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THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

HOUSE OF REPRESENTATIVES

AGED CARE (LIVING LONGER LIVING BETTER) BILL 2013

EXPLANATORY MEMORANDUM

(Circulated by authority of the Minister for Mental Health and Ageing,
the Hon Mark Butler MP)

AGED CARE (LIVING LONGER LIVING BETTER) BILL 2013

OUTLINE

The *Living Longer Living Better* aged care reform package was announced on 20 April 2012. The package encompasses a comprehensive ten year plan to reshape aged care.

The Aged Care (Living Longer Living Better) Bill 2013 is one of five Bills amending the *Aged Care Act 1997* and related legislation to give effect to the *Living Longer Living Better* reforms. The legislative package comprises:

- Aged Care (Living Longer Living Better) Bill 2013;
- Australian Aged Care Quality Agency Bill 2013;
- Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013;
- Aged Care (Bond Security) Amendment Bill 2013; and
- Aged Care (Bond Security) Levy Amendment Bill 2013.

The Aged Care (Living Longer Living Better) Bill 2013 implements reforms in four key areas:

- changes relating to residential care;
- changes to establish a new type of care (home care);
- changes relating to governance and administration; and
- changes that are minor, administrative or consequential.

In relation to residential care, most of the changes will take effect from 1 July 2014 and include:

- removal of the distinction between low level and high level residential care so there will only be one type of approval for permanent residential care. This enables anyone assessed as needing permanent residential care to access any residential care service that meets his or her needs;
- changes to the way that residential care subsidies and fees are calculated for care recipients who enter residential care on or after 1 July 2014. Key changes include a new means test combining income and assets tests, and new annual and lifetime caps on means tested care fees;
- an additional dementia supplement and a new veterans' mental health supplement payable to providers who care for eligible care recipients. A workforce supplement will also be payable to eligible providers. These supplements will be payable from 1 July 2013;

- enabling care recipients who can afford to contribute to their accommodation costs to have the choice of paying for their accommodation through a fully refundable lump sum, a rental style periodic payment, or a combination of both; and

- ensuring that people in care on 30 June 2014 will continue under their current arrangements unless they leave care for more than 28 days (and subsequently re-enter care) or they move between services and choose to have the new rules apply to them as if they entered care on or after 1 July 2014.

In relation to home care, the changes include:

- from 1 July 2013:
  - a new type of care, home care, will replace community care (Community Aged Care Packages) and some forms of flexible care delivered in a person's home (Extended Aged Care at Home and Extended Aged Care at Home - Dementia);

  - an additional dementia supplement and a new veterans' mental health supplement will be available to providers who care for eligible care recipients. A workforce supplement will also be payable to eligible providers;

  - the existing community visitors scheme for people receiving residential care will be extended to home care;

- from 1 July 2014:
  - changes to the way that home care subsidy and fees are calculated for care recipients who enter home care on or after 1 July 2014. Key changes will include: requiring some care recipients to contribute more to the cost of their care through an income tested care fee and putting safeguards in place to ensure that: no full rate pensioner will pay an income tested care fee; and new annual and lifetime caps will apply to income tested care fees; and

  - people receiving home care on 30 June 2014 will continue under their current arrangements unless they leave care for more than 28 days (and subsequently re-enter care) or they move between services and choose to have the new rules apply to them as if they entered home care on or after 1 July 2014.

In relation to governance and administration, amendments to:

- establish a new Aged Care Pricing Commissioner to make decisions on certain pricing issues within the legislative framework and broad policy framework set by the Minister; and

- provide for an independent review of the reforms to commence in 2016 with a report to be tabled in both Houses of Parliament by 30 June 2017.

Minor, administrative or technical changes including:

- consequential amendments relating to the reforms; and

- minor amendments to address drafting anomalies and inconsistencies and to remove redundant provisions.

Financial Impact Statement

The Bill gives effects to parts of the *Living Longer Living Better* package of reforms under which the Government will provide $3.7 billion over 5 years from 2012-13.

Statement of Compatibility with Human Rights

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

Aged Care (Living Longer Living Better) Bill 2013

This Bill is compatible with the 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 Bill

In April 2012, the Prime Minister and the Minister for Mental Health and Ageing announced a 10 year aged care reform package to build a better, fairer, more sustainable and nationally consistent aged care system. The reforms give priority to providing more support and care in the home, better access to residential care, additional support for those with dementia and strengthening the aged care workforce.

This Bill amends the *Aged Care Act 1997* to give effect to major components of the *Living Longer Living Better* reforms. The changes arising from this Bill fundamentally reform the regulation of aged care to provide for sustainable funding, expanded workforce capacity, higher quality of care, improved access and strengthened protections for care recipients.

Human Rights Implications

The Bill promotes the human right to health contained in Article 12 of the International Covenant on Economic, Social and Cultural Rights.

The Bill engages the right of everyone to the enjoyment of the highest attainable standard of physical and mental health as set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights. The Bill provides for the payment of additional government funding in the form of a new behaviour supplement and a new veterans' supplement to enable approved providers to meet the mental health needs of care recipients, whether the care is provided in a residential care service or in a person's own home.

The Bill both limits and promotes the human rights of equality and non-discrimination contained in Article 2(2) of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

The Bill limits the rights of equality and non-discrimination regarding property and financial status through increased means testing, but this is remedied through the minimisation of barriers to access, greater equity of access, increased choice of payment method, and provision of appropriate safety net provisions.

In order to ensure the sustainability of the aged care system so that all Australians get the care they need, the Bill strengthens the means testing arrangements for people entering residential care from 1 July 2014. It combines the current income and assets tests to ensure a consistent fees policy. This will address the issue of asset-rich, income-poor residents paying for all of their accommodation and nothing for care;

and income-rich, asset-poor residents paying for their care but not for accommodation. These provisions assume that where a person is responsible for their own accommodation needs in the community they continue to accept this responsibility where possible in residential care.

The Bill provisions regarding residential care means testing and home care income testing ensure that those who can afford to make a greater contribution to their care costs do so. Annual and lifetime caps will apply across both residential and home care.

Taking into consideration that the current treatment of a person's principal residence does not change under this Bill, and the combined safety net effect of increased hardship provisions and new annual and lifetime caps, this Bill appropriately manages the limitation on the rights of equality and non-discrimination in regard to the property and financial status of older Australians requiring aged care.

The Bill also promotes the rights of people with disabilities, particularly in regard to choice and independence, as contained in Article 3(a) of the Convention on the Rights of Persons with Disabilities (CRPD). The Bill introduces a five year review which will include consideration of the new requirement by 1 July 2015 for all home care packages to be offered to home care recipients on a consumer directed care basis. The review will be used to ensure that the policy of consumer directed care is having the desired effect of providing older Australians with greater choice and control over the delivery of their care.

Conclusion

This Bill is compatible with human rights because it promotes the human rights to the highest attainable standard of physical and mental health and achieves a balance in relation to the human rights of equity and non-discrimination.

The Hon Mark Butler MP, Minister for Mental Health and Ageing

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NOTES ON CLAUSES

Clause 1 – Short Title

This is a formal provision which provides that the Bill, once enacted, can be cited as the *Aged Care (Living Longer Living Better) Act 2013.*

Clause 2 – Commencement

This clause provides that each provision of the Bill commences in accordance with the table. Provisions, Schedules and Parts of Schedules commence as follows:

- Sections 1 to 3 and anything in the Bill not elsewhere covered by the table – the day the Act receives Royal Assent;
- Schedule 1 – 1 July 2013;
- Schedule 2 – 1 January 2014;
- Schedule 3 – 1 July 2014;
- Schedule 4, Part 1 – 1 July 2013;
- Schedule 4, Part 2 – 1 July 2014;
- Schedule 5, Part 1 – 1 July 2014; and
- Schedule 5, Parts 2 and 3 – 1 July 2014.

Clause 3 – Schedule(s)

This clause provides that each Act that is specified in a Schedule to this Bill is amended or repealed as set out in the applicable items in the Schedule. Other items do not amend provisions in the relevant Acts but instead describe, for example, arrangements that need to be preserved.

Clause 4 – Review of operation of amendments

This clause provides for the Minister to cause an independent review of the operation and amendments made by the Aged Care (Living Longer Living Better) Bill 2013, the Aged Care (Bond Security) Amendment Bill 2013 and the Aged Care (Bond Security) Levy Amendment Bill 2013 (once enacted).

Subclause (2) describes the mandatory issues that the review must take into account.

Subclause (2)(a)

The review will need to consider whether support and care options available for older people who want to stay in their own homes have been expanded and improved. In regards to older Australians who are no longer able to stay in their own home, the review will need to consider whether there is a sufficient supply of residential aged care services to meet the needs of an ageing population.

Subclause (2)(b)
The review will consider whether there is a continued need for controls on the number and mix of places for both home care and residential care. The review will consider the regulation of aged care places and make recommendations on the risks and benefits of adopting a less regulated aged care system in regards to the allocation of places. This will include considering the allocation arrangements as prescribed in the *Aged Care Act 1997* and the Allocation Principles.

Subclause (2)(c)
From 1 July 2015, consumer directed care will become a condition of allocation for all new home care packages, and a pilot of consumer directed care in residential care will be undertaken. The review will need to consider the effects of embedding consumer directed care into mainstream aged care program delivery, whether older Australians have a greater say over the delivery of their care, and whether there are opportunities to move towards a consumer demand driven model.

Subclauses (2)(d), (f) and (i)
As part of the reforms, care recipients with the necessary means will be asked to make a greater contribution to the cost of the care that they receive. The review will need to consider whether these changes have resulted in any groups having reduced access to care. This will need to be considered in the context of related reforms that are designed to improve access, including the Aged Care Gateway. The review is to consider whether people with similar circumstances pay similar fees and the adequacy of safeguards for those who can least afford to pay.

In particular, the review is to consider the effects on older Australians in regards to the changes to the income and asset tests and the implementation of annual and lifetime caps.

Subclauses (2)(e) and (h)
With regards to residential care, the review will consider, amongst other things, the effects of the increased accommodation supplement and whether the fairness and flexibility of accommodation payments in residential aged care has improved. In particular, the review is to examine the effects of the new accommodation payment arrangements, including the choice of payment method and changes to retention amounts.

The review will also consider the arrangements for protecting refundable deposits and accommodation bonds. This will include an assessment of the capacity to move towards arrangements such as providers obtaining insurance for refundable deposits via a private market.

Subsection (2)(g)
The review will need to consider supply issues such as the effectiveness of implementation of measures to improve aged care sector productivity, whether sector demand is being met in retaining and attracting a skilled workforce, and the impact of the Workforce Supplement.

Subclause (2)(j)
The review is required to address and report on any additional issue(s) specified by the Minister.

Subclause (3) details the scope of stakeholders who are required to be consulted during the conduct of the review.

To ensure broad consultation of consumers and providers across the aged care sector and other health industries, the review must undertake public consultation with groups which include and are not limited to: approved providers; aged care workers; consumers; people with special needs; carers; and representatives of consumers.

Subclause (4) gives legislative force to the requirement for the five year review to commence three years after the commencement of Schedule 1 of the Aged Care (Living Longer Living Better) Bill, which will be four years after the commencement of the *Living Longer Living Better* aged care reforms.

Subclause (5) ensures that the person appointed by the Minister to undertake the independent review must provide the Minister with a written report by 1 July 2017, that is, by the end of the fifth year of the reforms.

Subclause (6) requires the Minister to table the report in each House of Parliament within 15 sitting days of receiving it. This is to aid in the transparency of the review process.

Schedule 1 – Amendments commencing on 1 July 2013

Part 1 - Amendments

Aged Care Act 1997

Items 1, 18, 19, 21, 22, 23, 26, 27, 31, 32, 33, 56, 64, 70, 71, 72, 74, 75, 77, 81, 83, 86, 90, 93, 95, 100, 102, 103, 108, 110, 115, 122, 126, 129, 133, 135, 136, 139, 178, 186, 193 and 194
From 1 July 2013, community care (Community Aged Care Packages) and two kinds of flexible care, Extended Aged Care at Home and Extended Aged Care at Home Dementia, will be replaced with home care. Home care will consist of four levels to provide a continuum of home care options. These items replace the word ‘community’ with the word ‘home’, or the words ‘a community’ with ‘a home’, throughout the *Aged Care Act 1997*. The words are replaced in:

- sections 19-1, 23-1, 24-1 (note), 45-1, 56-2, 60-1, 85-1 (table items 49A and 49B);
- subsections 1-3(5) (table items 3 and 4), 20-1(2), 20-1(4), 46-1(1) (note), 46-1(2), 46-1(2) (note), 46-2(1), 46-3(1), 46-3(2), 47-1(2), 47-3(2), 47-3(3), 47-4(1), 47-4(2), 47-4(3), 48-1(1), 48-1(2), 54-4(1), 56-4(3), 60-2(1), 60-2(2), 61-1(1);
- paragraphs 18-5(1)(b), 21-1(b), 21-3(c), 22-1(1)(b), 23-3(2)(c), 45-3(2)(a) and (b), 46-1(1)(b), 46-1(1)(c), 46-4(1)(b), 54-1(1)(f); and

- Clause 1 of Schedule 1 (paragraph (b) of the definition of *aged care*), Clause 1 of Schedule 1 (paragraph (b) of the definition of *payment period*), Clause 1 of Schedule 1 (definition of *place*).

Items 2 and 165
Item 165 repeals Parts 5.2, 5.2A and 5.3 relating to community care grants, flexible care grants and assessment grants. These are either currently not in use or will not be needed from 1 July 2013. The capacity to make other grants (Part 5.7) may be used in the future for any type of grant proposed to be made in connection with aged care.

A number of provisions, which currently deal with matters relating to Parts 5.2, 5.2A and 5.3, are therefore either not required or require amendments.

Paragraph 3-5(b) provides an overview of the grants made under Chapter 5 of the *Aged Care Act 1997.* One of the specific types of grants mentioned is assessment grants but these will not be required from 1 July 2013 and as such the paragraph is being repealed. The definition of *assessment grant* under Clause 1 of Schedule 1 is no longer required and therefore is also being repealed.

Similarly section 69-1 (which describes Part 5) is being amended to better reflect the new content of Chapter 5.

Item 3
This item repeals section 3.6 which is a diagram that sets out the structure of the *Aged Care Act 1997*. The extent of the amendments in this Bill means this structure is no longer correct.

Items 4, 54, 57, 60, 62, 63, 91, 97, 116, 119, 121 and 183
These items replace the word ‘Community’ with the word ‘Home’ throughout the *Aged Care Act 1997*. The word is replaced in:

- Part 3.2 (heading);
- sections 5-2 (heading to table column headed ‘Community care subsidy’), 45-2 (heading), 45-2 (note), 54-4 (heading), 96-1(table item 12);
- subsections 45-3(1), 45-3(2), 47-3(4), 54-4(1); and
- paragraphs 47-2(b), 54-1(1)(f).

This change results from the removal of community care from the *Aged Care Act 1997*. From 1 July 2013, community care and two kinds of flexible care, Extended Aged Care at Home and Extended Aged Care at Home Dementia, will be replaced with home care. Consequently, headings and terms throughout the *Aged Care Act 1997* that refer to Community Care will be changed to Home Care.

Item 5
Section 5-2 relates to approvals and similar decisions that may be relevant to payments under Chapter 3. This item replaces note 2 in section 5-2 because from 1 July 2013, community care grants and flexible care grants will be repealed from the *Aged Care Act 1997* as they are redundant. Note 2 will therefore describe more generally that allocation of funding for grants is dealt with under Chapter 5 of the *Aged Care Act 1997*.

Item 6
Section 11-3 describes groups of people who are 'people with special needs' for the purposes of the *Aged Care Act 1997*. For example, when the Secretary is allocating aged care places the Secretary may determine, for those places, the proportion of care that must be provided to people with special needs.

This item amends section 11-3 so that it includes those people who are currently described in the Allocation Principles made under *Aged Care Act 1997*. The effect of the amendment is that all of the following people will be 'people with special needs' as described in section 11-3:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- veterans;
- people who are homeless or at risk of becoming homeless;
- care-leavers;
- lesbian, gay, bisexual, transgender and intersex people; and
- people of a kind (if any) specified in the Allocation Principles.

Items 7, 9 and 44
Subsections 12-3(2), 12-6(3) and 32-7(2) require determinations by the Minister or the Secretary in relation to various matters to be published. These items remove the requirement for the determinations to be published in the Australian Public Service Gazette. Instead the determinations will be published on the Department's website - www.health.gov.au. This ensures that information regarding aged care is more accessible and centrally located.

Item 8
Subsection 12-5(3) provides examples of the criteria that may be included in Allocation Principles relating to allocation of places by the Secretary. This item repeals subsection 12-5(3) as the subsection provides examples only and has no legal consequence.

Item 10
Section 14-2 relates to the competitive assessment of applications for allocation of places. This section provides that the Secretary must consider, in relation to each application for places, a range of matters (described in subsection 14-2(1)). By setting out the matters in *Aged Care Act 1997* this reduces the capacity for the criteria to be adjusted as the care needs of the population change. Section 14-2 is therefore being amended to provide that, in deciding which allocation of places would best meet the needs of the aged care community in the region, the Secretary must consider, in relation to each application, the matters set out in the Allocation Principles. The Allocation Principles are made by the Minister under section 96-1 and are legislative instruments (subject to disallowance by the Parliament) in accordance with the *Legislative Instruments Act 2003.*

The matters set out in the Allocation Principles will enable a fair and competitive assessment of each application during the allocation of places process.

Item 11
Subsection 14-5(1) provides that the Secretary may make an allocation of places subject to specified conditions. This item adds a note to make it clear that approved providers must comply with these conditions as part of their responsibilities under Part 4.3 and that if they fail to comply sanctions are able to be imposed under Part 4.4.

Item 12
Subsection 14-5(4) provides examples of the types of matters with which conditions of allocation may deal. These examples have become dated (and so may be misleading) despite having no legislative effect. This item therefore repeals the list of examples.

Item 13
Subsection 15-7(7) describes examples of matters with which the Allocation Principles may deal, with respect to provisional allocation periods. This item repeals subsection 15-7(7) because the subsection provides examples only and has no legal consequence.

Item 14
Subsection 16-9(2) describes examples of matters that may be specified in the Allocation Principles with respect to the information to be given to a transferee. This item repeals subsection 16-9(2) as this subsection includes examples only of the matters with which the Allocation Principles may deal and has no legal consequence.

Item 15, 20, 51, 55, 69, 73, 78, 80, 82, 85, 92, 94, 96, 99, 101, 107, 109, 111, 112, 128, 130, 140, 141, 185 and 192
These items replace the word ‘*community’ with the word ‘*home’ throughout the *Aged Care Act 1997*. The word is replaced in:

- sections 19-1, 40-1, 45-1, 96-5 (note)(replaces '*community' with 'home');
- subsections 46-1(2), 46-2(1), 46-3(1), 46-3(2), 47-3(1), 47-3(2), 47-4(1), 47-4(2), 48-1(1), 48-1(2), 48-1(3), 48-1(4), 56-4(3), 61-1(2), 61-1(3);
- paragraphs 16-11(c), 46-1(1)(b), 46-4(1)(a), 47-3(3)(a), 56-2(e); and
- Clause 1 of Schedule 1 (paragraph (b) of the definition of *payment period).*

This change results from the removal of community care from the *Aged Care Act 1997*. From 1 July 2013, community care (Community Aged Care Packages) and two kinds of flexible care, Extended Aged Care at Home and Extended Aged Care at Home Dementia, will be replaced with home care. The defined term '*community care' will be replaced with a new defined term, '*home care'. Similarly, throughout the *Aged Care Act 1997*, defined terms commencing with '*community', such as *community care agreement and *community care subsidy, will be replaced to read *home care agreement and *home care subsidy.

Item 16
Subsection 17-2(3) describes examples of matters that may be specified in the Allocation Principles with respect to applications for variation of allocations. This item repeals subsection 17-2(3) as this subsection provides only examples of the matters with which the Allocation Principles may deal and it has no legal consequence.

Item 17
Subsection 18-2(2) deals with information that must be included in the notice to the Secretary, provided by the approved provider, when the provider seeks to relinquish allocated places. When relinquishing an allocated place, the approved provider is required to report in writing to the Secretary about, for example, proposals for ensuring that care needs are appropriately met for those care recipients who are being provided with care in respect of the places to be relinquished. This item inserts an additional matter on which the approved provider must report. That is, the approved provider must provide the Secretary with a written proposal for ensuring that any responsibilities in relation to accommodation bond balances and entry contribution balances that the provider may hold are met. This will be further amended on 1 July 2014 via schedule 3 to include refundable deposit balances.

