-profit providers generally perform far worse than other provider types

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)²². 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.

²² 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)

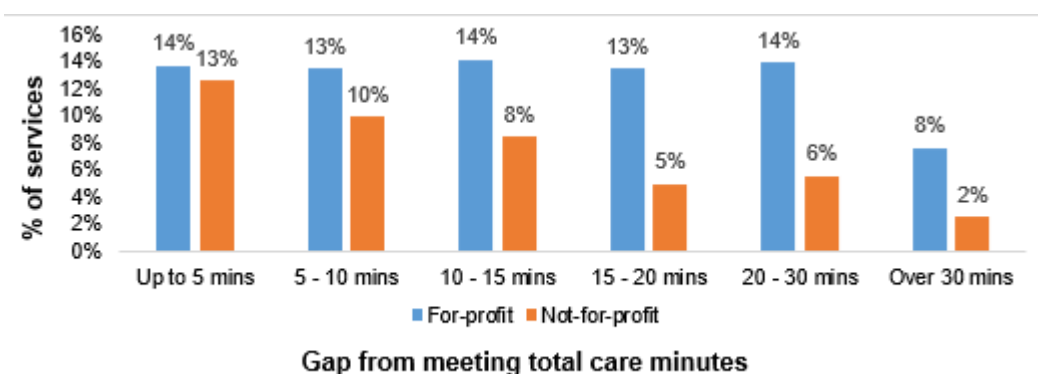


Source: DoHDA, Care minutes dashboard - Quarter 2 2024-25²³

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)



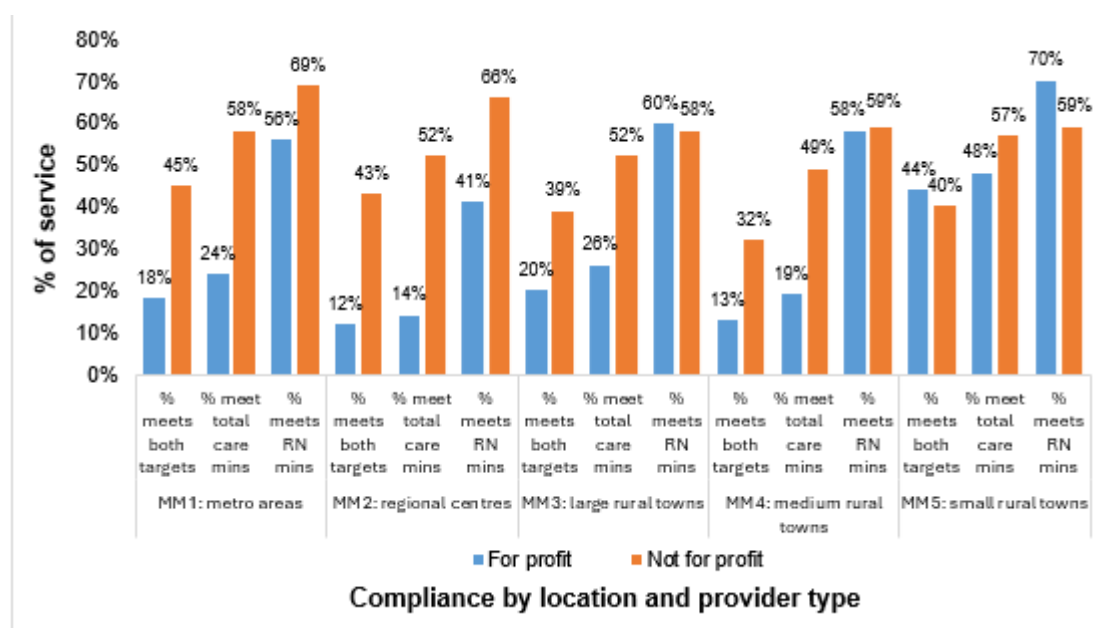
Source: DoHDA, QFR data

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.

²³ 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)²⁴. The latest ACFR data (from 2023-24) shows that on average care spending²⁵ 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 services²⁶. 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)²⁷.

Further analysis of care income and expense data by the department shows 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.