Items 24, 25, 61, 65, 66, 76, 84, 87, 88, 98, 104, 105, 106, 125, 131, 132, 134, 137 and 138
These items replace the word '**community**' or '***community***' with the word '**home**' or '***home***' throughout the *Aged Care Act 1997*. The word is replaced in:

- Divisions 46 (heading), 47 (heading), 48 (heading), 60 (heading), 61 (heading); and

- sections 21-3 (heading), 21-3, 45-3 (heading), 46-1 (heading), 46-2 (heading), 46-4 (heading), 47-1 (heading), 47-4 (heading), 47-4A (heading), 48-1 (heading), 56-2 (heading), 60-1 (heading), 60-2 (heading), 61-1 (heading).

These items replace the word ‘community’ with the word ‘home’ where it appears in a heading or as bolded text. This change results from the removal of community care from the *Aged Care Act 1997*. From 1 July 2013, community care (Community Aged Care Packages) and two kinds of flexible care, Extended Aged Care at Home and Extended Aged Care at Home Dementia, will be replaced with home care.

Item 28
This item amends section 22-3 which relates to limitations on approvals for care recipients to receive aged care. The amendment to subsection 22-3(3) enables the Secretary to limit an approval for a particular type of care, such as residential care or home care, to ‘one or more levels of care’. This will, for example, enable an approval for home care to be limited to one or more of the proposed four levels of home care that would best meet a person’s assessed care needs.

It will also enable the Secretary to limit an approval for residential care to a low level of residential care for the period from 1 July 2013 to 30 June 2014 at which time the high care/low care split is abolished. Decisions to limit an approval to one or more levels of care are reviewable under Part 6.1 of the *Aged Care Act 1997*.

Items 29
This item amends section 22-4 regarding assessments of care needs of care recipients. Currently only residential care has specified levels of care. As a result of item 28, it will also be possible to have levels of home care. This item removes the references to residential care to enable the limitation of assessments to be in respect of a person’s eligibility to receive a specified level of any type of care, including home care.

Items 30
Section 22-6 of the *Aged Care Act 1997* is about the Secretary’s requirement to notify decisions regarding approval as a care recipient of one or more types of care. This item repeals paragraph 22-6(2)(c) that requires the notice to include information specific to limits for approvals for residential care, and replaces it with a new paragraph that instead requires notice to be given regarding whether an approval more generally is limited to one or more levels of care. This reflects the changes being made through items 28 and 29.

Item 34
Section 25-2 deals with classification levels. This item repeals subsection 25-2(5). As this subsection provides only examples of the matters with which the Classification Principles may deal, it has no legal consequence and is therefore being repealed.

Items 35 to 38
In order to determine the amount of basic subsidy payable by the Government, in respect of a care recipient in residential care, *Aged Care Act 1997* enables approved providers to undertake appraisals of care recipients using the Aged Care Funding Instrument.

The approved provider submits the outcome of their appraisal of a care recipient and, on this basis the Secretary classifies the care recipient according to the level of care required by the care recipient relative to other care recipients. This classification influences the amount of basic subsidy payable in respect of the care recipient.

The Secretary may then review the approved provider's appraisals of care recipients, noting that approved providers are required to keep certain documentation to demonstrate how they have appraised a care recipient.

Under sections 25-4 and 27-3 of the *Aged Care Act 1997*, the Secretary can suspend an approved provider from making appraisals and reappraisals; require a reappraisal to be made of the level of care needed by one or more care recipients; or do both.

However, this power can only be invoked where it can be reasonably demonstrated that a provider is repeatedly using the Aged Care Funding Instrument in a way that is false, misleading or significantly incorrect.

These items broaden this power to enable the Secretary to take action in response to an approved provider giving false, misleading or inaccurate information in appraisals and reappraisals.

Specifically, items 35 to 38 amend section 25-4 such that:

- the Secretary can suspend an approved provider from making appraisals or reappraisals, with respect to care recipients in *one or more of the approved provider's services* (item 35). In other words, if an approved provider has a good record of appraisals at some services and a poor record at others, the Secretary can suspend the approved provider from undertaking appraisals or reappraisals at one or more services and not necessarily at all services of the approved provider;

- it is no longer a requirement that, before the Secretary can suspend an approved provider from making appraisals or reappraisals, he/she must first be satisfied that the approved provider gave false or misleading information in a *substantial* number of appraisals or reappraisals. The Secretary must be satisfied that the approved provider (or a person acting on the approved provider's behalf) gave false, misleading or inaccurate information in relation to one or more appraisals or reappraisals (items 36 and 37); and

- if the Secretary has been satisfied that the approved provider has provided false, misleading or inaccurate information, and the Secretary has changed one or more classifications in connection with the appraisal or reappraisal, then the Secretary must only be satisfied that, after the classifications change, the approved provider gave false, misleading or inaccurate information in relation to any other appraisal or reappraisal (item 38). It should no longer be necessary that the approved provider 'continued' to give false, misleading or inaccurate information.

It is proposed that corresponding changes be made to section 27-3. Decisions to suspend an approved provider from making appraisals under section 25-3 and reappraisals under section 27-3 of the *Aged Care Act 1997* are reviewable decisions

(subject to internal reconsideration and to review by the Administrative Appeals Tribunal).

Item 39
This item repeals subsection 25-4(2) which requires the Secretary to consider any criteria specified in the Classification Principles when considering if the number of false, misleading or inaccurate appraisals was ‘substantial’. This subsection is redundant as the term ‘substantial’ will be removed from section 25-4(1)(a).

Items 40 to 42
These items amend subsection 27-3(1) to make corresponding changes to those made to subsection 25-4.

Specifically the items amend subsection 27-3(1) to provide that the Secretary may give the approved provider a written notice requiring a reappraisal to be made if:

- the Secretary is satisfied that the approved provider (or a person acting on the approved provider’s behalf) gave false, misleading or inaccurate information in relation to one or more appraisals or reappraisals (item 40);

- the classification was changed under section 29-1 (item 41); and

- the Secretary is satisfied that, after that classification was changed the approved provider gave false, misleading or inaccurate information in another appraisal or reappraisal (item 42).

Item 43
This item repeals subsection 27-3(2) which compels the Secretary to consider any criteria specified in the Classification Principles when considering if the number of false, misleading or inaccurate appraisals was ‘substantial’. This subsection is redundant as the words ‘*substantial number of appraisals or re-appraisals*’ will be removed from section 27-3(1)(a) (see item 40).

Item 45
This item repeals subsection 32-8(5) which deals with the types of conditions that may be included without limiting the conditions relating to a grant of extra service. As subsection 32-8(5) is a list of examples and has no legal consequences, this redundant provision is being repealed.

Items 46 and 47
These items amend section 39-2 which relates to lapsing of certification on change of location of residential care services.

Item 46 inserts a subsection (1) into section 39-2, in order that a subsection (2) may be created.

Item 47 creates a new subsection (2) that allows for a temporary change in location of a residential care service if the Secretary is satisfied that exceptional circumstances exist.

These new arrangements put beyond doubt that certification does not lapse due to a temporary change in location at which residential care is provided through the service in the event of, for example, a natural disaster. If all the residents in a certified residential aged care service are moved from the service to place them out of harm's way during a bushfire or flood emergency and care continues to be provided through the service at a different location, then certification will not automatically lapse.

Items 48 and 49
These items amend section 39-3 which relate to revocation of certification by the Secretary.

Currently, certification of a residential care service must be revoked if the Secretary is satisfied that a service has ceased to be suitable for certification or if the Secretary is satisfied that the application for certification of the service contained information that was false or misleading in a material particular. The current process for revocation does not give the Secretary discretion to notify the provider and give the provider an opportunity to address the issue.

The amendments to subsection 39-3(1) and (2) provide for notice to be given to an approved provider where the Secretary is considering revocation. The amendments to subsection 39-3(2) allow for an approved provider to provide written submissions, within 28 days after receiving the notice, which the Secretary must consider in deciding whether to revoke certification.

Subsection 39-3(3A) is a new provision that states that unless the Secretary takes action under new section 39-3A or 39-3B, then revocation of certification is mandatory if the Secretary is satisfied that the residential care service has ceased to be suitable for certification or if the Secretary is satisfied that the application for certification of the service contained information that was false or misleading in a material particular.

Item 50
This item inserts new sections 39-3A and 39-3B.

Under section 39-3A, if the Secretary has notified an approved provider under subsection 39-3(2) that revocation of certification is being considered and the approved provider has provided satisfactory submissions on the matter, then the Secretary may give the provider a notice to rectify the unsuitability of the service.

In the case that the Secretary is not satisfied with the submissions, the new section 39-3B allows the Secretary to request further information from the approved provider in relation to the submissions. Failure to provide the further information or to propose appropriate action to rectify the unsuitability of the service will result in revocation of certification of the approved provider's residential care service.

Subsection 39-3A(4) sets out the matters with which an undertaking to rectify in response to a notice to rectify must comply. Section 39-3A also provides for the revocation of certification in the instance that a provider fails to give an undertaking to rectify or fails to comply with the undertaking to rectify.

Item 52
This item repeals subsection 42-5(2) which provides examples of matters the Secretary may be required to take into account, under the Residential Care Subsidy Principles, when making determinations allowing for exceptional circumstances. As this subsection provides only examples of the matters with which the Residential Care Subsidy Principles may deal and has no legal consequence, it is being repealed.

Item 53
Section 44-27 currently describes 'other supplements' that may be paid for a care recipient under step 5 of the residential care subsidy calculator. The amendment inserts a new paragraph to the end of the section (before the note) that provides for any other supplements for a care recipient under step 5 of the residential care subsidy calculator to be set out in Residential Care Subsidy Principles. The amendment provides the flexibility to create new supplements that are not required to be taken into account in applying the income test and therefore do not potentially have the effect of increasing the fees a care recipient may be asked to pay.

Items 58 and 89
These items replace the word '*Community' with the word '*Home' throughout the *Aged Care Act 1997*. The word is replaced in section 45-2 and subsections 47-1(1) and (2).

This change results from the removal of community care from the *Aged Care Act 1997*. From 1 July 2013, community care (Community Aged Care Packages) and two kinds of flexible care, Extended Aged Care at Home and Extended Aged Care at Home Dementia, will be replaced with home care. The defined term 'Community care subsidy' will be replaced with the new defined term 'Home care subsidy' throughout the *Aged Care Act 1997*.

Item 59
This item replaces the words 'Community Care' with the words 'Home Care'. This substitution appears in section 45-2 to reflect that from 1 July 2013, community care becomes home care and therefore the relevant Principles dealing with home care will be renamed the Home Care Subsidy Principles.

Item 67
This item replaces the defined term '*community care subsidy' with the term '*home care subsidy' in section 46-1. This change results from the removal of community care from the *Aged Care Act 1997*. From 1 July 2013, community care and two kinds of flexible care, Extended Aged Care at Home and Extended Aged Care at Home Dementia, will be replaced with home care. Consequently, in accordance with the *Aged Care Act 1997*, home care subsidy will be paid for a supply of home care.

Item 68
This item replaces the word 'community' with the word '*home'. The word is replaced in paragraph 46-1(1)(a) of the *Aged Care Act 1997*. This change results from the removal of community care (Community Aged Care Packages) from the *Aged Care Act 1997*. From 1 July 2013, community care and two kinds of flexible care, Extended Aged Care at Home and Extended Aged Care at Home Dementia, will be

replaced with home care. When describing eligibility for subsidy, this item replaces the term community care subsidy with the new defined term, home care subsidy.

Item 79
This item repeals subsections 46-2(3) to (5) which deal with the requirements relating to the suspension, on a temporary basis, of home care. These requirements will be detailed in the Home Care Subsidy Principles.

Item 113
This item replaces the words 'community care' with the words 'home care'. The words are replaced in section 49-3 to reflect that from 1 July 2013, community care becomes home care and therefore community care services (as used in section 49-3) will become home care services.

Item 114
The amendment made by this item provides that, in circumstances set out in the Flexible Care Subsidy Principles, flexible care subsidy is payable in respect of each day for the full number of allocated places. It is intended that this will put it beyond doubt that flexible care subsidy may be paid to the approved provider of a Multi-Purpose Service (MPS) based on the number of allocated places, rather than the actual number of care recipients on a particular day. This is designed to provide a consistent level of funding to ensure the continued availability of aged care services in small rural and remote communities served by MPSs despite natural fluctuations in demand at the local level.

Items 117 and 118
Section 54-2, which deals with accreditation standards, currently consists of two subsections. Item 117 omits '(1)' as a result of the only other subsection, subsection (2), being repealed under item 116.

Item 118 repeals subsection 54-2(2). As this subsection provides only examples of the matters with which the Accreditation Standards may deal and has no legal consequence, it is being repealed.

Items 120 and 123
Section 54-4, which deals with community care standards, currently consists of two subsections.

Item 120 omits '(1)' as a result of the only other subsection, subsection (2), being repealed under item 120.

Item 123 repeals subsection 54-4(2). As this subsection provides only examples of the matters with which the Community Care Standards may deal and has no legal consequence, it is being repealed.

Item 124
This item repeals subsection 54-5(3). As this subsection provides only examples of the matters with which the Flexible Care Standards may deal and it has no legal consequence, it is being repealed.

Item 127
This item inserts a new paragraph into the list of responsibilities of providers of home care set out in section 56-2. New paragraph 56-2(ca) provides that those care and services which an approved provider and a care recipient agree will be provided (other than those care and services which it is the provider's responsibility to provide under paragraph 54-1(1)(a) of the *Aged Care Act 1997*), must be provided in accordance with the agreement. This is consistent with the policy reflected in the *Living Longer Living Better* aged care package, that new home care packages will be provided on a consumer directed basis and that providers will deliver the services agreed in accordance with the agreement.

Item 142 and 143
Sections 66-1 and 66-2 of the *Aged Care Act 1997* set out sanctions that may be imposed on an approved provider by the Secretary where the provider has not, or is not, complying with one or more of its responsibilities under the *Aged Care Act 1997*. One of those sanctions is the revocation of the approved provider's approval as a provider of aged care services unless the provider appoints an adviser to assist the provider to comply with its responsibilities.

Item 142 adds the words 'in relation to care and services' to the end of subparagraph 66-2(1)(a)(iii). The addition of these words clarifies that when an adviser is appointed to assist an approved provider to comply with its responsibilities it is in relation to care and services the approved provider provides.

Item 143 omits from subparagraph 66-2(1)(a)(iv) the words 'administer an aged care service in respect of which the approved provider has not complied with its responsibilities' and substitutes the words 'assist the approved provider to comply with its responsibilities in relation to governance and business operations'.

These words clarify that when an administrator is appointed, their role is to assist the approved provider to comply with its responsibilities in respect of their governance and business operations.

Item 144
This item substitutes wording in paragraph 66A-1(2)(a) in respect of the establishment of the administrator panel and adviser panel. The Secretary may appoint a person to the panel if satisfied that the person has the skills and experience required to assist an approved provider to comply with their responsibilities under the *Aged Care Act 1997*. In addition, the appointee cannot be a disqualified individual (as defined in section 10A-1 of the *Aged Care Act 1997*), or in the case of a body corporate, the executive decision makers of the body corporate cannot be disqualified individuals.

The current criterion, 'that the person has at least 3 years' experience in senior positions in managing, or providing professional advice and support to an aged care service or a similar undertaking', is too broad and does not give relevant consideration to the skills a person may or may not have developed through their experience.

This amendment enables the skills and experience of the person to be considered, which better provides for the establishment of panels that constitute people who can effectively assist a provider under sanction to meet its responsibilities.

Item 145
This item repeals subsection 66A-1(2A) which requires the administrator panel and the adviser panel to include at least one medical practitioner. This requirement is repealed as it is not necessary to the constitution of the panels. The amendment ensures that appointees to the administrator panel or to the adviser panel are properly skilled and experienced to assist an approved provider under sanction to meet its responsibilities.

Item 146
This item amends subsection 66A-1(5) which deals with the procedure for resignation of appointment by a person on a panel. This amendment broadens the scope of the procedure to establish not only the requirements for resignation of a ‘person’, but also to provide for the resignation of a ‘body corporate’ from the relevant panel.

Items 147 and 148
Currently under paragraph 66A-2(1)(c) a person is eligible to be appointed as an adviser only if the person has not been one of the relevant personnel of a body whose application for approval as a provider of aged care services has been refused.

Item 148 repeals paragraph 66A-2(1)(c) to remove the barrier for relevant personnel of a body corporate whose application for approval as a provider of aged care services has been refused to be eligible for appointment as an adviser. This amendment recognises that a person could have been ‘relevant personnel’ without the authority or influence to address the issue that was the basis for the refusal to approve.

Items 147 makes a consequential change to paragraph 66A-2(1)(b) as the result of the change to paragraph 66A-2(1)(c).

Item 149 and 150
These items make the same changes, as described at items 149 and 150 in relation to advisers, to administrators.

Item 150 repeals paragraph 66A-3(1)(c) to remove the barrier for relevant personnel of a body corporate whose application for approval as a provider of aged care services has been refused to be eligible for appointment as an administrator. This amendment recognises that a person could have been ‘relevant personnel’ without the authority or influence to address the issue that was the basis for the refusal to approve.

Item 149 makes a consequential change to paragraph 66A-3(1)(b) as the result of the repeal of paragraph (c).

Items 151 and 152
Section 66A-4 describes the powers of administrators and advisers.

These items amend this section to:

- ensure that approved providers provide all relevant information required by an administrator or advisor (currently subsection 66A-4(2) only references provision of information to administrators); and

- ensure that the information provided is all relevant information required by the person to assist the approved provider to comply with its responsibilities.

Item 153
This item repeals subsections 66A-4(3) and (4) which deal with powers of certain persons appointed as administrators under section 66A-3. This is a technical amendment to repeal redundant provisions which refer to residential care standards that are no longer used under the *Aged Care Act 1997*.

Item 154
This item repeals section 66A-5 which provides interpretation of *'relevant personnel'*. This is a technical amendment which repeals the now redundant definition of '*relevant personnel'* as the term will no longer appear in Division 66A of the *Aged Care Act 1997*.

Item 155 and 156
These items amend section 69-1 which outlines what Chapter 5 is about. These items are technical amendment which remove 'community care grants', 'flexible care grants' and 'assessment grants' from the outline of Chapter 5 of the *Aged Care Act 1997*. This is because provisions relating to community care grants, flexible care grants, and assessment grants are being repealed as these grants are not used or will not be used from 1 July 2013.

Item 157
This item amends paragraph 71-2(2)(b) which refers to criteria for allocations of residential care grants as specified in section 72-2. This is a technical amendment to replace the reference to section 72-2 with a reference to 72-1(2). Section 72-2 of the *Aged Care Act 1997* will be repealed and criteria for allocations of residential care grants will be set out in the Residential Care Grant Principles.

Item 158
This item repeals paragraph 71-2(2)(d) which refers to matters of a kind specified in subsection 72-3(1). The cross reference is no longer relevant as section 72-3 is repealed from 1 July 2013. The amendments in Part 5.1 of the *Aged Care Act 1997* regarding residential care grants are intended to simplify the allocation process and remove duplication of criteria for allocation of grants.

Item 159
This item repeals subsection 72-1(2) which deals with how grants are allocated and replaces it with a new subsection that provides that the allocation must meet the criteria for allocations specified in the Residential Care Grant Principles.

Item 160
This item repeals sections 72-2 and 72-3 relating to criteria for allocations of a residential care grant and the requirement for the allocation to meet the needs of people with special needs. These criteria will appear in the Residential Care Grant Principles to improve consistency with other grants provisions and to increase flexibility, as funding needs and priorities change.

Item 161
Currently subsection 73-1(2) provides that a grant is subject to such conditions, if any, as the Secretary determines in writing. This item repeals this subsection and replaces it with a new provision that not only provides that a grant is subject to conditions determined by the Secretary but it is also subject to any other conditions detailed in the Residential Care Grant Principles.

Item 162
This item repeals section 73-2 because that section only sets out examples of matters with which the conditions of a residential care grant may deal. As this section has no legal effect, it is being repealed.

Item 163
Currently section 73-5 provides that if an approved provider applies for variation of an allocation of a residential care grant, the Secretary must within 28 days after receiving the application make a variation or reject the application and, within that period, notify the approved provider.

The section does not currently allow the Secretary to request more information and if he or she does so, to extend the timeframe to make the decision.

This item therefore repeals existing subsection 73-5(4) and replaces it with new subsections that provide that:

- if the Secretary needs further information, he or she may request the further information from the approved provider and the provider must give the information within 28 days or such shorter period specified in the notice;

- the Secretary must make the variation or reject the application within 28 days of receiving the application (if there has been no request for additional information) or if the Secretary has requested further information, within 28 days of receiving that information; and

- the Secretary must notify the approved provider in writing of the Secretary's decision.

Item 164
This item repeals subsection 74-1(3) which gives examples of matters that may be dealt with in the Residential Care Grant Principles. As this provision has no legal effect, it is being repealed.

Item 166
Item 166 repeals subsection 80-1(2) which provides examples of matters with which accreditation grants may deal. As the subsection provides examples only and has no legal consequence, it is being repealed.

Items 167 and 168
Item 168 repeals subsection 81-3(2) which gives examples of matters that may be dealt with in the Advocacy Grant Principles. As the provision gives examples only and has no legal consequence, it is being repealed.

Item 167 is consequential to item 168 and omits '(1)' as a result of subsection (2) being repealed under item 168.

Items 169 and 170
Item 170 repeals subsection 81-4(2) which gives examples of the types of conditions to which an advocacy grant may be subject. As the provision gives examples only and has no legal consequence, it is being repealed.

Item 169 is consequential to item 170 and omits '(1)' as a result of subsection (2) being repealed under item 170.

Item 171
This item amends paragraph 82-1(1)(a) which currently describes the community visitors grants program facilitating contact with the community for residential care recipients. This amendment extends the community visitor grants to include home care recipients by inserting 'or home care' at the end of the paragraph.

Item 172 and 173
Item 173 repeals subsection 82-3(2) which describes examples of matters to which criteria set out in the Community Visitor Grant Principles may relate. As the provision gives examples only and has no legal consequence, it is being repealed.

Item 172 is consequential to item 173 and omits '(1)' as a result of subsection (2), being repealed under item 173.

Items 174 and 175
Item 175 repeals subsection 82-4(2) which gives example of matters to which conditions of community visitors grants may be subject. As the provision gives examples only and has no legal consequence, it is being repealed.

Item 174 is consequential to item 175 and omits '(1)' as a result of subsection (2) being repealed under item 175.

Item 176
This item amends section 85-1 (table item 21) which lists as a reviewable decision, the decision to limit a person's approval as a care recipient to a low level of residential care. The item amends the description of the decision so that it refers to a decision to limit a person's approval to one or more levels of care. This reflects the change that is being made to section 22-2(3) so that, from 1 July 2013, approvals for any type of care may be limited to one or more levels of care.

Item 177
This item amends table item 35 in section 85-1, which lists as a reviewable decision, the decision to revoke the certification of a residential care service. The item amends the provision under which the decision is made, omitting '39-3(1)' and substituting it with '39-3(3A)'. This reflects the change to the *Aged Care Act 1997* that is being made in item 49 which inserts a new subsection 39-3(3A). The power to revoke certification is from 1 July 2013 set out in subsection 39-3(3A) and it is therefore a decision under this subsection that is reviewable.

Item 179
This item repeals table items 57 and 58 in section 85-1, which set out the reviewable decisions relating to varying an allocation, or rejecting an application to vary an allocation, of a residential care grant. The item amends the provision under which the decision is made, omitting '73-5(4)' and substituting it with '73-5(5)'. This reflects the change that is being made in item 163 which inserts subsection 73-5(5). Subsection 73-5(5) provides that the Secretary must make the variation or reject the application within 28 days of receiving the application (if there has been no request for additional information) or if the Secretary has requested further information, within 28 days of receiving that information.

Item 180
This item repeals section 85-1 (table items 59-64) which lists the reviewable decisions relating to community care grants and flexible care grants. As decisions relating to community care and flexible care grants will no longer exist from 1 July 2013, there is no longer any need to reference them in the table of reviewable decisions.

This item also introduces a new decision to the table to ensure decisions made under Principles are reviewable decisions.

Item 181
This item repeals subsection 88-2(2) which outlines examples of the kinds of records that may be specified in the Records Principles. As the provision gives examples only and has no legal consequence, it is being repealed.

Items 182 and 184
Section 96-1 describes the Aged Care Principles that may be made by the Minister.

These items repeal table items 7, 11 and 14A of section 96-1 which enables Aged Care Principles to be made with respect to assessment grants, community care grants and flexible care grants. As these types of grants will no longer exist from 1 July 2103, there is no need for any Principles to be made with respect to these matters.

Items 187 to 189
These items repeal definitions which are no longer necessary, specifically the definitions of:

- assessment grant;
- community care;
- community care agreement;
- community care grant;
- community care service;
- community care subsidy; and

- flexible care grant.

Item 190
This item inserts a number of new definitions in Clause 1 of Schedule 1, including:

home care, which has the meaning given by section 45-3 of the *Aged Care Act 1997*. Home care is care consisting of a package of personal care services and other personal assistance provided to a person not being provided with residential care.

home care agreement means an agreement referred to in section 61-1. A home care agreement is an agreement entered into by a recipient of home care and an approved provider of home care for personal care services and other personal assistance.

home care service means an undertaking through which home care is provided.

home care subsidy means a subsidy payable under Part 3.2

Items 191
This item amends existing definition of payment period in Clause 1 of Schedule 1 to replace references to 'community care' with references to 'home care'.

Part 2 – Transitional and savings provisions

Item 195
This item inserts four new definitions – commencement time, home care, old law, and new law which are used in items 196 to 199.

The term 'commencement time' refers to the time when this Schedule commences (1 July 2013).

The term 'old law' means the *Aged Care Act 1997* as in force immediately before 1 July 2013.

The term 'new law' means the *Aged Care Act 1997* as in force from 1 July 2013.

'Home care' has the same meaning as in the new law. Home care is care consisting of a package of personal care services and other personal assistance provided to a person not being provided with residential care.

Item 196
This item ensures that a provider approved to provide community care immediately prior to 1 July 2013 is taken to be approved to provide home care from 1 July 2013.

A provider approved to provide flexible care immediately prior to 1 July 2013 is taken to be approved to provide both home care and flexible care from 1 July 2013.

This will be automatic without providers needing to apply. This will result in a larger number of providers being approved for home care, but only those that have been allocated home care places will actually be providing such care.

Item 197
This item ensures that an allocation of community care places that was made prior to 1 July 2013 will be taken to be an allocation of home care places from 1 July 2013.

An allocation of certain kinds of flexible care places made prior to 1 July 2013 will also be taken to be an allocation of home care places from 1 July 2013. The relevant kinds of flexible care places will be set out in the Allocation Principles.

Item 198
This item ensures that a care recipient approved to receive community care prior to 1 July 2013 will be taken to be approved to receive level 1 or level 2 home care from 1 July 2013. These levels will be set out in Allocation Principles.

An approval to receive certain kinds of flexible care prior to 1 July 2013 will be taken to be an approval to receive any level of home care from 1 July 2013. The relevant kinds of flexible care will be specified in the Approval of Care Recipient Principles (namely Extended Aged Care at Home and Extended Aged Care at Home-Dementia).

Item 199
This item enables the Minister, by legislative instrument to make Allocation Principles or Approval of Care Recipient Principles (or to include provisions in these existing Principles) in order to give effect to these transitional and savings provisions

Schedule 2 – Amendments commencing on 1 January 2014

Part 1 – Amendments

Item 1
Section 42-4 currently provides that a residential care service meets its accreditation requirements if it has accreditation from an accreditation body (the Australian Aged Care Standards and Accreditation Agency) or if there is a determination in force under section 42-5 that the service is taken to meet its accreditation requirements. Section 42-5 determinations allow for exceptional circumstances.

From 1 January 2014 accreditation of aged care services will be undertaken by the new Australian Aged Care Quality Agency (the Quality Agency) which will replace the existing Aged Care Standards and Accreditation Agency (the Accreditation Agency).

This item therefore amends section 42-4 to provide that a residential aged care service is taken to meet its accreditation requirements if the service has accreditation from the Chief Executive Officer (CEO) of the Quality Agency.

For services that were granted accreditation by the Aged Care Standards and Accreditation Agency prior to 1 January 2014, the accreditation will be deemed to have been from the CEO of the new Quality Agency (refer item 25 of Schedule 2). This ensures that all providers do not have to renew their accreditation on 1 January 2014 but instead will follow their usual accreditation cycle.

Item 2
Currently under the aged care legislation, detailed accreditation requirements are set out in:

- the Accreditation Grant Principles 2011 – these Principles set out matters such as:
  - how providers apply for accreditation;
  - the way the Aged Care Standards and Accreditation Agency assesses applications and makes accreditation decisions;
  - what the Agency does when it identifies non-compliance; and how the Agency registers quality assessors; and

- the Quality of Care Principles 1997 – these Principles describe the Accreditation Standards with which residential aged care services must comply. These are also the Standards against which the Agency measures the performance of residential aged care services.

When the new Quality Agency is established from 1 January 2014:

- the Accreditation Grant Principles 2011 will be repealed;

- the Quality Agency Principles, to be made under the new *Australian Aged Care Quality Agency Act 2013*, will include many of the matters that were previously in the Accreditation Grant Principles 2011. For example, the Quality Agency Principles will include all of those matters that relate to how the Quality Agency will conduct accreditation assessments and make decisions including how it registers quality assessors. It is not expected that there will be any significant change to the process for accreditation that is currently adopted and described in the Accreditation Grant Principles;

- the Quality of Care Principles 1997 (made under the *Aged Care Act 1997*) will continue to describe the Accreditation Standards with which residential aged care services must comply. Again, no change is anticipated to these Accreditation Standards; and

- new Quality Agency Reporting Principles will be made under the *Aged Care Act 1997*. These Principles will describe the relationship between the new Quality Agency and the Secretary who has responsibility for administering the *Aged Care Act 1997*. In particular, these principles will describe the information that must be given by the Quality Agency to the Secretary.

Item 2 enables the making of the Quality Agency Reporting Principles under the *Aged Care Act 1997* by inserting a new section in that Act.

Section 65-1A – Information about compliance with responsibilities
This section provides that, in deciding whether an approved provider has complied or is complying with its responsibilities, the Secretary may have regard to any information provided by the CEO of the Quality Agency in accordance with the Quality Agency Reporting Principles and any other relevant information.

Subsection 65-1A(2) further provides that the Quality Agency Reporting Principles may specify the kind of information that the CEO of the Quality Agency must provide to the Secretary.

It is anticipated that these Principles would include a number of matters that are currently in the Accreditation Grant Principles 2011 that will be repealed. For example, the Quality Agency Reporting Principles will describe:

- the information that the Quality Agency must give the Secretary if the Quality Agency becomes aware of evidence of non-compliance by an approved provider; and

- the information that must be provided to the Secretary if the Quality Agency finds that an approved provider of a residential aged care service has failed to meet the Accreditation Standards.

Item 3
Section 69-1 describes the types of grants which may be made by the Commonwealth in accordance with Chapter 5 of the *Aged Care Act 1997*.

One of those types of grants is an accreditation grant. Currently an accreditation grant is paid to the Aged Care Standards and Accreditation Agency to enable it to undertake accreditation functions.

From 1 January 2014 the new Australian Aged Care Quality Agency will replace the Australian Aged Care Standards and Accreditation Agency. As a statutory agency, the new Quality Agency will be able to receive direct appropriation from Government. As such, it will no longer be necessary for the Secretary to provide a grant to the accreditation body to enable it to undertake its functions.

It is therefore unnecessary to retain the capacity, in Chapter 5, for the Secretary to make accreditation grants.

This item, therefore, amends section 69-1 to remove the reference to accreditation grants from 1 January 2014.

Item 4
This item repeals Part 5.4 of the *Aged Care Act 1997*. Part 5.4 sets out the arrangements for accreditation grants. As the new Quality Agency will be funded through a combination of Government appropriation and fees for services, it will no longer be necessary for the Secretary to make an accreditation grant to the new Agency.

Item 5
Section 84-1 summarises the content of Chapter 6 (Administration). As new provisions will be included in Chapter 6 establishing the Aged Care Pricing Commissioner, this item amends section 84-1 so that it refers to the Aged Care Pricing Commissioner, whose functions include approving accommodation payments that are higher than the maximum amount of accommodation payments determined by the Minister and approving extra service fees.

Further information about the Aged Care Pricing Commissioner is provided at item 14.

Item 6
This items amends subsection 95A-1(2) which describes the functions of the Aged Care Commissioner. The Aged Care Commissioner currently has the power to examine complaints about the conduct of the accreditation body (currently the Aged Care Standards and Accreditation Agency) relating to its responsibilities under the Accreditation Grant Principles 2011, or the conduct of a person carrying out an audit or undertaking an assessment contact under those Principles.

With the transfer of responsibility for accreditation to the new Quality Agency, staff of the Agency will be officers of the Australian Public Service. As such, it will not be necessary for the Aged Care Commissioner to examine the conduct of employees of the Quality Agency as they will be subject to the requirements of the *Public Service Act 1999* including with regard to conduct.

The item therefore repeals paragraphs 95A-1(2)(d) and (e) and replaces them with new provisions that allow the Aged Care Commissioner to:

- examine complaints about the Quality Agency's processes relating to accrediting residential care services and conducting quality reviews of home care services (as described in the *Australian Aged Care Quality Agency Act 2013*). The Aged Care Commissioner may not, however, consider a complaint about the merits of a particular decision. This is because there will be separate processes for reconsideration of accreditation and review decision along with opportunities for providers to seek review by the Administrative Appeals Tribunal; and

- examine, on the Aged Care Commissioner's own initiative, the Quality Agency's processes relating to accrediting residential care services and conducting quality reviews of home care services.

Following an examination, the Aged Care Commissioner may make recommendations to the CEO of the Quality Agency arising from the examination.

Item 7
This item amends subsections 95A-4(1) and (2).

Currently these subsections describe the remuneration arrangements for the Aged Care Commissioner and provide that:

- if no determination of remuneration has been made by the Remuneration Tribunal the Aged Care Commissioner is to be paid the remuneration prescribed by the Complaints Principles; and

- the Complaints Principles may prescribe allowances to be paid to the Aged Care Commissioner.

From 1 January 2014 there will be two Commissioners described in the *Aged Care Act 1997* – the existing Aged Care Commissioner and the new Aged Care Pricing Commissioner.

To minimise duplication and maintain consistency with respect to the matters prescribed for each Commissioner, it is proposed that all matters relating to the governance arrangements for the Commissioners will be dealt with in new Commissioner Principles. Consequently, references to the Complaints Principles in subsections 95A-4(1) and (2) are replaced with the Commissioner Principles.

Items 8 and 9
Currently section 95A-9 provides that the Aged Care Commissioner may resign his or her appointment by giving the Minister a written resignation. The drafting of this provision is not consistent with contemporary drafting practice whereby greater detail is provided about when the resignation takes effect.

These items therefore amend this section to add a new subsection (subsection 95A-9(2) which provides that the resignation takes effect on the day it is received by the Minister or, if a later day is specified in the resignation, on that later day.

This ensures that the resignation provision for the Aged Care Commissioner is consistent with that of the Aged Care Pricing Commissioner.

Item 10
This item amends section 95A-10 which describes the grounds on which the Minister may terminate the appointment of the Aged Care Commissioner. This item has been amended to align with contemporary drafting practice and to align the termination provisions for the Aged Care Commissioner with those for the Aged Care Pricing Commissioner.

The changes do not substantially affect the grounds on which the Minister may terminate the Aged Care Commissioner's appointment.

Item 11
This item makes a minor amendment to the heading of section 95A-11 to change it from 'Delegations of Aged Care Commissioner's functions' to 'Delegation of Aged Care Commissioner's functions'. This ensures that all references to delegation are consistent throughout the *Aged Care Act 1997*.

Item 12
This item amends subparagraphs 95A-12(2)(b) (ii) and (iii) which describes the matters to be included in the Aged Care Commissioner's annual report. With the establishment of the new Quality Agency, the Aged Care Commissioner will no longer review complaints about the conduct of the accreditation body relating to its responsibilities under the Accreditation Grant Principles, or the conduct of a person carrying out an audit or undertaking an assessment contact under those Principles.

Consequently, this item replaces the provision relating to the Aged Care Commissioner reporting on the number of complaints received about the conduct of the accreditation body with a provision to report on the complaints received about the

processes of the Quality Agency in undertaking its accreditation and quality review functions.

Item 13
This item amends paragraph 95A-12(2)(k) which provides that the Aged Care Commissioner must include in the annual report any other information required by the Complaints Principles. This item replaces the reference to the Complaints Principles with a reference to the new Commissioner Principles.

Item 14
This item inserts a new Part 6.7, at the end of Chapter 6, to establish the Aged Care Pricing Commissioner.

All of the provisions relating to the appointment, terms and related matters for the Aged Care Pricing Commissioner are consistent with existing provisions relating to the Aged Care Commissioner.

Part 6.7 - Aged Care Pricing Commissioner

Division 95B - Aged Care Pricing Commissioner

Section 95B-1 - Aged Care Pricing Commissioner
This section establishes the Aged Care Pricing Commissioner and provides that the functions of the Aged Care Pricing Commissioner are:

- to approve extra service fees. The Aged Care Pricing Commissioner's functions in relation to extra service fees do not commence until 1 July 2014;

- to approve an accommodation payment that is higher than the maximum amount determined by the Minister. See Schedule 2 Item 26 for further information regarding this function during the period 1 January 2014 until 30 June 2014;

- such other functions conferred on the Aged Care Pricing Commissioner by the *Aged Care Act 1997* or by any other law of the Commonwealth; and

- the functions specified in a written instrument given to the Aged Care Pricing Commissioner by the Minister.

Section 95B-2 – Appointment
The Aged Care Pricing Commissioner will be appointed by the Minister by written instrument either on a full-time or part-time basis for a term not exceeding three years. However, a person may be re-appointed for further terms, as provided for by the *Acts Interpretation Act 1901*.

Section 95B-3 - Acting appointments
The Minister may appoint a person to act as the Aged Care Pricing Commissioner when:

- there is a vacancy in the office of the Aged Care Pricing Commissioner (whether or not an appointment has previously been made to the office); or

- the Aged Care Pricing Commissioner is absent from duty, or from Australia, or is unable to perform the duties of his or her office.

A note at the end of the section draws the reader's attention to section 33A of the *Acts Interpretation Act 1901* which describes additional rules in relation to acting appointments.

Section 95B-4 - Remuneration
The Aged Care Pricing Commissioner will be paid the remuneration determined by the Remuneration Tribunal. If no determination exists, the Aged Care Pricing Commissioner will be paid the remuneration prescribed by the Commissioner Principles.

The Aged Care Pricing Commissioner will also be paid the allowances prescribed by the Commissioner Principles.

This section is subject to the *Remuneration Tribunal Act 1973*.

Section 95B-5 - Leave of absence
If the Aged Care Pricing Commissioner is appointed on a full time basis, he or she has the recreation leave entitlements determined by the Remuneration Tribunal.

The Minister may grant the Aged Care Pricing Commissioner leave of absence, other than recreation leave, on the terms and conditions as to remuneration or otherwise that the Minister determines.

If the Aged Care Pricing Commissioner is appointed on a part time basis, the Minister may grant leave of absence to the Aged Care Pricing Commissioner on the terms and conditions that the Minister determines.

Section 95B-6 - Other terms and conditions
The Aged Care Pricing Commissioner holds office on the terms and conditions (if any) in relation to matters not covered by the *Aged Care Act 1997* as determined by the Minister.

Section 95B-7 Restrictions on outside employment
If the Aged Care Pricing Commissioner is appointed on a full time basis, he or she must not engage in paid employment outside the duties of the Aged Care Pricing Commissioner's office without the Minister's approval.

If the Aged Care Pricing Commissioner is appointed on a part time basis, he or she must not engage in any paid employment that conflicts or may conflict with the proper performance of his or her duties.

Section 95B-8 - Disclosure of interests
The Aged Care Pricing Commissioner must give written notice to the Minister of all interests, pecuniary or otherwise, that the Commissioner has, or acquires, that could conflict with the proper performance of the Commissioner's functions.