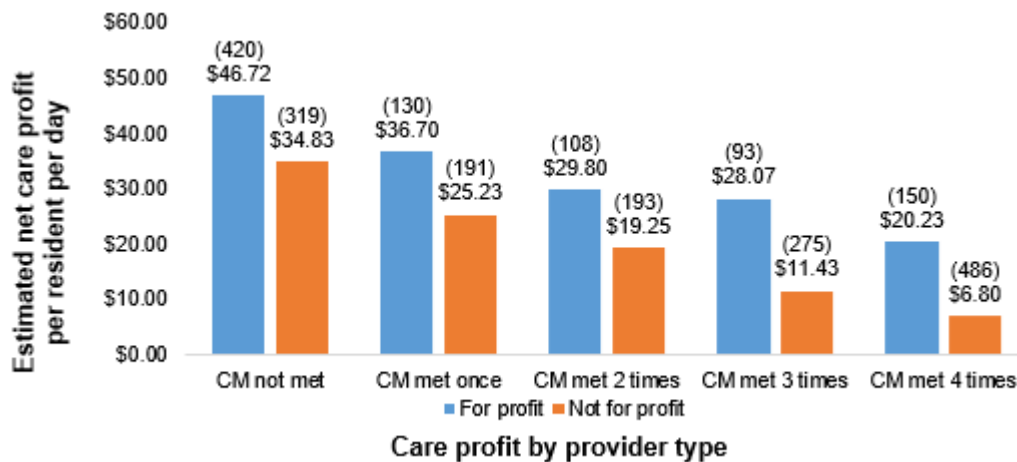
²⁴ ACFR income and expense data is self-reported by providers, and like QFR data, validation checks are applied by the department, with providers asked to resubmit or explain their data if it falls outside of expected boundaries.

²⁵ 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.

²⁶ 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.

²⁷ 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 2023-24²⁸. This report incorporated analysis of StewartBrown survey data from July to December 2023²⁹ 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 2023-24³⁰ 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 sector³¹ published 1 October 2024, the ACQSC updating its regulatory bulletin

²⁸ 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.

²⁹ 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.

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

³¹ 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.

and hosting a webinar in November 2024, and providing an update through its 13 January 2025 media release³² 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 sector³³. 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 setting³⁴. 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.

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

³³ 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.

³⁴ 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 website³⁵. 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 strategy³⁶ and regulatory bulletin concerning workforce-related responsibilities³⁷ 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-compliance³⁸.

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

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

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

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

³⁸ 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 homes³⁹.

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

³⁹ 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 Care⁴⁰.

Like care minutes requirements, Star Ratings⁴¹ 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 levels⁴², and the department also reporting a trend of increasing occupancy in the Quarterly Financial Snapshots⁴³) 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 directly with the desire to avoid a competitive disadvantage by incurring increased workforce costs of complying with their care minutes targets.

⁴⁰ 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.

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

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

⁴³ 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.

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 inaccurate⁴⁴. The department does not currently disclose which providers have submitted incorrect data. Any Government intervention that increases the onus on providers to improve their care minutes performance will also increase the likelihood of providers over-reporting care minutes delivered. The proposed policy Option

⁴⁴ This is internal departmental data.

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 bulletin⁴⁵ 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

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

meeting their 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'⁴⁶ 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 spreadsheet⁴⁷ (viewed on 889 occasions from 31 July to 30 November 2024) on the department's website alongside the care minutes dashboard⁴⁸ 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 ratings⁴⁹. 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.

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

⁴⁷ 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.

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

⁴⁹ 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 NWAU⁵⁰ 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 tariff⁵¹ (BCT) component as this allows the funding change to be targeted at only MM1 non-specialised services⁵² 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).

⁵⁰ 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.

⁵¹ 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.

⁵² 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*

% total care minutes	% RN 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.

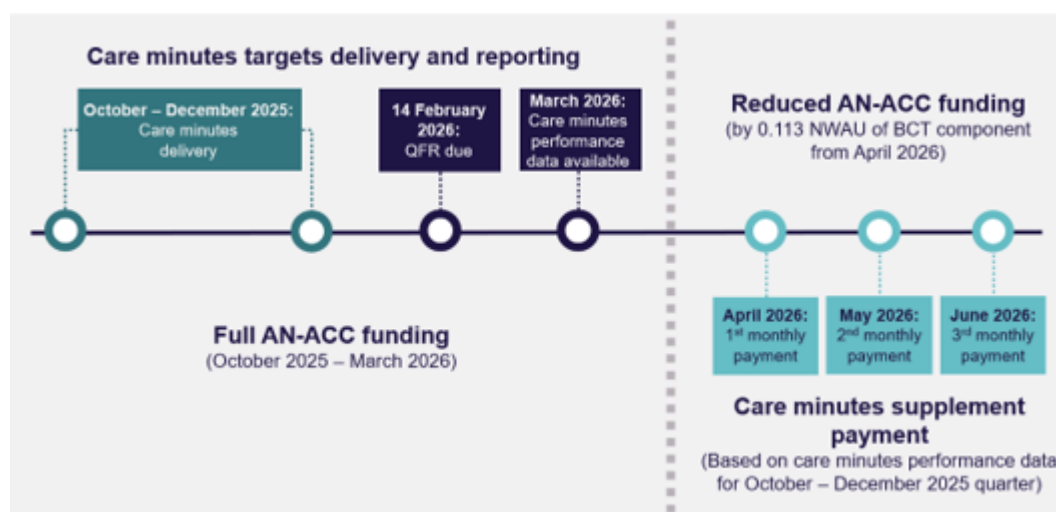
While the supplement generally provides funding to support a 2.5 percentage point improvement in care minutes compliance, once compliance gets close to 100% (above 95%) the additional funding is wound back or the financial impact of not meeting the care minutes target is reduced. For example, moving 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