This would include, for example, notification of any interests that the Aged Care Pricing Commissioner may have in any aged care service. It would also include notifying the Minister if the Aged Care Pricing Commissioner is considering any application from an approved provider that is providing aged care services to a relative or friend of the Aged Care Pricing Commissioner.

Section 95B-9 - Resignation
The Aged Care Pricing Commissioner may resign his or her appointment by notifying the Minister in writing. The resignation takes effect on the day it is received by the Minister or, if a later day is specified in the resignation, on that later day.

Section 95B-10 - Termination of appointment
The Minister may terminate the Aged Care Pricing Commissioner's appointment:

- for misbehaviour; or
- if he or she is unable to perform his or her duties because of physical or mental incapacity.

The Minister must terminate the appointment of the Aged Care Pricing Commissioner if he or she:

- becomes bankrupt; or
- applies to take the benefit of any law for the relief of bankrupt or insolvent debtors; or
- compounds with his or her creditors; or
- makes an assignment of his or her remuneration for the benefit of his or her creditors; or
- is absent, except on leave of absence, for 14 consecutive days or for 28 days in any 12 months; or
- is appointed on a full time basis and engages, except with the Minister's approval, in paid employment outside the duties of his or her office; or
- is appointed on a part time basis and engages in paid employment that conflicts or may conflict with the proper performance of the duties of his or her office; or
- fails, without reasonable excuse, to give to the Minister written notice of a conflict of interest.

Section 95B-11- Delegation of Aged Care Pricing Commissioner's functions
The Aged Care Pricing Commissioner may delegate in writing all or any of his or her functions to an Australian Public Service employee in the Department of Health and Ageing.

In delegating a function or functions, the Aged Care Pricing Commissioner must have due regard to the nature of the task or tasks being delegated, and the appropriateness of delegating to the particular employee.

A delegate who is performing functions delegated by the Aged Care Pricing Commissioner must comply with any directions of the Aged Care Pricing Commissioner.

Section 95B-12 - Annual report
The Aged Care Pricing Commissioner must, as soon as practicable after the end of each financial year, prepare and give to the Minister, for presentation to the Parliament, a report on the Aged Care Pricing Commissioner's operations during that year.

The report must include:

- the number of applications that were made during the financial year for approval to charge an accommodation payment that is higher than the maximum amount determined by the Minister;

- the number of such applications that were approved, rejected or withdrawn during the financial year;

- the number of applications that were made during the financial year for approval to charge an extra service fee; and

- any other information specified for inclusion in the report by the Commissioner Principles.

The Aged Care Pricing Commissioner's first annual report will cover only the first six months of operation, that is the period from 1 January 2014 until 30 June 2014.

Section 34C of the *Acts Interpretation Act 1901* contains extra rules about annual reports. For example, section 34C of the *Acts Interpretation Act 1901* provides that:

- where an Act requires a person to furnish a periodic report to a Minister, but does not specify a period within which the report is to be so furnished, that person shall furnish the report to the Minister as soon as practicable after the end of the particular period to which the report relates and, in any event, within six months after the end of that particular period;

- where an Act requires a person to furnish a periodic report to a Minister for presentation to the Parliament, but does not specify a period within which the report is to be presented, that Minister shall cause a copy of the periodic report to be laid before each House of the Parliament within 15 sitting days of that House after the day on which he receives the report; and

- if it is not possible to meet the time requirements, a person may apply to the Minister for an extension of the period, and the Minister may grant an extension.

Item 15
Section 96-1, table item 2, provides that the Minister may make Accreditation Grant Principles. Item 15 repeals this item of the table because, from 1 January 2014, there will no longer be any Accreditation Grant Principles. These Principles will be replaced with the new Quality Agency Reporting Principles (made under the *Aged Care Act 1997*) and also the new Quality Agency Principles made under the *Australian Aged Care Quality Agency Act 2013.*

Items 16 and 17
These items amend section 96-1 to empower the Minister to make:

- The Commissioner Principles will set out necessary governance provisions relating to both the Aged Care Commissioner and the new Aged Care Pricing Commissioner; and

- The Quality Agency Reporting Principles will describe the information to be provided by the CEO of the Quality Agency to the Secretary.

Item 18
This item makes a minor amendment to the heading of section 96-2 to change it from 'Delegations of Secretary's powers' to 'Delegation of Secretary's powers'. This ensures that all references to delegation are consistent throughout the *Aged Care Act 1997.*

Item 19
Subsection 96-2(6) currently provides that the Secretary may delegate to a body to which an accreditation grant is payable any functions of the Secretary that the Secretary considers necessary for the purposes of the grant. This section has the effect of enabling the Secretary to delegate to the Aged Care Standards and Accreditation Agency.

As the Accreditation Agency is being replaced with the new Australian Aged Care Quality Agency, changes are needed to this subsection. This item repeals the existing subsection 96-2(6) and replaces it with a new subsection that provides that the Secretary may, in writing, delegate to the CEO of the Quality Agency the functions of the Secretary that the Secretary considers are necessary for the CEO of the Quality Agency to perform his or her functions.

Items 20, 21 and 23
Items 20 and 21 repeal the definitions of 'accreditation body' and 'accreditation grant'. These terms are no longer necessary because accreditation grants will no longer be made to an accreditation body (the Aged Care Standards and Accreditation Agency) under the *Aged Care Act 1997*. Instead, a direct appropriation will be made to the new Australian Aged Care Quality Agency which is being established by the Australian Aged Care Quality Agency Bill 2013.

Consistent with this change, item 23 inserts a new definition of 'CEO of the Quality Agency' in Schedule 1 (the Dictionary) of the *Aged Care Act 1997*. The 'CEO of the Quality Agency' means the Chief Executive Officer of the Australian Aged Care Quality Agency appointed under the *Australian Aged Care Quality Agency Act 2013*.

Item 22
This item inserts into Schedule 1 of the *Aged Care Act 1997* (the Dictionary) a definition of the term 'Aged Care Pricing Commissioner' as meaning the person holding the office of the Aged Care Pricing Commissioner under Part 6.7.

Part 2 – Transitional and savings provisions

This Part describes the transitional and savings provisions relating to the amendments made by Schedule 2 of the Bill.

Item 24
This item provides five definitions for terms that are used in items 25 and 26:

- 'accreditation body' – item 24 provides that this has the same meaning as the old law. In other words, where the term is used in item 25, 'accreditation body' refers to the Aged Care Standards and Accreditation Agency;

- 'CEO of the Quality Agency' – this has the same meaning as in the new law, that is the Chief Executive Officer of the Australian Aged Care Quality Agency appointed under the *Australian Aged Care Quality Agency Act 2013;*

- 'commencement time' means the time when this Schedule commences, namely 1 January 2014;

- 'new law' means the *Aged Care Act 1997* as in force immediately after the commencement time (that is, the *Aged Care Act 1997* as in force on 1 January 2014); and

- 'old law' means the *Aged Care Act 1997* as in force immediately before the commencement time (that is, the law in force on 31 December 2013).

Item 25
This item provides that an accreditation of a residential care service by an accreditation body (namely the Aged Care Standards and Accreditation Agency) that was in force immediately before 1 January 2014 is taken, from 1 January 2014, to have been an accreditation by the CEO of the Quality Agency.

Item 26
There are a number of amendments in Schedule 3 of this Bill which describe the new arrangements relating to accommodation payments that will take effect from 1 July 2014. One of the provisions included in that Schedule enables the Minister to determine a maximum rate of accommodation payment that can be charged by an approved provider for entry into residential care on or after 1 July 2014.

Another provision enables approved providers to apply to the newly created Aged Care Pricing Commissioner to approve the charging of accommodation payments that are higher than that set in the determination made by the Minister.

If these provisions did not take effect until 1 July 2014 this would mean that there would be a period of time in which providers would be limited to the maximum set in the Determination because they would need to wait until an application had been processed by the Aged Care Pricing Commissioner before charging a higher amount of accommodation payment.

To enable the smooth implementation of the new arrangements from 1 July 2014, this item enables the Aged Care Pricing Commissioner to commence considering applications from approved providers seeking a higher accommodation payment from 1 January 2014. The Commissioner will also be able to make decisions on these applications. While the decision won't take effect until 1 July 2014, this provides certainty to providers and enables them to advertise their prices prior to 1 July 2014.

The transitional provision described in this item also enables approved providers to seek reconsideration by the Commissioner and review by the Administrative Appeals Tribunal if the approved provider is dissatisfied with a decision of the Commissioner. All reconsideration and review rights must be exercised in accordance with section 85-1 of the *Aged Care Act 1997.*

Schedule 3 – Amendments commencing on 1 July 2014

Part 1 - Amendments

Aged Care Act 1997

Item 1
From 1 July 2014, subsidies will be paid under Chapter 3 of the *Aged Care Act 1997* and also under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997.*

This is because Chapter 3 of the *Aged Care Act 1997,* which relates to subsidy, will only apply to care recipients who enter care on or after 1 July 2014, whereas Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997* will apply to care recipients who enter care before 1 July 2014 and have neither:

- ceased to be provided care for more than 28 days (other than because the person is on leave); nor
- on moving to another service providing the same type of care, chosen to have the new arrangements apply to them under Chapter 3 of the *Aged Care Act 1997.*

Similarly, the new Chapter 3A of the *Aged Care Act 1997,* which relates to fees and payments, will only apply to care recipients who enter care on or after 1 July 2014.

Those who entered care before that date (and have not left care for more than 28 days nor moved and opted to have the new arrangements apply to them) will continue to be subject to the arrangements relating to fees and payments that existed in the *Aged Care Act 1997* on 30 June 2014. These arrangements will, from 1 July 2014, be reflected in the *Aged Care (Transitional Provisions) Act 1997.*

As a result of this distinction, a number of technical and consequential changes are made throughout the *Aged Care Act 1997*.

Item 1 of Schedule 3 makes the first of these changes by inserting a new section (section 1-5) into the *Aged Care Act 1997*.

Section 1-5 Application to continuing care recipients
This section provides that Chapters 3 and 3A of the *Aged Care Act 1997* do not apply in relation to continuing care recipients. A continuing care recipient is defined in the Dictionary to the *Aged Care Act 1997* as meaning a continuing residential care recipient, a continuing home care recipient, or a continuing flexible care recipient.

A continuing residential care recipient means a person who entered a residential care service before 1 July 2014 and has not:

- ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave); or

- before moving to another residential care service, made a written choice to be covered by Chapters 3 and 3A of the *Aged Care Act 1997.*

A continuing home care recipient is further defined to mean a person who entered a home care service before 1 July 2014 and has not:

- ceased to be provided with home care by a home care service for a continuous period of more than 28 days (other than because the person is on leave); or

- before moving to another home care service, made a written choice to be covered by Chapters 3 and 3A of the *Aged Care Act 1997.*

A continuing flexible care recipient is further defined to mean a person who entered a flexible care service before 1 July 2014 and has not:

- ceased to be provided with flexible care by a flexible care service for a continuous period of more than 28 days (other than because the person is on leave); or

- before moving to another flexible care service, made a written choice to be covered by Chapters 3 and 3A of the *Aged Care Act 1997.*

Items 2 to 4
Currently, throughout the *Aged Care Act 1997* there is reference to subsidies paid in accordance with Chapter 3 of that Act.

From 1 July 2014, subsidies will be paid under Chapter 3 of the *Aged Care Act 1997* and also under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997.*

The word ‘subsidy’ has therefore been defined in item 286 to mean subsidy paid under Chapter 3 of the *Aged Care Act 1997* or under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997*.

These items amend subsection 3-1 (which provides an overview of the *Aged Care Act 1997*) so that it is clear that subsidy is payable under both the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997.*

Item 5
This item amends section 3-2 (which describes preliminary matters relating to subsidies) so that instead of referring to subsidy paid to a provider of aged care under Chapter 3 of the *Aged Care Act 1997*, it refers to subsidy paid to a provider of aged care. The definition of subsidy includes both subsidy paid under Chapter 3 of the *Aged Care Act 1997* and subsidy paid under the *Aged Care (Transitional Provisions) Act 1997*.

Items 6 and 7
These items remove the reference to Chapter 3 in the heading of section 3-3 and also changes the reference to subsidy being paid under Chapter 3 to a reference to subsidy being paid.

This change reflects the fact that subsidies are not only payable under Chapter 3 of this Act but also under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997*.

Item 8
This item inserts a new section (section 3-3A) into the *Aged Care Act 1997*.

Section 3-3A Fees and payments
This new section provides that care recipients may be required to pay for, or contribute to, the costs of their care and accommodation. Fees and payments are dealt with in Chapter 3A of this Act (for care recipients who enter care on or after 1 July 2014) and in Divisions 57, 57A, 58 and 60 of the *Aged Care (Transitional Provisions) Act 1997* (for continuing care recipients).

Item 9
This item replaces the word ‘subsidy’ with the word ‘*subsidy’ in section 3-4.

A subsidy is defined as a subsidy paid either under Chapter 3 of the *Aged Care Act 1997* or under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997*.

Items 10, 12, 14, 29, 30, 31, 32, 36, 39, 40, 43, 44, 49, 169, 218, 219, 220, 228, 229, 230, 231 and 232
From 1 July 2014, subsidies will be paid under Chapter 3 of the *Aged Care Act 1997* and also under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997.*

To ensure that, where appropriate, reference is made to both subsidy payable under the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*, the phrase ‘subsidy under Chapter 3’ is being replaced with the newly defined word ‘*subsidy’ in a number of locations throughout the *Aged Care Act 1997*. The words are replaced in:

- sections 5-1 (including the note), 6-1, 11-1, 11-4;

- subsections 12-1(1), 12-3(1), 13-2(2), 14-1(1), 15-1(1), 95-1(1);

- paragraphs 14-3(a), 14-8(2)(b), 16-11(a), 66-1(c), 88-1(5)(b), 88-3(2)(c), 93-1(3)(b), 93-4(2)(b); and

- subparagraphs 88-1(1)(a)(i), 93-1(4)(b)(ii), 93-4(3)(b)(ii).

Item 11
Section 5-1 sets out what is contained in Chapter 2 of the *Aged Care Act 1997*. Chapter 2 sets out the decisions that must be made before the Commonwealth can pay subsidy to an approved provider in respect of a care recipient. This item amends the section to provide that approved providers are able to charge accommodation payments and accommodation contributions once they are certified, thereby treating these amounts in the same way as accommodation bonds and accommodation charges.

Item 13
Section 5-2 describes those approvals that are relevant to an approved provider receiving subsidy. This item amends that section so that the section is equally applicable to circumstances where subsidy is payable under the *Aged Care Act 1997* or under the *Aged Care (Transitional Provisions) Act 1997*.

Item 15
Section 7-1 describes the preconditions to the payment of subsidy. This item amends that section so that it is clear that subsidy cannot be paid under the *Aged Care Act 1997* or the *Aged Care (Transitional Provisions) Act 1997* unless the preconditions described in section 7-1 are met.

Item 16
Section 7-2 provides that if there is a restriction on an approved provider's approval (as the result of sanctions) then subsidy can only be paid under Chapter 3 of the *Aged Care Act 1997* in respect of certain services or certain care recipients. This item replaces the reference to 'subsidy can only be paid under Chapter 3' with a more general reference to 'subsidy can only be paid' noting that subsidy is defined to mean both subsidy payable under Chapter 3 of the *Aged Care Act 1997* and subsidy payable under the *Aged Care (Transitional Provisions) Act 1997.*

Items 17 and 18
Section 9-3 establishes that an approved provider may be required to provide certain information to the Secretary that is relevant to any payments made in relation to the provision of aged care.

Subsection 9-3(1) is amended by both items 17 and 18 to reflect that payments made in relation to aged care are made under the *Aged Care Act 1997* for care recipients entering care after 1 July 2014, as well as under the *Aged Care (Transitional Provisions) Act 1997* for continuing care recipients.

Items 19 to 22
Section 9-3A currently provides that the Secretary may request approved providers or former approved providers to give the Secretary specified information about bonds and accommodation charges

These items amend that section so that an approved provider's obligation to give information also relates to refundable deposits and refundable deposit balances. Refundable deposits include both refundable accommodation deposits and refundable accommodation contributions, both of which are new types of lump sum payments for accommodation introduced through this bill.

Items 23 to 28
Section 9-3B currently provides that in certain circumstances where the Secretary has concerns about the capacity of the approved provider to refund bonds or has concerns that the provider may be using bonds for uses that are not permitted, the Secretary may request the approved provider (or former approved provider) to give the Secretary specified information about bonds.

These items amend that section so that an approved provider's obligation to give information also relates to refundable deposits and refundable deposit balances. Refundable deposits include both refundable accommodation deposits and refundable accommodation contributions.

Items 33, 35 and 37
These items replace the word 'subsidy' with the word '*subsidy' in:

- subsections 12-4(1) and (3), 12-6(1) and (2); and
- paragraph 13-2(3)(b).

This ensures that these provisions apply equally where subsidy is paid under the *Aged Care Act 1997* or under the *Aged Care (Transitional Provisions) Act 1997*. This is because the word 'subsidy' is defined in the Dictionary to the *Aged Care Act 1997* as a subsidy paid either under Chapter 3 of the *Aged Care Act 1997* or under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997*.

Items 34 and 38
Section 12-5 currently allows the Secretary to determine that a certain proportion of available places must be set aside to provide care to certain types of residents such as those requiring a particular level of care, or respite care, or those with special needs.

Similarly section 13-2 allows the Secretary to invite applications for available places that have been distributed to a region. Subsection 13-2(3) provides that the invitation must specify particular information including the proportion of available places which must be set aside to provide care to certain groups of residents.

As a result of the changes to the *Aged Care Act 1997*, a number of the terms used in sections 12-5 and 13-2 to describe groups of residents will no longer be relevant or are being changed. To ensure that all relevant groups are still considered, these items repeal existing subsection 12-5(1) and paragraph13-2(3)(e) and replace them with

provisions that provide that the Secretary may, in respect of each type of subsidy, determine for allocated places the proportion of care that must be provided to people of kinds specified in the Allocation Principles.

It is proposed that the Allocation Principles will then describe all the relevant classes of people for the purposes of allocating places. The classes of people will continue to include all of the existing classes.

Items 41 and 42
Section 14-5 deals with the conditions that the Secretary may specify in relation to allocations of places.

Subsection 14-5(5) describes some specific rules relating to the treatment of pre-allocation lump sum payments. The intent of these rules is to ensure that if a person has paid a provider a lump sum before the provider has received an allocation of places, then if the provider subsequently receives an allocation of places (and therefore Government subsidy for the care recipient) that any lump sum paid by the care recipient is to be treated as if it were an accommodation bond under the *Aged Care Act 1997*. The purpose of this provision is to ensure that care recipients have all of the protections of the *Aged Care Act 1997* in respect of any lump sums they have paid to a provider, even where this was paid before the provider commenced receiving subsidy for the care recipient.

Item 41 repeals the existing subsection 14-5(5) and replaces it with two new subsections, which ensure that the same protections exist in circumstances where an allocation of places is granted on or after 1 July 2014. Where this occurs, the pre-allocation lump sum will be treated in the same way as a refundable deposit (whereas if the allocation of places was received before 1 July 2014 then the pre-allocation lump sum is treated as an accommodation bond).

Item 42 amends the definition of pre-allocation lump sum in subsection 14-5(6) to clarify that a pre-allocation lump sum is not a refundable deposit (it is currently defined not to include an accommodation bond and this is being retained).

Item 45
This item replaces the word 'Subsidy' with the defined word '*Subsidy' in the note under subsection 15-1(2)(note).

A subsidy is defined as a subsidy paid either under Chapter 3 of the *Aged Care Act 1997* or under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997*.

Item 46
Subdivision 16-A sets out the process for transferring an allocated place from one approved provider to another. Section 16-6 sets out the information that must be included in a notice from the Secretary when approving a transfer. Paragraph 16-6(e) provides that such information must include the proportion of care, in respect of certain classes of people, that must be provided.

As a result of the changes to the *Aged Care Act 1997,* a number of the terms used in paragraph 16-6(e) to describe classes of people will no longer be relevant or are being

changed. To ensure that all relevant classes of people are still referred to, this item repeals existing paragraph 16-6(e) and replaces it with a new paragraph that provides that the notice may, in respect of each type of subsidy, determine for allocated places the proportion of care that must be provided to people of kinds specified in the Allocation Principles.

It is proposed that the Allocation Principles will then describe all the relevant classes of people for the purposes of allocating places.

Items 47 and 48
Section 16-10 describes the records that must be provided by an approved provider when places are transferred to another approved provider.

These items amend:

- paragraph 16-10(2)(d) so that instead of referring to retention amounts relating to bonds, the paragraph refers more generally to the transferor giving the transferee information about the schedule of fees and charges of care recipients. This schedule of fees and charges should include any allowable deductions, regardless of whether those deductions are retention amounts from accommodation bonds or deductions from other refundable deposits; and

- paragraph 16-10(2)(g) so that information about prudential requirements for accommodation bonds and refundable deposits must be given to another approved provider if there is a transfer of places.

Item 50
Section 16-11 deals with the effect of a transfer of places on matters such as entitlement to subsidy and approved provider responsibilities.

This item amends paragraph 16-11(b) to provide that on the transfer date any responsibilities under Part 4.2 that the transferor had immediately before the transfer date in relation to an accommodation bond balance or a refundable deposit balance (which refers to both refundable accommodation deposit balances and refundable accommodation contribution balances) connected with the place become the responsibilities of the transferee under Part 4.2.

Item 51
Subdivision 16-B sets out the process for transferring a provisionally allocated place from one provider to another. Section 16-18 sets out the information that must be included in a notice from the Secretary when approving a transfer. One of the matters that must be included is the proportion of care (in respect of the places to be transferred) to be provided to certain classes of people.

As a result of the changes to the *Aged Care Act 1997,* a number of the terms used in paragraph 16-18(e) to describe classes of people will no longer be relevant or are being changed. To ensure that all relevant classes of people are still referred to, this item repeals existing paragraph 16-18(e) and replaces it with a new paragraph that provides that the notice must, in respect of the places to be transferred, describe the

proportion of care that must be provided to people of kinds specified in the Allocation Principles.

Item 52
From 1 July 2013, it is proposed that subsection 18-2(2) be amended so that if an approved provider wishes to relinquish places, the approved provider must notify the Secretary and include in such a notification the provider's proposals for ensuring that the provider meets its responsibilities in relation to any accommodation bond balances or entry contribution balances (see Schedule 1).

This item repeals subparagraph 18-2(2)(f)(ii) and replaces it with a new subparagraph to extend this requirement to proposals for ensuring that the provider meets its responsibilities in relation to refundable deposit balances (which include both refundable accommodation deposits and refundable accommodation contributions).

Item 53
This item replaces the words 'Subsidy cannot be paid under Chapter 3' with the words '*Subsidy cannot be paid' in subsections 20-1(1) to (3).

This ensures that these provisions relate to circumstances where subsidy cannot be paid under either the *Aged Care Act 1997* or the *Aged Care (Transitional Provisions) Act 1997*. This is because the word 'subsidy' is defined in the Dictionary to the *Aged Care Act 1997* as a subsidy paid either under Chapter 3 of the *Aged Care Act 1997* or under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997*.

Item 54
This item amends section 20-1, which describes the types of approvals care recipients must be granted before subsidy can be paid.

This item amends paragraph 20-1(3)(b) to remove the words 'Flexible Care' before 'Subsidy Principles'. This is because, from 1 July 2014, the Subsidy Principles will deal with all matters relating to subsidies for all care types. There will no longer be Flexible Care Subsidy Principles.

Item 55
Section 20-2 provides that, if a person's approval as a care recipient is limited under section 22-2, then Government payments cannot be made unless the care is provided in accordance with the limitation.

This item inserts a reference to the *Aged Care (Transitional Provisions) Act 1997*, reflecting that payments in relation to the provision of aged care may also be made under that Act. Subsidies in respect of continuing care recipients will be paid under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997.*

Items 56 and 57
Section 23-1 provides, among other things, that an approval for a care recipient lapses in accordance with section 23-3. Section 23-3 currently provides that a person's approval lapses after 12 months except in special circumstances described in that section. The effect of the existing provision is that approvals for home care, residential care and flexible care will lapse. In order to promote better access to

services and improve efficiencies with respect to approvals, it is proposed that from 1 July 2014 approvals for home care and residential care will not lapse.

Items 56 and 57 therefore amend sections 23-1 and 23-3 to have this effect. Approvals will continue to lapse for certain types of flexible care because such care is more likely to be for a particular period of time or in response to a particular event in a person's life (for example, transition care).

Item 58
Section 30-1 describes Part 2.5 (extra service places). Item 58 omits the reference in section 30-1 to 'a lower amount of residential care subsidy being payable'. This is because, from 1 July 2014, residential care subsidy will not be reduced by the extra service reduction. Item 105 of this Schedule repeals the extra service reduction.

Item 59
Section 30-1 describes Part 2.5 (extra service places). Following the section, there are four notes which explain the interactions between extra service and other provisions in the *Aged Care Act 1997* including, for example, provisions relating to subsidy.

Given the substantial changes to Chapter 3 (subsidy), the notes are no longer appropriate. This item repeals the notes.

Items 60, 61 and 62
Subsection 30-3(1) provides a meaning for the term 'distinct part', which is used when determining that a place is an extra service place.

Item 60 repeals paragraph 30-3(1)(b) which requires that a distinct part include sufficient living space for the care recipients. Currently this prevents a room or rooms in a service from being granted extra service status. From 1 July 2014, extra service status will be able to be granted in respect of a room.

Item 61 provides an additional example to clarify, and put beyond doubt, that a distinct part can also include an individual resident's room in a service.

Item 62 removes the note from section 30-3(1). The note refers to the definition of a distinct part requiring living space.

Items 63 and 64
Section 32-4 provides that the Secretary must not grant an application for extra service unless certain criteria are satisfied.

One of the criteria is that granting of extra service status would not unreasonably reduce access to residential care by supported residents, concessional residents, assisted residents or anyone in a class of people specified in the Extra Service Principles.

From 1 July 2014, the terms supported, assisted and concessional residents will no longer exist in the *Aged Care Act 1997* (but will continue to exist in the *Aged Care (Transitional Provisions) Act 1997*). This item amends subsection 32-4(1) to remove references to those terms and replace them with a requirement that the Secretary must

not grant an application for extra service unless granting it would not unreasonably reduce access to residential care by people who are included in a class of people specified in the Extra Service Principles.

Item 65
Section 32-9 provides that the Secretary must notify an applicant as to whether their application for an extra service place has been successful.

This item removes the requirement for the notice given by the Secretary under subsection 32-9(1) to be given within a specified timeframe.

As applications for extra service status may be submitted and considered as part of the Aged Care Approval Rounds (ACAR), the requirement that the Secretary notify applicants within a specified time is not always consistent with the timing for the announcement of the ACAR.

Items 66, 67 and 68
Section 35-1 currently provides that a person who has been granted extra service status for a place may apply to the Secretary for approval of the fee that may be charged for that extra service place. Section 35-1 also sets out the circumstances where the Secretary must approve the proposed fees.

From 1 July 2014, the Aged Care Pricing Commissioner will take over responsibility for the approval of extra service fees.

These items remove the Secretary's power to make decisions about extra service fees, and give the Aged Care Pricing Commissioner the power to make such decisions.

Item 69
Section 35-2 sets out the requirements and format for making an application for the approval of an extra service fee under section 35-1.

As the Aged Care Pricing Commissioner will take over responsibility for the approval of extra service fees from 1 July 2014, this item replaces the reference to 'the Secretary' with a reference to the 'Aged Care Pricing Commissioner'.

Item 70
Section 35-3 currently sets out the rules that govern the extra service fee that the Secretary may approve, including minimum amounts and when a change to the amount of extra service fee may be approved.

As the Aged Care Pricing Commissioner will take over responsibility for the approval of extra service fees from 1 July 2014, this item replaces the reference to 'the Secretary' with a reference to the 'Aged Care Pricing Commissioner'.

Items 71 to 74
Section 35-4 provides that an applicant must be notified in relation to a decision on the fees for an extra service place.

Items 71, 72 and 73 replace references to 'the Secretary' with references to the 'Aged Care Pricing Commissioner'. From 1 July 2014, the Aged Care Pricing Commissioner will take over responsibility for the approval of extra service fees.

Item 74 removes the requirement that the notification of a decision on extra service fees must be given within 28 days. There will no longer be a requirement for the notice to be given within a time period. This is because applications for approval of extra service fees are often made as part of an application for extra service status under section 32-3. As applications for extra service status may be submitted as part of the ACAR, the requirement that the Aged Care Pricing Commissioner notify applicants within a specified time is not always consistent with the timing for the announcement of the ACAR. An appropriate timeframe for the notification of a decision on extra service fees where the applicant has already been granted extra service status, will be advised in further guidance to applicants.

Item 75
Section 36-4 (additional protection for existing residents) includes a note which cross-references approved provider responsibilities under paragraph 56-1(f). This item makes a consequential change to this paragraph reference to reflect changes to that section. The note will refer to paragraph 56-1(g), which describes the approved provider responsibilities to comply with requirements relating to extra service.

Item 76
This item repeals section 37-1, which describes what Part 2.6 is about, and replaces that section with a new section to better describe Part 2.6, including the changes within the Part.

Section 37-1 What this Part is about
This section indicates that Part 2.6 describes how a residential care service is certified and the circumstances in which certification ceases to have effect.

Item 77
Section 38-6 provides that if a residential care service has been certified, the Secretary must give the relevant provider a notice setting out a range of matters. One of the matters to be included in the notice is the consequence of failure by the approved provider to meet its responsibilities relating to accommodation bonds and charges, and that failure to comply may lead to revocation or suspension of the certification.

From 1 July 2014, providers will not only have responsibilities in relation to accommodation bonds and charges (for care recipients who entered care before 1 July 2014) but will also have responsibilities relating to accommodation payments and accommodation contributions paid by care recipients who enter care on or after 1 July 2014.

Rather than simply amend this section to refer to the additional responsibilities in relation to the new types of accommodation payments, the opportunity has also been taken to address an anomaly in the section whereby it does not also reference all responsibilities of the provider which, if not complied with, may lead to revocation or suspension of certification.

Item 77 therefore repeals paragraph 38-6(2)(d) and replaces it with a new paragraph that provides that the notice given by the Secretary to the approved provider must detail the consequences of the approved provider failing to comply with any of its responsibilities under Parts 4.1. 4.2 or 4.3 of the *Aged Care Act 1997*, any of which may lead to revocation or suspension of certification.

Item 78
This item amends the description of Chapter 3, which deals with residential care subsidy, home care subsidy and flexible care subsidy that the Commonwealth pays to approved providers. This item clarifies that Chapter 3 only relates to subsidies paid under the *Aged Care Act 1997*, and that subsidies will also be paid under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997*.

Items 79, 80, 81, 82, 83, 86, 88, 89, 90, 91, 92, 93, 94, 97, 102, 106, 108, 111, 112, 113, 128, 173, 175, 176, 177 and 237
These items amend those sections of the *Aged Care Act 1997* which refer to the Residential Care Subsidy Principles. From 1 July 2014, the Residential Care Subsidy Principles, Flexible Care Subsidy Principles and Home Care Subsidy Principles (currently known as the Community Care Subsidy Principles but being changed on 1 July 2013) will be consolidated into one set of Principles – the Subsidy Principles.

This will mean that all information in relation to the payment of Government subsidy to approved providers under the *Aged Care Act 1997* in respect of care recipients will be dealt with in one location.

These items therefore replace the references to Residential Care Subsidy Principles with references to Subsidy Principles in the following provisions:

- sections 41-2 (including heading and note), 70-2 (heading), 70-2 (note);
- subsections 42-5(1), 43-1(3), 43-3(4), 43-6(3), 43-8(2) and (4), 44-20(5) and (6), 44-20(8), 44-24(5), 44-24(11), 74-1(1);
- paragraphs 41-3(1)(b), 41-3(2)(d), 42-2(3A)(b), 42-3(3)(b), 42-5(3)(d), 43-2(b), 44-3(3)(e), 44-30(2)(a), 73-1(2)(b) (as amended on 1 July 2013), 96-2(5)(b); and
- subparagraphs 44-24(6)(c)(ii) and (7)(b)(ii).

Item 84 and 85
Section 42-1 sets out the circumstances under which an approved provider is eligible for a residential care subsidy in respect of a care recipient. Included in these circumstances is the requirement that the approved provider must actually be providing care for the particular care recipient at that particular time.

Subsection 42-1(4) currently describes an exception to this rule. Where a care recipient enters low level residential care and subsequently requires a high level of residential care, and has to move to a new provider because the initial provider does not provide high care, both the original provider and second provider are eligible for a Government subsidy. This is referred to as ‘high dependency leave’.

Item 85 removes this exception for care recipients entering care from 1 July 2014, as there will no longer be a distinction between high and low care.

The *Aged Care (Transitional Provisions) Act 1997* will retain the existing provisions for the limited circumstances it applies to continuing care recipients.

As a consequence of the repeal of subsection 42-1(4), item 84 removes the cross reference to subsection 42-1(4) that is in paragraph 42-1(2)(c).

Item 87
Section 42-2 describes the circumstances under which a care recipient, who is absent from a residential care service is to be taken to be on leave. When a care recipient is on leave under these circumstances it is treated as if they are still being provided with residential care by the approved provider.

Section 42-3 describes how to work out these periods of leave.

This item amends subsection 42-3(3), which describes how to work out periods of leave with respect to pre-entry leave. The existing subsection does not expressly refer to pre-entry leave. As 'pre-entry leave' is a term that is well known in the aged care industry, this subsection is amended to include the term so as to clarify the purpose of the subsection.

Item 95
This item amends section 43-6 which describes when capital repayment deductions apply in respect of a residential care service. Subsection 43-6(5) defines capital payment as a residential care grant or a payment of a kind specified in the Residential Care Subsidy Principles. This subsection is amended by replacing the reference to the Residential Care Subsidy Principles with a reference to the new Subsidy Principles. While amending this subsection to refer to the new Subsidy Principles, the opportunity has also been taken to correct the numbering of this subsection.

Item 96
Subsection 43-8(1) allows deductions from a Government subsidy if conditions that apply to the places that have been allocated to an approved provider are not met. Currently, the conditions include providing a proportion of places to supported, concessional and assisted residents.

From 1 July 2014, the terms supported, assisted and concessional residents will no longer exist in the *Aged Care Act 1997* (but will continue to exist in the *Aged Care (Transitional Provisions) Act 1997*). This item amends 43-8(1) to remove references to those terms, and replace them with a requirement that non-compliance deductions apply if conditions specified in the Subsidy Principles, to which the allocation of places is subject, have not been met.

Item 98
Section 44-2 of sets out how to calculate the amount of residential care subsidy payable by the Government to an approved provider in respect of a care recipient. This item repeals existing Step 4 from the residential care subsidy calculator as it is no longer required.

Step 4 reduces the amount of Government subsidy payable by an amount calculated under an income test. This is in addition to the other reductions in subsidy (Step3). Under the *Living Longer Living Better* reforms, the residential care subsidy is reduced by an amount based on the care recipient's means, both income and assets. This amount is referred to as a 'care subsidy reduction' and is included in the residential care subsidy calculator at Step 3 (reductions in subsidy).

Item 99
This item renumbers Step 5 of the residential care subsidy calculator as a consequence of the removal of Step 4 in the residential care subsidy calculator.

Items 100 and 101
Section 44-3 sets out how the basic subsidy amount for a care recipient is calculated, and the circumstances the Minister may consider when determining different amounts. These circumstances are listed in subsection 44-3(3).

Items 100 and 101 amend subsection 44-3(3) to remove the circumstances that will no longer apply to care recipients entering care from 1 July 2014. That is, from 1 July 2014 the basic subsidy amount will no longer be influenced by:

- whether the care recipient is receiving a high or low level of care, as there will no longer be a distinction;
- the time at which the care recipient entered care; or
- the State or Territory where the service is located.

Item 103
This item repeals sections 44-5 to 44-16.

These sections currently deal with:

- primary supplements (section 44-5). This item replaces existing 44-5 with a new section describing the relevant primary supplements from 1 July 2014 (refer discussion below);
- the accommodation supplement (currently section 44-5A). This section will be repealed because from 1 July 2014 the accommodation supplement will be an 'other' supplement rather than a primary supplement. The replacement provisions relating to the accommodation supplement are described at item 125. Accommodation supplement will also continue to be able to be paid for continuing residents as the supplement will be retained in the *Aged Care (Transitional Provisions) Act 1997*;
- the meaning of supported resident (section 44-5B), post-2008 reform resident (section 44-5C), pre-2008 reform resident (section 44-5D), concessional resident (section 44-7), assisted resident (section 44-8), charge exempt resident (section 44-8B) and pre-entry leave (section 44-5E) and people taken not to be supported concessional or assisted residents (section 44-a). These terms will not be relevant

to care recipients who enter care on or after 1 July 2014 and these sections are therefore no longer necessary in the *Aged Care Act 1997*. The sections are however being retained in the *Aged Care (Transitional Provisions) Act 1997* to enable subsidy to continue to be paid to care recipients who were in permanent residential care on 30 June 2014 and remain subject to the existing arrangements for subsidy;

- the concessional resident supplement (section 44-6) and charge exempt resident supplement (section 44-8A). These supplements will not be relevant to care recipients who enter care on or after 1 July 2014 and the sections are therefore being removed from the *Aged Care Act 1997*. These supplements will remain relevant to care recipients who entered care before 1 July 2014 and are therefore being retained in the *Aged Care (Transitional Provisions) Act 1997*;

- how to work out assets and make determinations relevant to the supplements (sections 44-8AA, 44-8AB, 44-10, 44-11 and 44-15). These provisions are being replaced with new provisions adapted to the way that subsidy will be calculated from 1 July 2014 under Chapter 3 of the *Aged Care Act 1997.* The existing provisions will be retained in the *Aged Care (Transitional Provisions) Act 1997* for continuing residents; and

- the respite supplement (section 44-12), the oxygen supplement (section 44-13), the enteral feeding supplement (section 44-14), and additional primary supplements (section 44-16). All of these supplements will continue to exist for both care recipients who entered care before 1 July 2014 and those that entered care after 1 July 2014. Currently the eligibility for these supplements is described partly in the *Aged Care Act 1997*, partly through Principles and partly through Determinations. The value of the supplement is described either in the Principles or in Determinations. In order to achieve greater consistency and better enable providers and care recipients to navigate the regulatory framework, it is proposed that:

  - only two supplements will remain in the *Aged Care Act 1997* – the accommodation supplement and the hardship supplement. These will stay in that Act because a number of other provisions in the Act rely on these concepts; and

  - one set of Principles (the Subsidy Principles) will describe the eligibility for all other supplements. Determinations will describe the value of all supplements. This will also provide flexibility to adjust eligibility to meet care needs and also to enable the value of supplements to be indexed without needing to amend the *Aged Care Act 1997*.

For continuing care recipients these supplements will be paid in accordance with the *Aged Care (Transitional Provisions) Act 1997*. In addition to repealing sections 44-5 to 44-16, item 103 also inserts a new section.

Section 44-5 Primary supplements
This section provides that the primary supplements for each care recipient are whichever of the following that apply to that care recipient:

- the respite supplement, the oxygen supplement and the enteral feeding supplement. These are all existing supplements and will be described in detail in the Subsidy Principles;

- the dementia supplement. This is a new supplement to provide additional financial assistance for dementia care in recognition of the additional costs involved. This supplement will commence from 1 July 2013 (enabled through amendments to Principles) but will be mentioned in the *Aged Care Act 1997* from 1 July 2014 when the broader changes are being made to the sections relating to subsidy and supplements;

- the veterans' supplement. This is also a supplement that will become available from 1 July 2013. The supplement is designed to support veterans with mental health conditions;

- the workforce supplement. This supplement will support providers to attract and retain sufficient numbers of skilled and trained workers. Like the dementia and veterans' supplements, the workforce supplement will be available to eligible providers from 1 July 2013, but will be included in new section 44-5 from 1 July 2014; and

- any other primary supplement set out in the Subsidy Principles.

The section further provides that:

- Subsidy Principles may specify, in respect of each primary supplement, the circumstances in which the supplement will apply. In other words, the Principles are intended to describe the eligibility for each supplement; and

- the Minister may determine by legislative instrument the amount of each supplement, or the way in which it is to be worked out.

Item 104
Section 44-17 sets out the reductions to be included at Step 3 of the residential care subsidy calculator.