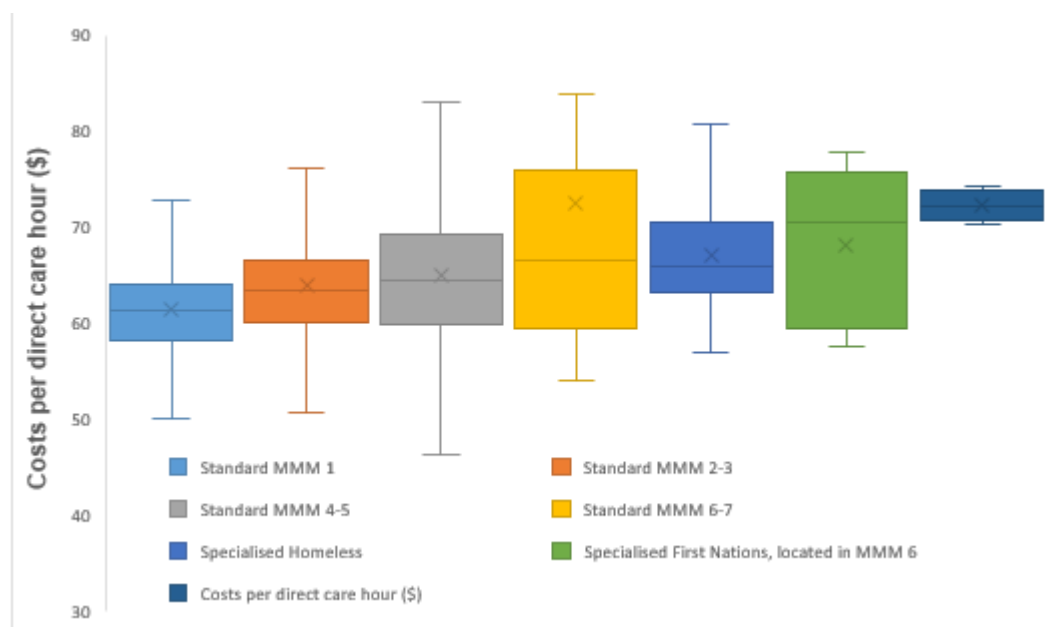
Option 2 proposes to link funding to care minutes compliance in homes operating in metropolitan areas (MM1) which is the majority (around 64%) of all aged care homes. As was shown in Chart 4, homes in MM1 areas also have the lowest compliance rate with their care minutes target.

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 obligations⁵³.

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

⁵³ 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)⁵⁴. 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.

⁵⁴ 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)
Consumers	
Increased care minutes delivered to residents in non-compliant homes - Appendix A	\$7,390.7
Providers	
Decreased care funding for providers not meeting their care minutes (only impacts non-compliant providers) – Appendix B	-\$221.4
Australian Government	
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
Total net benefit	\$7,380.1

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)
Consumers	
Increased care minutes delivered to residents in non-compliant homes – Appendix A	\$12,742.6
Providers	
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
Australian Government	
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
Total net benefit	\$12,716.2

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

Average annual regulatory costs				
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 Elders⁵⁵ 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)⁵⁶ which is an advisory group of key residential aged care industry stakeholders who advise on aged care reform related activities. Members include key Government

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

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

stakeholders. Industry advocates, providers, professional associations and academic groups to name just some.

- National Aged Care Advisory Council (NACAC) ⁵⁷ 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 residents⁵², 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.

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

Adversely impacting care innovation

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 option 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.