This item amends section 44-17 to remove the 'extra service reduction' , and add the 'care subsidy reduction'.

From 1 July 2014, a care recipient entering an extra service place will not have the Government subsidy payable on their behalf reduced by the extra service reduction (25 per cent of the extra service fee) (see item 105).

The care subsidy reduction takes account of the amount the care recipient can be asked to pay as a means tested care fee (see item 110).

The adjusted subsidy reduction and the compensation payment reduction will continue to be set out in section 44-17.

Item 105
This item repeals the extra service reduction (section 44-18).

Currently, where a care recipient is in an extra service place, the Government reduces the subsidy it pays to an approved provider on a care recipient's behalf by 25 per cent of the extra service fee. This is the extra service reduction.

From 1 July 2014, the Government subsidy is no longer reduced based on the extra service fee.

Item 107
Section 44-20 describes the compensation payment reduction. Subsection 44-20(8) provides that references in the section to the costs of providing residential care do not include amounts paid by way of accommodation bond, except to the extent provided in the Residential Care Subsidy Principles (item 108 amends this item so that, from 1 July 2014, the provision refers to the Subsidy Principles).

Item 107 amends subsection 44-20(8) so that it refers to refundable deposits (which include refundable accommodation deposits and refundable accommodation contributions). The existing provision is retained in the *Aged Care (Transitional Provisions) Act 1997*.

This amendment ensures that refundable deposits are treated in the same way as accommodation bonds for the purposes of working out the compensation payment reduction.

Item 109
Subdivision 44-E currently sets out the income test and the income test calculator which reduces the amount of residential care subsidy paid by the Government.

The new means test introduced as part of the *Living Longer Living Better* reforms introduces a new care subsidy reduction which replaces the existing income tested reduction for new care recipients entering care from 1 July 2014.

This item removes the heading 'Subdivision 44-E – The income test' as it is no longer needed. Subdivision 44-D – Reductions in Subsidy, better describes the operation and effect of the provisions that will exist from 1 July 2014.

Item 110
This item inserts new sections that:

- provide the Secretary with powers to obtain information on compensation amounts being received by a care recipient;
- establish the care subsidy reduction;
- establish the means tested amount calculator; and
- describe circumstances in which the care subsidy reduction is taken to be zero (such that the care recipient does not pay any means tested care fee).

Section 44-20A Secretary's powers if compensation information is not given
Section 44-20A establishes powers for the Secretary to obtain information on compensation amounts a care recipient is believed to be receiving.

If there are reasonable grounds for the Secretary to believe a care recipient is receiving a compensation amount, and the Secretary has insufficient information to apply section 44-20, this section enables the Secretary to require the care recipient to provide information about the compensation payment. Information obtained under this section would be used in determining the compensation payment reduction amount in accordance with the Subsidy Principles (section 44-20 sets out the parameters for calculating the amount). At the time of requesting the information, the Secretary will specify the timeframe in which the information must be provided. If the information is not provided within this timeframe the Secretary may determine compensation payment reductions for the care recipient. The amount of subsidy and primary supplements payable on behalf of a care recipient is reduced by any compensation amounts which the care recipient is receiving where the compensation takes into account the cost of providing residential care.

Section 44-21 The care subsidy reduction
The *Living Longer Living Better* reforms introduce a strengthened means test whereby both a care recipient's assets and income will be used to determine the maximum means tested care fee he or she can be asked to pay. The amount of funding provided by Government in respect of the care recipient is reduced accordingly and is known as the care subsidy reduction.

Section 44-21 establishes the care subsidy reduction calculator and safeguards to limit the amount of means tested care fee a care recipient can be asked to pay.

Care subsidy reduction calculator

Step 1. Work out the ***means tested amount*** for the care recipient.

Step 2. Subtract the ***maximum accommodation supplement amount*** for the day from the means tested amount.

Step 3. If the amount worked out under Step 2 does not exceed zero, the ***care subsidy reduction*** is zero.

Step 4. If the amount worked out under Step 2 exceeds zero but not the sum of the following, the ***care subsidy reduction*** is the amount worked out under Step 2:
(a) the basic subsidy amount for the care recipient;
(b) all primary supplement amounts for the care recipient.

Step 5. If the amount worked out under Step 2 exceeds the sum of the following, the ***care subsidy reduction*** is that sum:
(a) the basic subsidy amount for the care recipient;
(b) all primary supplement amounts for the care recipient.

Care subsidy reduction

The care subsidy reduction reduces the amount of Government subsidy and primary supplements payable to an approved provider in respect of a care recipient. It is included at Step 3 of the residential care subsidy calculator (item 104).

An approved provider is able to recoup the amount by which the Government payment has been reduced by charging the care recipient a means tested care fee (see section 52C-3). The means tested care fee cannot be greater than the care subsidy reduction.

Step 1 of the calculator refers to the means tested amount which is determined by the means tested amount calculator. This calculator is established under section 44-22.

At Step 2 this means tested amount is compared to the maximum daily accommodation supplement.

Subsection 44-21(6) defines the term maximum accommodation supplement amount. The maximum accommodation supplement is the highest amount of accommodation supplement that could be paid, as determined by the Minister. Under the new arrangement this will be payable to services that are either new or significantly refurbished on or after 20 April 2012. It is not the highest amount that a particular service is entitled to receive. Nor is it the amount payable in respect of a care recipient based on his or her means.

The comparison to the maximum accommodation supplement amount determines whether a care subsidy reduction will be applied for a care recipient. However the actual amount of accommodation supplement paid by Government will be influenced by the means of the care recipient and the status of the building. Different levels of accommodation supplement will be determined by the Minister. Further information about the accommodation supplement is at section 44-28.

- If the means tested amount is less than or equal to the accommodation supplement then the care subsidy reduction will be zero, and the care recipient cannot be asked to pay a means tested care fee (Step 3).

- If the means tested amount is more than the accommodation supplement there will be a care subsidy reduction and the care recipient can be asked to pay a means tested care fee.

- The care subsidy reduction (and maximum means tested care fee) will be the difference between the means tested amount and the accommodation supplement (Step 4), unless, this is more than the sum of the basic subsidy amount and primary supplements for the care recipient. In this case the care subsidy reduction (and maximum means tested care fee) would be the sum of the basic subsidy amount and primary supplement. The care recipient never pays more than the sum of the basic subsidy and all primary supplements (Step 5) that is, the cost of care for that resident.

Annual and lifetime caps

Safeguards are also established to limit the amount of means tested care fees a care recipient can be asked to contribute over time.

- Subsection 44-21(4) has the effect of capping the amount that a care recipient pays in means tested care fees in a year through an annual cap. The level of the annual cap is set by the Minister.

- Subsection 44-21(5) has the effect of capping the amount that a care recipient pays in means tested care fees during their time in, any residential care, flexible care or home care service. This is also set by the Minister.

The care subsidy reductions for a particular care recipient will be tracked by Government. When the total over a year exceeds the annual cap, the care subsidy reduction will be reduced to zero for the remainder of the year. The care recipient pays no additional means tested care fees that year. For the purposes of the caps, a year commences from the date on which a care recipient first enters care, either residential or home care, or an anniversary of that date.

Similarly when the lifetime cap is reached the care subsidy reduction is set to zero and the care recipient pays no additional means tested care fees. The lifetime cap continues to apply even if a care recipient spends time out of care.

Where the approved provider charges a lower means tested care fee than the maximum allowed under the law (ie the care subsidy reduction), the annual and lifetime caps will still have been met once the accrued care subsidy reductions exceed the relevant amounts.

The annual and lifetime caps do not apply to reductions in subsidy as a result of the income test for continuing care recipients. That is, the new caps do not apply to continuing care recipients. The annual and lifetime caps also do not apply to reductions in subsidy calculated for a pre-1 July 2014 period.

> *Example – Application of the annual cap in residential care*
> Assume that the annual cap for the year 1 July 2014 to 30 June 2015 is $25,000.
>
> *Example 1:*
> Annie enters residential care on 2 July 2014.
> Based on her care needs, Annie's care costs (the sum of the basic subsidy amount and all relevant primary supplements) are $150 per day. The care subsidy reduction calculated for Annie based on her means tested amount is $74.63. The Government reduces the amount it pays for Annie's care by $74.63 per day. The approved provider is able to recoup the care subsidy reduction by charging Annie a means tested care fee up to $74.63.
>
> If Annie is charged a means tested fee of $74.63 per day Annie will have paid $25,000 in means tested care fees by 2 June 2015.

From 3 June 2015, the care subsidy reduction will be set to zero and Annie will pay no additional means tested care fees for the rest of that year, that is, until 2 July 2015. The Government will pay the full value of $150 per day until the anniversary of Annie's entry into care.

If Annie's provider only charged her $50 per day in means tested care fee, her care subsidy reduction would still be set to zero from 3 June 2015. Annie's provider would not be able to charge Annie a means tested care fee for the period 3 June 2015 to 2 July 2015.

Section 44-22 Working out the means tested amount

Section 44-22 establishes a means tested amount calculator which determines the means tested amount. The means tested amount is the maximum amount by which Commonwealth Government funding is reduced.

The means tested amount will determine whether the individual will contribute towards their care costs and if so by how much. It is also used to determine whether or not the care recipient can be charged an accommodation payment or an accommodation contribution.

Means tested amount calculator

Work out the ***income tested amount*** using steps 1 to 4:

Step 1. Work out the care recipient's total assessable income on a yearly basis using section 44-24.

Step 2. Work out the care recipient's total assessable income free area using section 44-26.

Step 3. If the care recipient's total assessable income does not exceed the care recipient's total assessable income free area, the ***income tested amount*** is zero.

Step 4. If the care recipient's total assessable income exceeds the care recipient's total assessable income free area, the per day ***income tested amount*** is 50% of that excess divided by 364.

Work out the ***per day asset tested amount*** using steps 5 to 10:

Step 5. Work out the value of the care recipient's assets using section 44-26A.

Step 6. If the value of the care recipient's assets does not exceed the ***asset free area***, the ***asset tested amount*** is zero.

Step 7. If the value of the care recipient's assets exceeds the ***asset free area*** but not the ***first asset threshold***, the ***asset tested amount*** is 17.5% of the excess.

Step 8. If the value of the care recipient's assets exceeds the first asset threshold but not the ***second asset threshold***, the ***asset tested amount*** is the sum of the following:

(a) 1% of the excess;
(b) 17.5% of the difference between the asset free area and the first asset threshold.

Step 9. If the value of the care recipient's assets exceeds the second asset threshold, the ***asset tested amount*** is the sum of the following:
(a) 2% of the excess;
(b) 1% of the difference between the first asset threshold and the second asset threshold;
(c) 17.5% of the difference between the asset free area and the first asset threshold.

Step 10. The ***per day asset tested amount*** is the asset tested amount divided by 364.

The means tested amount is calculated by adding the income tested amount and the per day asset tested amount.

The income tested amount is 50 per cent of a care recipient's total assessable income above the total assessable income free area divided by 364.

To calculate the per day asset tested amount the following amounts are added together then divided by 364:

- 17.5 per cent of a care recipient's assets above the asset free area up to the first asset threshold; plus

- 1 per cent of a care recipient's assets above the first asset threshold up to the second asset threshold; plus

- 2 per cent of a care recipient's assets above the second asset threshold.

Any or all of these amounts may be zero, depending on the care recipient's assets. The asset free area is an amount equal to 2.25 times the basic age pension or an amount calculated in accordance with the Subsidy Principles. The first asset threshold and the second asset threshold are amounts determined by legislative instrument.

Examples:
The following assumptions are made for the following examples (parameters based on prices current at the announcement of the *Living Longer Living Better* reforms):

- The **total assessable income free area** is $22,701
- The **asset free area** is $40,500
- The **first asset threshold** is $144,500
- The **second asset threshold** is $353,500
- The **maximum accommodation supplement** is $50 per day
- The **annual cap** is $25,000

- The value of the principal residence is capped at $144,500. The principal residence is not considered an asset if occupied by a protected person (as currently).

Example 1:
Amelia is entering a residential care facility on 4 July 2014. Amelia receives the full age pension and has assets valued at $120,000. Amelia's means tested care fees are calculated as follows, based on the means tested amount calculator:

Working out the income tested amount
Step 1: Amelia's total assessable income is $19,643 per annum.

Step 2 and 3: The total assessable income free area is $22,701 per annum. As Amelia's total assessable income is less than the total assessable income free area, the income tested amount is zero.

Working out the per day asset tested amount
Step 5: Amelia's assets are valued at $120,000.

Steps 6 and 7: Amelia's assets exceed the asset free area which is $40,500, but do not exceed the first asset threshold. The asset tested amount is as follows:

0.175 x (120,000 – 40,500) = $13,912.50
Asset tested amount = $13,912.50

(Steps 8 to 9 do not apply as Amelia's assets are not greater than the first asset threshold.)

Step 10: Amelia's per day asset tested amount is $13,912.50/364, which is $38.22 (rounded to the nearest cent).

Amelia's means tested amount is her income tested amount (zero) plus her per day asset tested amount ($38.22) Amelia's means tested amount can then be used in the care subsidy reduction calculator to calculate the amount (if any) by which Amelia's means reduce the amount paid by the Government on her behalf. The care subsidy reduction calculator operates as follows:

Step 1: Amelia's means tested amount is $38.22.

Step 2 and Step 3: The maximum accommodation supplement is subtracted from the means tested amount = $38.22 - $50 = ($11.78).

As this amount is not greater than zero, the care subsidy reduction is zero. Amelia cannot be asked to make a means tested contribution towards her care costs.

Example 2:
Peter is entering a residential care facility on 30 August 2014. Peter's assets are valued as $1,344,500, which includes the capped value of Peter's former

principal residence ($144,500 (2012 value)). Peter's annual assessable income is $65,000. Peter's means tested care fees are calculated as follows based on the means tested amount calculator:

Working out the income tested amount
Step 1: Peter's total assessable income is $65,000 per annum.

Step 2: The total assessable income free area is $22,701 per annum.

Step 3: Peter's total assessable income is above the total assessable income free area. The excess is the difference between the two = $42,299.

Step 4: The income tested amount is 50 per cent of this excess calculated on a daily basis.
=0.5 x $42,299/364
=$21,149.50/364
=$50.10 (rounded to the nearest cent).

Working out the per day asset tested amount
Step 5: Peter's assets are valued at $1,344,500

Step 6: Peter's assets exceed the asset free area which is $40,500.

Steps 7 to 9: As Peter's assets exceed the second asset threshold the asset tested amount is as follows:
= 0.175 x (144,500 – 40,500)
= $18,200
+
= 0.01 x (353,500 – 144,500)
= $2,090
+
= 0.02 x (1,344,500 – 353,500)
= 19,820

Asset tested amount = $40,110.00

Step 10: Peter's per day asset tested amount is $40,110/364, which is $110.19 (rounded to the nearest cent).

Peter's means tested amount is the sum of the income tested amount and the per day asset tested amount ($50.10 + $110.19) which is $160.29.

Peter's means tested amount can then be used in the care subsidy reduction calculator to calculate the amount by which Peter's means reduce the amount to be paid by the Government on his behalf. The care subsidy reduction calculator operates as follows:

Step 1: Peter's means tested amount is $160.29.

Step 2 and Step 3: The maximum accommodation supplement is subtracted from the means tested amount = $160.29 - $50 = $110.29 (as the fee that is being derived is the fee in respect of care).

As this amount is greater than zero, there will be a care subsidy reduction and Peter will need to pay a means tested care fee to contribute to his care costs. However, the amount of care subsidy reduction will be no greater than the actual cost of Peter's care. The annual cap will mean that Peter pays no more than $25,000 in means tested care fees in a year. Peter would also pay an amount for his accommodation.

Example 3:
Mary is entering a residential care facility on 10 October 2014. Mary receives a part pension and has assets valued at $60,500. Mary's means tested care fees are calculated as follows based on the means tested amount calculator:

Working out the income tested amount
Step 1: Mary's total assessable income is $39,000 per annum.

Step 2: The total assessable income free area is $22,701 per annum.

Step 3: Mary's total assessable income is above the total assessable income free area. Her assessable income exceeds the income free area by $16,299.

Step 4: The income tested amount is 50 per cent of the excess calculated on a daily basis.
=0.5 x $16,299/364
=$8,149.50/364
=$22.39 (rounded to the nearest cent).

Working out the per day asset tested amount
Step 5: Mary's assets are valued at $60,500.

Steps 6 and 7: Mary's assets exceed the asset free area which is $40,500, but not the first asset threshold. The asset tested amount is as follows:

= 0.175 x (60,500 – 40,500)
= $3,500
Asset tested amount = $3,500

(Steps 8 to 9 do not apply as Mary's assets are not greater than the first asset threshold)

Step 10: Mary's per day asset tested amount is $3,500/364, which is $9.62 (rounded to the nearest cent).

Mary's means tested amount is the sum of the income tested amount and the per day asset tested amount ($22.39 + $9.62) which is $32.01.

Mary's means tested amount can then be used in the care subsidy reduction calculator to calculate the amount (if any) by which Mary's means reduce the amount to be paid by the Commonwealth Government on her behalf. The care subsidy reduction calculator operates as follows:

Step 1: Mary's means tested amount is $32.01.

Step 2 and Step 3: The maximum accommodation supplement is subtracted from the means tested amount = $32.01 - $50.

As this amount is not greater than zero, the care subsidy reduction is zero. Mary cannot be asked to make a means tested contribution towards her care costs.

Section 44-23 Care subsidy reduction taken to be zero in some circumstances

This section provides for circumstances when the care subsidy reduction will be zero. Where a care subsidy reduction is zero, the care recipient to whom it relates cannot be asked to pay a means tested care fee.

The care subsidy reduction will be set to zero where a care recipient is being provided with respite care, where the Secretary has made a determination in accordance with the Subsidy Principles or where the care recipient is in a class of care recipients specified in the Subsidy Principles.

This provision is intended to operate in a similar way to existing section 44-22, which will be repealed from 1 July 2014 and replaced with this new section for care recipients who enter care on or after 1 July 2014. Section 44-22 will be retained in the *Aged Care (Transitional Provisions) Act 1997* for care recipients who are continuing care recipients.

An example of a class of care recipient that is prescribed in Principles and does not pay a means tested care fee is former prisoners of war.

Subsection 44-23(7) states that a determination made under this section is not a legislative instrument. This subsection is included to assist readers and clarify that the determination is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Items 114, 115, 116 and 117

Section 44-26 currently contains three methods for calculating a care recipient's total assessable income free area: a specific rule for protected residents; a specific rule for phased residents; and a general rule for all other care recipients.

As care recipients entering care after 1 July 2014 will not be defined as protected or phased residents only one rule, the general rule, is required for calculating the total assessable income free area for these residents. The general rule for determining the total assessable income free area will apply to all care recipients entering care on or after 1 July 2014.

Item 117 repeals subsections 44-26(2) to (6) which set out the rules for calculating the total assessable income free area for protected residents and phased residents. The rules for calculating the total assessable income free area for protected residents and phased residents are retained in the *Aged Care (Transitional Provisions) Act 1997* for continuing care recipients.

Items 114, 115 and 116 make consequential amendments and respectively remove the heading 'General Rule', renumber the subsections and remove the exemption from the application of the general rule to protected and phased residents.

Item 118
This item inserts sections 44-26A, 44-26B and 44-26C into the *Aged Care Act 1997*. These sections enable the valuation of a care recipient's assets for the purposes of the means tested calculator.

Section 44-26A The value of a person's assets
Currently, the value of a person's assets is determined in accordance with section 44-10 for a number of specific purposes, including whether the care recipient is a supported resident, concessional resident, or assisted resident and the amount of accommodation supplement payable. This Bill repeals section 44-10 (see item 103).

Section 44-26A sets out the method for determining the value of a person's assets. The method is largely unchanged from section 44-10 with the following exceptions.

- Subsection 44-26A(1) provides that the value of a care recipient's assets, for the purposes of calculating the means tested amount under section 44-22, is worked out in accordance with the Subsidy Principles rather than the Residential Care Subsidy Principles. Provisions in the Residential Care Subsidy Principles will be consolidated along with other Principles into new Subsidy Principles.

- Subsection 44-26(5) provides that a refundable deposit balance is included as an asset. This is consistent with current treatment of accommodation bonds.

- Subsection 44-26(7) limits the value of a care recipient's former principal residence where it is being included in the asset test. If the house is not occupied by a protected person, it will be included in the asset test up to a maximum value amount determined by the Minister in a legislative instrument.

Subsection 44-26A(10) states that the determinations made under paragraphs 44-26A(2)(a), (2)(b), (3)(a) or (3)(b) or subsection (4) are not legislative instruments. This subsection is included to assist readers and clarify that the determinations are not legislative instruments within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Section 44-26B Definitions relating to the value of a person's assets
Section 44-26B includes definitions used to determine the value of a person's assets. These definitions are existing definitions in the *Aged Care Act 1997* other than the definition of the 'maximum home value'.

'Maximum home value' is defined as an amount determined by the Minister by

legislative instrument. The ‘maximum home value’ caps the value of the family home, which is included as an asset when it is not occupied by a protected person.

Section 44-26C Determination of value of person’s assets
Section 44-26C provides that a person may request that the Secretary make a determination of the person’s assets in accordance with section 44-26A. The request must be made in the approved form and the person must give the Secretary sufficient information to make the determination.

The Secretary may revoke the determination if the Secretary is satisfied that the determination is incorrect.

Subsection 44-26 C(6) states that a determination made under this section is not a legislative instrument. This subsection is included to assist readers and clarify that the determination is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Items 119, 120, 121, 122, 123 and 124
Currently, section 44-27 lists the supplements that are defined as ‘other supplements’. These items collectively amend section 44-27 to provide that, from 1 July 2014:

- the pensioner supplement will not be listed as an ‘other supplement’. The pensioner supplement is not payable for residents entering care on or after 1 July 2014. It will however, be retained in the *Aged Care (Transitional Provisions) Act 1997* for continuing care recipients;

- the ‘accommodation supplement’ will be listed as an ‘other supplement’. The accommodation supplement is currently listed as a primary supplement in section 44-5A. The reclassification of the accommodation supplement as an ‘other supplement’ is a result of the new means test. Primary supplements are taken into account when applying the new income and assets tests, whereas other supplements are not;

- the resident contribution top up supplement will not be listed as an ‘other supplement’. The resident contribution top-up supplement is not payable for care recipients entering care on or after 1 July 2014;

- the Subsidy Principles will also list ‘other supplements’ and specify the circumstances where these will apply to a care recipient; and

- the Minister may determine by legislative instrument the amount of an ‘other supplement’ or the way in which the supplement is to be worked out.

Item 120 replaces the reference to ‘step 5 in the residential care subsidy calculator’ in the definition of other supplements with a reference to step 4 in the residential care subsidy calculator.

Item 123 repeals an unnecessary note at the end of section 44-27.

The *Aged Care (Transitional Provisions) Act 1997* will retain the existing provisions for continuing care recipients.

Item 125
This item replaces existing section 44-28 with a new section.

Existing section 44-28 currently sets out eligibility for a pensioner supplement. The pensioner supplement is not payable for care recipients entering care on or after 1 July 2014. The *Aged Care (Transitional Provisions) Act 1997* will retain the definition and eligibility requirements for continuing care recipients.

Section 44-28 The accommodation supplement
New section 44-28 sets out when a care recipient will be eligible for an accommodation supplement and the amount of the accommodation supplement payable.

Subsections 44-28(2) and (3) provide the eligibility criteria for an accommodation supplement.

A care recipient will be eligible for an accommodation supplement if the person is not on the lowest ACFI classification level, the residential care service is certified, the care is not provided on an extra service basis, and the care recipient's means tested amount on the date of entry was less than the maximum accommodation supplement for that day. Even if a care recipient's means later decreases, the Government will not pay an accommodation supplement for a care recipient who at entry into care was assessed as being able to pay an accommodation payment. This holds until such time that a financial hardship determination is in force for the care recipient. Subsection 44-28(3) provides that a care recipient is eligible for an accommodation supplement if a financial hardship determination is in force.

Subsection 44-28(4) provides that the accommodation supplement for a particular day will be determined by the Minister by legislative instrument or worked out in accordance with a method determined by legislative instrument.

Subsection 44-28(5) also provides that in determining the amounts or methodology for determining the accommodation supplement, the Minister may take into account the income or assets of the care recipient; the status of the building in which the care is provided; and other matters specified in the Subsidy Principles. This allows a higher supplement to be provided for new or significantly refurbished services. It also allows the amount of supplement paid for a particular care recipient to reflect that individual's means.

Item 126
Section 44-29 currently sets out the provisions governing eligibility for the viability supplement and the method for calculating the supplement amount.

This item removes section 44-29 from the *Aged Care Act 1997*. The eligibility criteria will be included in the new Subsidy Principles.

This is consistent with other changes made by this Bill to include eligibility details for all supplements (other than the accommodation and hardship supplements) in Principles.

The details about the viability supplement (to be included in the Principles) are expected to remain the same as the details currently contained in the *Aged Care Act 1997*.

Item 127, 128, 129, 130, 131, 132 and 133
Section 44-30 sets out the circumstances in which a care recipient is eligible for a hardship supplement and how the amount of hardship supplement is determined.

Currently, a care recipient is eligible for a hardship supplement if:

- he or she is in a class of care recipients specified in the Residential Care Subsidy Principles for whom paying the maximum daily amount of resident fees worked out using the resident fee calculator in section 58-2 would cause financial hardship (subsection 44-30(2)); or

- the Secretary has determined that he or she is eligible for a hardship supplement (subsection 44-30(3) and section 44-31).

Items 128 and 129 amend paragraph 44-30(2)(a) so that the Subsidy Principles may specify one or more classes of care recipients for whom paying a daily amount of residents fees of more than the amount specified in the Principles (including nil) would cause financial hardship. This recognises that, for some classes of care recipients, paying an amount that is less than the maximum amount worked out using the resident fee calculator would cause financial hardship.

Currently, subsection 44-30(4) provides that a hardship supplement is not payable if a care recipient is being provided with residential care on an extra service basis. Item 132 repeals this exclusion. This means that the Secretary may determine that a care recipient who commences receiving residential care on or after 1 July 2014 and is receiving care on an extra service basis is eligible for a hardship supplement. Items 127 and 131, which remove references to subsection 44-30(4), are consequential amendments reflecting the repeal of this subsection.

Item 133
Currently section 44-31 sets out how the Secretary makes a financial hardship determination. Subsection 44-31(1) provides that the Secretary may determine that a care recipient is eligible for a hardship supplement if the Secretary is satisfied that paying the maximum daily amount of resident fees would cause the care recipient financial hardship.

The hardship supplement is intended to ensure that no one is denied access to the care they need because of financial hardship and will assist with both the basic daily fee and income tested care fee (if any).

This item repeals subsections 44-31(1) and (2) and replaces them with new subsections that provide that the Secretary may, in accordance with the Subsidy

Principles, determine that the care recipient is eligible for a hardship supplement if the Secretary is satisfied that paying a daily amount of resident fees of more than the amount specified in the determination would cause the care recipient financial hardship. This means that the Secretary may make a determination at even where the care recipient is not paying the maximum daily amount of fees because the Secretary is satisfied that even paying a lower amount would cause financial hardship.

In deciding whether to make a determination, and in determining the specified amount (which may be nil), the Secretary must have regard to any matters specified in the Subsidy Principles.

Refusals to make determinations are reviewable under Part 6.1 of the *Aged Care Act 1997*.

Item 134
This item repeals section 44-32 as the resident contribution top up supplement will not be required for care recipients entering care on or after 1 July 2014. The *Aged Care (Transitional Provisions) Act 1997* will retain the provisions for care recipients in care on 30 June 2014.

Item 134 also inserts a new section 44-32.

Section 44-32 Revoking determinations of financial hardship
This section provides that:

- the Secretary may, in accordance with the Subsidy Principles, revoke a financial hardship determination. This decision is reviewable under Part 6.1;

- before deciding to revoke a hardship determination, the Secretary must notify the person and the relevant approved provider. The Secretary must invite them to make written submissions within 28 days and inform them that if no submissions are made within that period, the hardship determination will be revoked on the 29th day;

- in making the decision whether to revoke the determination, the Secretary must consider any submissions received within the time period. The Secretary must make the decision and notify the person and the approved provider (in writing) within 28 days after the end of the period for making submissions. If the notice is not given within that period, the Secretary is taken to have decided not to revoke the determination; and

- a revocation has effect the day after the person and the approved provider have both received their notices.

Items 135 to 141
The following provisions will, from 1 July 2013, refer to Home Care Subsidy Principles:

- section 45-2 (including the heading and note);

- subsections 45-3(2), 46-2(3), 47-3(4); and
- paragraph 47-2(b).

From 1 July 2014 the Home Care Subsidy Principles will be consolidated into new Subsidy Principles, along with provisions in the Flexible Care Subsidy Principles and the Residential Care Subsidy Principles. These items therefore amend these provisions in the *Aged Care Act 1997* to replace the references to Home Care Subsidy Principles with references to Subsidy Principles.

Item 142
This item repeals section 48-1 (amount of home care subsidy) and inserts new sections 48-1, 48-2, 48-3, 48-4, 48-5, 48-6, 48-7, 48-8, 48-9, 48-10, 48-11, and 48-12.

Existing section 48-1 sets out the amount of home care subsidy payable by the Government. Currently, the fees paid by a care recipient to a home care provider do not reduce the amount of Government funding payable.

As part of the *Living Longer Living Better* reforms, from 1 July 2014, care recipients beginning a home care package may be asked to pay a fee based on their income. The amount of Government funding paid on the care recipient's behalf will also be reduced according to the income test.

New sections describe the home care subsidy arrangements.

Section 48-1 Amount of home care subsidy
Section 48-1 establishes a home care subsidy calculator to determine the amount of home care subsidy payable to the approved provider by the Government.

Subsection 48-1(1) provides that home care subsidy is only payable in relation to care recipients with a home care agreement in place, and in respect of whom the approved provider was eligible for home care subsidy during the period. This is the same as current requirements.

Subsection 48-1(2) sets out a home care subsidy calculator.

Home care subsidy calculator
Step 1. Work out the ***basic subsidy amount*** using section 48-2.

Step 2. Add to this amount the amounts of any ***primary supplements*** worked out using section 48-3.

Step 3. Subtract the amounts of any ***reductions in subsidy*** worked out using section 48-4.

Step 4. Add the amounts of any ***other supplements*** worked out using section 48-9.

The result is the ***amount of home care subsidy*** for the care recipient in respect of the payment period.

Section 48-2 The basic subsidy amount
Section 48-2 provides that the basic subsidy amount is determined by the Minister by legislative instrument. It may be different amounts depending on the level of care being provided or any matter specified in the Subsidy Principles or determined by the Minister.

Section 48-3 Primary supplements
The primary supplements for a home care recipient are whichever of the following that apply to him or her:

- the oxygen supplement and the enteral feeding supplement. These are existing supplements paid on behalf of eligible home care recipients (but these are not currently referenced in the *Aged Care Act 1997*);

- the dementia supplement. This is a new supplement to provide additional financial assistance in recognition of the additional costs involved in caring for people with dementia and other mental health issues. This supplement will commence from 1 July 2013 (enabled through amendments to existing Determinations) but will be mentioned in the *Aged Care Act 1997* from 1 July 2014 when the broader changes are being made to the sections relating to home care subsidy and supplement;

- the veterans' supplement. This is also a supplement that will become available from 1 July 2013. The supplement is designed to support veterans with mental health conditions;

- the workforce supplement. This supplement will support providers to attract and retain sufficient numbers of skilled and trained workers. Like the dementia and veterans' supplements, the workforce supplement will be available to eligible providers from 1 July 2013 but will be included in new section 48-3 from 1 July 2014; and

- any other primary supplement set out in the Subsidy Principles.

The section further provides that:

- Subsidy Principles may specify, in respect of each primary supplement, the circumstances in which the supplement will apply. In other words, the Principles are intended to describe the eligibility for each supplement; and

- the Minister may determine by legislative instrument, the amount of each supplement, or the way in which the amount is to be worked out.

Section 48-4 Reductions in subsidy
The possible reductions in subsidy for a care recipient under step 3 of the home care subsidy calculator are the compensation payment reduction (see section 48-5) and the care subsidy reduction (see sections 48-7 and 48-8).

Section 48-5 The compensation payment reduction
This section enables a compensation payment reduction to be made to the total Government subsidy paid in respect of a care recipient if that care recipient has received compensation which includes a component to support home care.

This is a new provision with respect to home care, but it mirrors the existing arrangements in residential care whereby Government subsidy is reduced if a person has already received a compensation amount that is intended to cover some, or all, of their residential care costs.

Subsection 48-5(8) states that a determination made under this section is not a legislative instrument. This subsection is included to assist readers and clarify that the determination is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Section 48-6 Secretary's powers if compensation information is not given
Section 48-6 establishes powers for the Secretary to obtain information on compensation amounts a care recipient is believed to be receiving.

If there are reasonable grounds for the Secretary to believe a care recipient is receiving a compensation amount, the Secretary may require the care recipient to provide information. If the information is not given within the specified time, the Secretary may determine the compensation payment reductions for the care recipient.

Section 48-7 The care subsidy reduction
This section supports a key part of the *Living Longer Living Better* reforms. Care recipients entering home care after 1 July 2014 will make a contribution towards their care based on their income.

Section 48-7 establishes the care subsidy reduction calculator which reduces the Government subsidy based on the care recipient's assessable income. An approved provider will be able to recoup this reduction in subsidy by charging the care recipient an income tested care fee of up to the same amount.

The level at which the total assessable income free area is set ensures that a care recipient receiving the full age pension, or a care recipient earning an equivalent amount of annual income, does not pay an income tested care fee.

Safeguards are built into the calculator to limit the amount of income tested care fee a care recipient can be asked to make (the first cap and the second cap. The first cap applies to those on a part pension or equivalent and the second cap applies to those who are not eligible for an age pension). In addition, the annual and lifetime caps also limit the amount that can be paid.

Care subsidy reduction calculator

Step 1. Work out the care recipient's ***total assessable income*** on a yearly basis using section 44-24.

Step 2. Work out the care recipient's ***total assessable income free area*** using section 44-26.

Step 3. If the care recipient's total assessable income does not exceed the care recipient's total assessable income free area, the ***care subsidy reduction*** is zero.

Step 4. If the care recipient's total assessable income exceeds the care recipient's total assessable income free area but not the ***income threshold***, the ***care subsidy reduction*** is equal to the lowest of the following:
(a) the sum of the basic subsidy amount for the care recipient and all primary supplements for the care recipient;
(b) 50% of the amount by which the care recipient's total assessable income exceeds the income free area (worked out on a per day basis); and
(c) the amount (the ***first cap***) determined by the Minister by legislative instrument for the purposes of this paragraph.

Step 5. If the care recipient's total assessable income exceeds the ***income threshold***, the ***care subsidy reduction*** is equal to the lowest of the following:
(a) the sum of the basic subsidy amount for the care recipient and all primary supplements for the care recipient;
(b) 50% of the amount by which the care recipient's total assessable income exceeds the income threshold (worked out on a per day basis) plus the amount specified in paragraph (c) of step 4;
(c) the amount (the ***second cap***) determined by the Minister by legislative instrument for the purposes of this paragraph.

Section 44-24 sets out how to calculate a care recipients' total assessable income (Step 1). Section 44-26 sets out how to calculate a care recipients' total assessable income free area (Step 2). Both of these calculations are also used in the calculators for residential care and are substantially unchanged from current arrangements.

Care subsidy reduction

Step 3 in the calculator considers whether the care recipient's total assessable income exceeds the income free area. If the care recipient's total assessable income is less than or equal to the income free area, the care subsidy reduction is zero. The care recipient will not pay an income tested care fee. The care recipient will, however, continue to pay the basic daily care fee which is up to 17.5% of the basic age pension amount.

If the care recipient's total assessable income is greater than the income free area there will be a care subsidy reduction. The approved provider will be able to charge the care recipient an income tested care fee up to the value of the care subsidy reduction. The amount of the care subsidy reduction is worked out under Steps 4 and 5 of the calculator.

The Minister will determine (by legislative instrument) an income threshold (subsection 48-7(6)). It is proposed that it be set at the income level at which an individual is no longer entitled to an age pension under the *Social Security Act 1991*.

Under Step 4, if the care recipient's total assessable income is less than or equal to the income threshold then the care subsidy reduction is the lower of:

- Step 4(a): The sum of the basic subsidy and primary supplements for the care recipient; or

- Step 4(b): 50 per cent of the amount by which the total assessable income exceeds the income free area; or

- Step 4 (c): An amount, referred to as the first cap, determined by the Minister in a legislative instrument.

In this way the care subsidy reduction (and therefore the income tested care fee paid by the care recipient) is limited by the amount Government would pay in basic subsidy and primary supplements (Step 4(a)), the person's income (Step 4(b)), and the relevant cap (the first cap under Step 4(c)).

Under Step 5, if the care recipient's total assessable income is more than the income threshold then the care subsidy reduction is the lower of:

- Step 5(a): The sum of the basic subsidy and primary supplements for the care recipient; or

- Step 5(b): 50 per cent of the amount by which the total assessable income exceeds the income threshold, plus the first cap; or

- Step 5(c): An amount, referred to as the second cap, determined by the Minister in legislative instrument.

In this way the care subsidy reduction (and therefore the income tested care fee paid by the care recipient) is limited by the amount Government would pay in basic subsidy and primary supplements (Step 5(a)), the person's income (Step 5(b)), and the relevant cap (the second cap under Step 5(c)).

The effect of Steps 4 and 5 is that the income tested care fee, for part pensioners will gradually increase until it reaches the first cap. For those with income above the pension cut off their income tested care fee will rise further until it reaches the second cap.

Subsection 48-7(3) provides that if the care recipient has not provided sufficient information to determine the care subsidy reduction, the care subsidy reduction will be the lower of either the basic subsidy plus all primary supplements for the care recipient, or the second cap.

Annual and lifetime caps

As is the case in residential care, annual and lifetime caps also apply to the home care subsidy reduction calculator.

The care subsidy reductions for a particular care recipient will be tracked by Government. When the total care subsidy reduction over a year exceeds the relevant cap, the care subsidy reduction will be reduced to zero. This will mean that the care recipient will pay no further income tested care fees for that year. For the purposes of the caps, a year commences from the date on which a care recipient first enters care, either residential or home care, or an anniversary of that date.

Similarly when the lifetime cap is reached, the care subsidy reduction will be set to zero and the care recipient pays no additional income tested care fees.

Where the approved provider charges a lower income tested care fee than is allowed under the law (ie the care subsidy reduction), the annual and lifetime caps are met once the accrued care subsidy reductions exceed the relevant amounts.

Example 1:

The following assumptions are made for the following example:

The **total assessable income free area** is $22,701
The **income threshold for a single is** $43,186
The **first capped amount for a single is** $13.74 (being the daily calculation of a $5,000 annual cap)
The **second capped amount for a single is** $27.47 (being the daily calculation of a $10,000 annual cap)

Joseph lives alone. He will begin to receive home care from 29 September 2014. His basic subsidy plus any primary supplements are calculated as $37.36 per day. His annual assessable income is $65,000. Joseph's contribution to his care is calculated as follows:

Step 1: Joseph's total assessable income is $65,000 per annum.

Step 2: Joseph's total assessable income free area is $22,701 per annum.

Step 3: As Joseph's income exceeds the total assessable income free area there will be a care subsidy reduction and Joseph can be asked to pay an income tested care fee.

Step 4 does not apply as Joseph's total assessable income exceeds the income threshold ($65,000>$43,186).

Step 5:

The care subsidy reduction will be the lower of:

- The sum of the basic subsidy and all primary supplements, that is $37.36 per day;

- $13.74+ 0.5 x [(65,000-43,186)/364] that is $43.70 per day; or
- $27.47 per day (the second cap).

His care subsidy reduction, and therefore the maximum he can be asked to pay in income tested care fees is $27.47 per day.

Example 2:
The following assumptions are made for the following example:

The **total assessable income free area for a married person** is $17,605
The **income threshold** is $33,046
The **first capped amount** is $13.74
The **second capped amount** is $27.47

Rose lives with her husband, Robert, and will start to receive home care from 1 November 2014. Rose and Robert have a combined annual income of $29,000. Rose’s contribution to her care is calculated as follows:

Step 1: A care recipient who is a member of a couple is taken to have half of the couple’s combined assessable income. Rose’s total assessable income is ($29,000/2) $14,500.