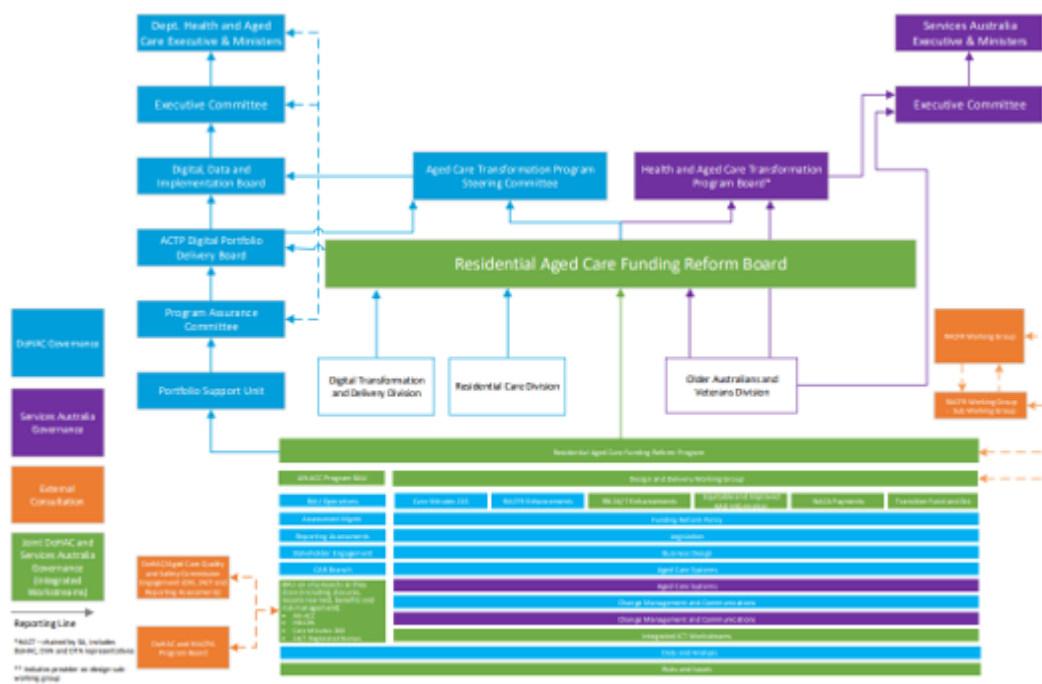
Implementation of preferred option

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 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 Elders⁵⁸, 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)⁵⁹ and the National Aged Care Advisory Council (NACAC)⁶⁰ 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.

⁵⁸ See details and membership at: Aged Care Council of Elders | Australian Government Department of Health, Disability and Ageing

⁵⁹ See details and membership at: Residential Aged Care (RAC) Funding Reform Working Group | Australian Government Department of Health, Disability and Ageing

⁶⁰ See details and membership at: National Aged Care Advisory Council | Australian Government Department of Health, Disability and Ageing, Accessed 6 July 2025.

Ethical risks will likely arise in the evaluations because there is:

- 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

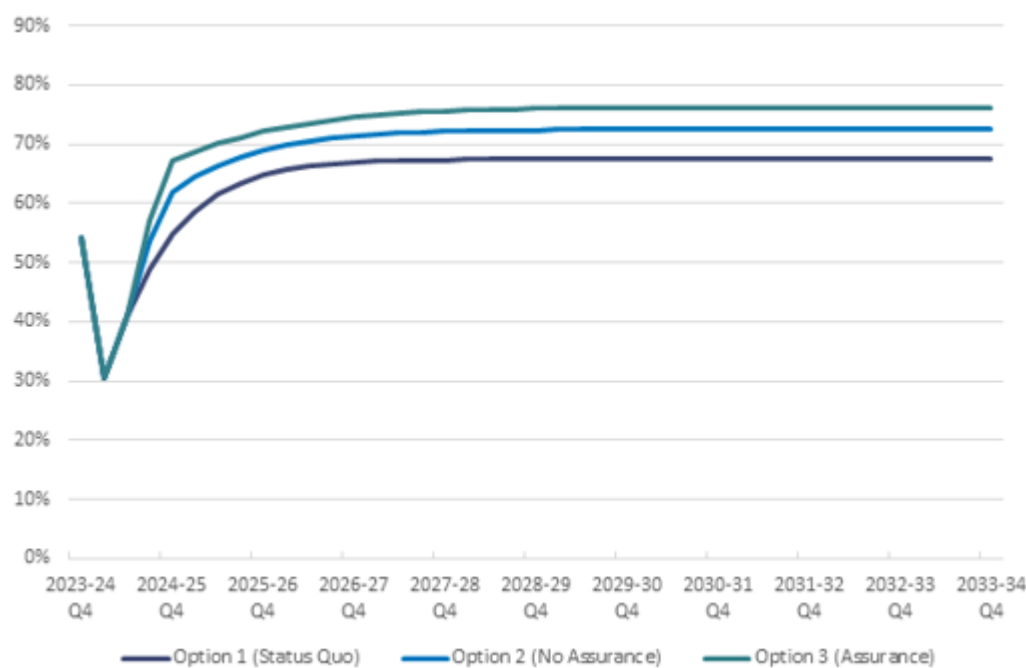


Table A.1 - Additional Care Minutes Delivered

	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 (\$) ⁶¹

	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

⁶¹ 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 (\$)⁶²

	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

⁶² 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 MMI 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.⁴⁹

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 \$70.3.⁶³

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

⁶³ 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