Step 2 & 3: Rose’s total assessable income free area is $17,605 per annum. As Rose’s total assessable income does not exceed the total assessable income free area, there is no care subsidy reduction. Rose cannot be asked to pay an income tested care fee.

Example 3:
The following assumptions are made for the following example:

The **total assessable income free area for a single** is $22,701
The **income threshold for a single** is $43,186
The **annual cap for residential care** is $25,000 per annum
The **annual cap in home care for a care recipient with income below the income threshold** is $5,000
The **annual cap in home care for a care recipient with income above the income threshold** is $10,000

Thomas enters residential care on 14 August 2014. His annual assessable income is $65,000. On 30 May 2015 he moves from residential care to home care. Due to his means, Thomas has been eligible to pay means tested care fees while in residential care. The sum of the amounts he could have been asked to pay (which is equivalent to the care subsidy reductions) in residential care is greater than $10,000. As Thomas has reached the annual cap that applies to someone with his level of income in home care, Thomas will pay no income tested care fees in home care until 14 August 2015.

Section 48-8 Care subsidy reduction taken to be zero in some circumstances
Section 48-8 describes the circumstances in which the care subsidy reduction will be zero. Where a care subsidy reduction is zero, the care recipient to whom it relates cannot be asked to pay an income tested care fee.

The care subsidy reduction will be set to zero where the Secretary has made a determination in accordance with the Subsidy Principles or where the care recipient is in a class of care recipients specified in the Subsidy Principles.

This provision is similar to section 44-23 which applies to residential care.

Subsection 48-8(7) states that a determination made under this section is not a legislative instrument. This subsection is included to assist readers and clarify that the determination is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Section 48-9 Other supplements
Section 48-9 sets out the other supplements that may apply to a care recipient in home care. Subsection 48-9(1) provides that a care recipient in home care may be entitled to a hardship supplement or any other supplement set out in the Subsidy Principles.

Subsection 48-9(2) provides that the Subsidy Principles may specify the circumstances in which a supplement will apply to a care recipient, that is, the eligibility criteria.

Subsection 48-9(3) provides that the Minister may determine by legislative instrument the amount of an 'other supplement' or the methodology for working out the amount of the supplement.

Section 48-10 The hardship supplement
Section 48-10 sets out the circumstances when a care recipient in home care is eligible for a hardship supplement and how the amount of hardship supplement is determined.

The hardship supplement is intended to ensure that no one is denied access to the care they need because of financial hardship and will assist with both the basic daily fee and income tested care fee (if any).

A person will be eligible for a hardship supplement if:

- the care recipient is in a class of care recipients specified in the Subsidy Principles for whom paying a daily amount of home care fees, more than the amount in the Subsidy Principles, would cause financial hardship; or

- a determination is in force under section 48-11. That is, that a financial hardship determination is in place.

The amount of hardship supplement for a day is determined by the Minister in a legislative instrument or worked out in accordance with a method determined by the Minister.

In setting the amount of hardship supplement the Minister has the ability to determine (by legislative instrument) different amounts of hardship supplement or methods for determining the amount of hardship supplement.

Section 48-11 Determining cases of financial hardship
Section 48-11 sets out how the Secretary makes a financial hardship determination for home care recipients. The Secretary may determine that a care recipient is eligible for a hardship supplement if the Secretary is satisfied that paying an amount of home care fees would cause the care recipient financial hardship. The determination has to be made in accordance with the Subsidy Principles.

Broadly, section 48-11 is intended to operate in the same way as section 44-31 operates in determining a hardship supplement for a care recipient in residential care.

- When making a determination the Secretary will have regard to matters specified in the Subsidy Principles.

- The determination can be time limited, or can cease to apply if a specified event occurs.

- Either the care recipient or the approved provider who is providing home care (or will be providing home care to the care recipient) can apply to the Secretary for a hardship determination.

- The Secretary may request additional information from the care recipient or approved provider by way of a notice. If the additional information is not provided within the timeframe specified in the notice from the Secretary (or within 28 days if there is no specified timeframe) the application is taken to have been withdrawn.

- The Secretary has 28 days after receiving the application to make a decision and notify the approved provider and care recipient of the decision. If the Secretary has requested additional information, then the Secretary has 28 days from when the additional information is received to make a decision and notify the approved provider and care recipient of the decision.

- The notice including the Secretary's determination must set out any time limit on the determination, or any event which will cause the determination to end.

Subsection 48-11(9) states that a determination made under this section is not a legislative instrument. This subsection is included to assist readers and clarify that the determination is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Section 48-12 Revoking determinations of financial hardship
This section is similar to new section 44-32 which applies to financial hardship determinations for residential care.

This section provides that:

- the Secretary may, in accordance with the Subsidy Principles, revoke a financial hardship determination. This decision is reviewable under Part 6.1;

- before deciding to revoke a hardship determination, the Secretary must notify the person and the relevant approved provider. The Secretary must invite them to make written submissions within 28 days and inform them that if no submissions are made within that period, the hardship determination will be revoked on the 29th day;

- in making the decision whether to revoke the determination, the Secretary must consider any submissions received within the time period. The Secretary must make the decision and notify the person and the approved provider (in writing) within 28 days. If the notice is not given within that period, the Secretary is taken to have decided not to revoke the determination; and

- a revocation has effect the day after the person and the approved provider have both received their notices.

Items 143 to 148
The following provisions refer to Flexible Care Subsidy Principles:

- section 49-2 (including the heading and note);

- subsections 50-2(1), 51-1(1) and (2); and

- subparagraphs 50-1(1)(b)(ii) and (iii).

From 1 July 2014, the Flexible Care Subsidy Principles will be consolidated into new Subsidy Principles, along with provisions in the Home Care Subsidy Principles and the Residential Care Subsidy Principles. These items therefore amend these provisions in the *Aged Care Act 1997* to replace the references to Flexible Care Subsidy Principles with references to Subsidy Principles.

Item 149
This item inserts a new Chapter 3A (Fees and Payments) into the *Aged Care Act 1997*. This Chapter sets out the resident and home care fee calculators, the provisions governing accommodation payments, accommodation contributions, and the rules around managing refundable deposits, accommodation bonds and entry contributions.

Currently, provisions relating to fees and payments are spread across a number of sets of Principles, making it difficult for care recipients and approved providers to find and understand the rules. To remedy this, all matters relating to fees and payments are being included in one chapter of the *Aged Care Act 1997* (Chapter 3A). Further, the detailed information that underpins the *Aged Care Act 1997* will all be included in one set of Principles - the new Fees and Payments Principles, made by the Minister under section 96-1.

Chapter 3A - Fees and payments

Division 52A - Introduction

Section 52A-1 What this Chapter is about
This section summarises the contents of Chapter 3A. In summary Chapter 3A provides that:

- care recipients may contribute to the cost of their care by paying fees;
- care recipients may pay for, or contribute to the cost of, accommodation provided with their care by paying an accommodation payment or an accommodation contribution; and
- accommodation payments or accommodation contributions may be paid by daily payments, or refundable deposit, or a combination of the two.

Chapter 3A also sets the rules for managing refundable deposits, accommodation bonds and entry contributions. Accommodation bonds and entry contributions are paid under the *Aged Care (Transitional Provisions) Act 1997.*

Part 3A.1 – Resident and home care fees

Division 52B – Introduction

Section 52B-1 What this Part is about
This section summarises Part 3A.1. This Part provides that care recipients may pay, or contribute to the cost of, residential care or home care by paying resident fees or home care fees. These provisions are set out in three Divisions: 52B – Introduction; 52C-Resident Fees; and 52D – Home care fees.

Section 52B-2 The Fees and Payments Principles
This section explains that resident fees and home care fees are also dealt with in the Fees and Payments Principles. Provisions under part 3A.1 reference the new Fees and Payments Principles accordingly.

Division 52C – Resident fees

Section 52C-2 Rules relating to resident fees
This section sets out the rules relating to the charging of resident fees. The term ‘resident fees’ refers to any fees charged to a care recipient in respect of residential care he or she is receiving.

This section provides that:

- subject to section 52C-5 the resident fee must not exceed the sum of the amount worked out under the resident fee calculator (section 52C-3) plus any other amounts specified in, or worked out in accordance with, the Fees and Payments Principles. Section 52C-5 sets out the rules for the fees that can be charged for reserving a place in a residential care service;

- the care recipient must not be required to pay resident fees more than one month in advance;

- the care recipient must not be required to pay resident fees for periods prior to their entry to the residential care service. The only exception to this is when, because of subsection 42-3(3), the care recipient is considered to be on leave under section 42-2; and

- any fees paid in advance must be refunded in accordance with the Fees and Payments Principles, if the care recipient has died or otherwise departed from the service.

Section 52C-3 Maximum daily amount of resident fees

Section 52C-3 inserts a new calculator to work out the maximum daily amount of resident fees payable by the residential care recipient. The provider may charge the care recipient up to the maximum daily amount but can choose to charge a lower amount.

Resident fee calculator

Step 1. Work out the standard resident contribution for the care recipient using section 52C-4.

Step 2. Add the ***compensation payment fee*** (if any) for the care recipient for the day in question.

Step 3. Add the ***means tested care fee*** (if any) for the care recipient for that day.

Step 4. Subtract the amount of any hardship supplement applicable to the care recipient for the day in question under section 44-30.

Step 5. Add any other amounts agreed between the care recipient and the approved provider in accordance with the Fees and Payment Principles.

Step 6. If, on the day in question, the place in respect of which residential care is provided to the care recipient has extra service status, add the extra service fee in respect of the place.

The result is the ***maximum daily amount of resident fees*** for the care recipient.

The standard resident contribution (Step 1) is described in section 52C-4.

The compensation payment fee (Step 2) is equal to the compensation payment reduction applicable to the care recipient on that day and is calculated according to section 44-20 or section 44-20A.

If the amount paid by the Government to a provider on behalf of a care recipient, is reduced as a result of the care recipient's means (see the care subsidy reduction calculator), the provider is able to charge the care recipient a means tested care fee (Step 3) up to the value of the care subsidy reduction. The means tested care fee is equal to the amount calculated as the care subsidy reduction under section 44-21 for that particular day, or is equal to zero for a care recipient receiving respite care.

If a financial hardship determination is in force in respect of a care recipient, the approved provider must reduce the amount the care recipient is charged by the amount of hardship supplement the provider is receiving from the Government (Step 4). Step 5 of the calculator provides that the resident fees also include any other amounts agreed between the care recipient and the approved provider in accordance with the Fees and Payment Principles. Step 6 of the calculator applies only to those care recipients receiving care on an extra service basis. These care recipients must also pay the relevant extra service fee.

Section 52C-4 The standard resident contribution
The standard resident contribution is either an amount determined by the Minister (by legislative instrument), or if no amount is determined, then an amount equal to 85 per cent of the basic age pension amount (rounded down to the nearest cent). This amount is paid by all residents irrespective of their means tested amount, unless a financial hardship determination is in force.

Section 52C-5 Maximum daily amount of resident fee for reserving a place
When a care recipient is absent from a residential care service but not on leave, (as set out under subsection 42-2(3)(c)), the resident can be charged a fee for reserving a place in the service during their absence.

The maximum fee for reserving a place that can be charged to a care recipient is equal to: the maximum resident fee a care recipient could be charged, calculated using the resident fee calculator (section 52C-3); plus the total amount of residential care subsidy (calculated under section 44-2) that would have been payable to a provider by the Government had the care recipient been provided with residential care on that day.

Division 52D – Home care fees

Section 52D-1 Rules relating to home care fees
Home care fees are fees charged to a care recipient for, or in connection with, home care. This section sets out the rules applicable to approved providers charging home care fees.

A care recipient cannot be charged a home care fee:

- greater than the total of the maximum daily amount worked out by using the home care fee calculator (section 52D-2) plus any other amounts as specified in, or worked out in accordance with, the Fees and Payments Principles;

- more than one month in advance of receiving care; and
- for a period prior to being provided with home care.

Once the provision of home care stops or a care recipient dies, any amounts paid in advance must be refunded in accordance with the Fees and Payments Principles.

Section 52D-2 Maximum daily amount of home care fees
Section 52D-2 inserts a new calculator to work out the maximum daily amount of home care fees payable by the home care recipient. The provider may charge the care recipient up to the maximum daily amount but can choose to charge a lower amount.

Home care fee calculator
Step 1. Work out the ***basic daily care fee*** using section 52D-3.
Step 2. Add the ***compensation payment fee*** (if any) for the care recipient for the day in question.
Step 3. Add the ***income tested care fee*** (if any) for the care recipient for the day in question.
Step 4. Subtract the amount of any hardship supplement applicable to the care recipient for the day in question under section 48-10.
Step 5. Add any other amounts agreed between the care recipient and the approved provider in accordance with the Fees and Payments Principles.
The result is the ***maximum daily amount of home care fees*** chargeable to the care recipient.

The basic daily care fee (Step 1) is described in section 52D-3.

The compensation payment fee (Step 2) is equal to the compensation payment reduction applicable to the care recipient on that day and is calculated according to section 48-5.

If the amount paid by the Government to a provider is reduced as a result of the income of a care recipient, the provider will be able to charge the care recipient an income tested care fee (Step 3) up to the value of the care subsidy reduction. The income tested care fee is equal to the amount calculated as the care subsidy reduction under section 48-7 for that particular day.

If a financial hardship determination is in force in respect of a care recipient for that day, the approved provider must reduce the amount the care recipient is charged by the amount of hardship supplement the provider is receiving from the Government (Step 4). Step 5 provides that the home car fees for a care recipient also include any other amounts agreed between the care recipient and the approved provider in accordance with the Fees and Payments Principles.

Section 52D-3 The basic daily care fee
For home care, the basic daily care fee is either an amount determined by the Minister (by legislative instrument) or, if no determination has been made, an amount not greater than 17.5 per cent of the basic age pension amount (rounded down to the nearest cent). All home care recipients can be asked to pay this amount irrespective of their means unless a financial hardship determination (section 48-11) is in force. This amount is payable independently of whether any income tested fee is also payable.

Part 3A.2 – Accommodation payments and accommodation contributions

Division 52E – Introduction

Section 52E-1 What this Part is about
This section summarises Part 3A.2. This Part provides that care recipients may pay, or contribute to, the cost of accommodation provided in residential care or by an eligible flexible care service.

These accommodation payments or accommodation contributions may be made through either daily payments; or a refundable deposit; or a combination of the two. These provisions are set out in six Divisions:

- Division 52E – Introduction;
- Division 52F – Accommodation agreements;
- Division 52G – Rules about accommodation payments and accommodation contributions;
- Division 52H – Rules about daily payments;
- Division 52J – Rules about refundable deposits; and
- Division 52K – Financial hardship.

Section 52E-2 The Fees and Payments Principles
This section explains that the new Fees and Payments Principles will provide the detail for matters relating to accommodation payments and accommodation contributions. Provisions under Part 3A.2 reference the new Fees and Payments Principles accordingly.

Division 52F – Accommodation agreements
This Division outlines requirements for accommodation agreements. There are some new and important steps to entering into accommodation agreements which are explained in this Division. It explains documents and information which approved providers must give to care recipients before they enter care. Importantly, the accommodation agreement, which must be entered into between the approved provider and the care recipient, must set out the ways in which the care recipient can decide to pay for their accommodation and the time period within which this decision must be made.

Section 52F-1 Information to be given before person enters residential or eligible flexible care
This section describes the general rules relating to information that must be given to a care recipient before they enter a residential care service, or an eligible flexible care service. An eligible flexible care service is a flexible care service that is allowed to charge accommodation payments under the Fees and Payments Principles. For example, this includes a Multi-Purpose Service (MPS).

The section specifies that prior to entering residential care an approved provider must provide the care recipient with an accommodation agreement as defined in section 52F-3, as well as any other information specified in the Fees and Payments Principles.

Prior to entry to the service, the approved provider must agree in writing with the care recipient on the maximum accommodation payment the care recipient would have to pay for that service.

The care recipient does not, prior to entry, need to decide how they will pay for their accommodation. It is also acknowledged that the care recipient may not know their means tested amount upon entry and so will not know if they will be required to pay an accommodation payment. If the care recipient's means tested amount is later found to be less than the maximum accommodation supplement the care recipient will not have to pay an accommodation payment. The care recipient will be eligible for some accommodation supplement and may also need to pay an accommodation contribution. See section 52G-2 and section 52G-6 for rules regarding the charging of accommodation contributions.

Section 52F-2 Approved provider must enter accommodation agreement
This section describes the time period within which an approved provider must enter into an accommodation agreement with a person. The approved provider is required to enter into an agreement with the care recipient prior to, or within 28 days after, the care recipient enters the service.

Subsection 52F-2(2), allows for an extension to the 28 day rule where the approved provider and the care recipient have not entered into an accommodation agreement and there is a legal process underway to appoint a legal representative for the care recipient due to mental impairment. In these circumstances the timeframe for entering into an accommodation agreement may be extended until the end of 7 days after an appointment is made, or a decision is made not to make the appointment, or the legal process ends for some other reason. This subsection also provides that the Secretary may extend for a further period having regard to any matters specified in the Fees and Payments Principles.

Section 52F-3 Accommodation agreements
This section outlines the matters that must be included in an accommodation agreement. Subsection 52F-3(1) sets out information that must be contained in the accommodation agreement including but not limited to:

- the person's date of entry to the service or the person's proposed date of entry to the service;

- the circumstances under which a person will be required to pay an accommodation payment or an accommodation contribution;

- that an accommodation payment or accommodation contribution may be reduced if a financial hardship determination is in place;

- that, within 28 days after entering the service, the care recipient must choose how to pay for their accommodation (by daily payment, refundable deposit or a combination of both) and that if no election is made, the person must pay by daily payment;

- that if the person elects to pay a refundable deposit, the refundable deposit is not required to be paid for up to 6 months. During this time, a daily payment must be paid;

- amounts that are permitted to be deducted from a refundable deposit (see section 52J-7); and

- the conditions for refunding refundable deposits (see Division 52P).

By way of further explanation:

- Paragraph 52F-3(1)(e) provides that the care recipient has up to 28 days after the date of entry to decide how they will pay for their accommodation. Before the end of this period the care recipient must choose to pay their accommodation payment or accommodation contribution as either a daily payment (daily accommodation payment or daily accommodation contribution), refundable deposit (refundable accommodation deposit or refundable accommodation contribution), or a combination of both. From the date of entry until the care recipient makes a choice as to how they will pay for their accommodation, the care recipient must pay for their accommodation by daily payments.

- Paragraph 52F-3(1)(f) requires the care recipient to continue to pay by daily payments if the care recipient does not choose how to pay within the 28 day period after entry.

Subsection 52F-3(2) describes the additional conditions that must be set out in the accommodation agreement in regard to an accommodation payment. With regard to an accommodation payment, the accommodation agreement must outline:

- the amount of accommodation payment payable by the care recipient (either the daily accommodation payment, refundable accommodation deposit, or the method for working out amounts if paid as a combination of both);

- that the daily accommodation payment must be drawn down from the refundable accommodation deposit upon the care recipient’s request; and

- that the care recipient may be required to maintain the agreed accommodation payment, even when the refundable accommodation deposit is reduced by drawing down, and the methods by which this can be maintained.

Subsection 52F-3(3) describes the conditions that must be set out in the accommodation agreement in relation to an accommodation contribution. With regard to an accommodation contribution, the accommodation agreement must outline:

- how the amount of accommodation contribution is worked out including how to work it out as a refundable accommodation contribution, or a combination of a refundable accommodation contribution and daily accommodation contributions;

- that the amount of accommodation contribution will vary from time to time depending on the maximum accommodation supplement for the residential care service and the care recipient's means tested amount;

- that if the care recipient requests it, the daily accommodation contributions must be drawn down from the refundable accommodation contribution;

- the care recipient may be required to maintain the accommodation contribution, even when the refundable accommodation contribution is reduced from draw downs, and the payment methods by which this can be maintained; and

- if the accommodation contribution increases, for example, because the person's means increase, the care recipient may be required to pay the increase, and the methods by which this payment can be made.

Section 52F-4 Refundable deposit not to be required for entry
This section states that the approved provider must not require the care recipient to choose how they will pay their accommodation payment or accommodation contribution prior to entering their residential care service (or, in some cases, their flexible care service).

This section prevents the approved provider from requiring any care recipient to pay by a refundable deposit for entry to their service. This ensures the care recipient has choice as to how they pay for their accommodation. This also prevents approved providers from discriminating between refundable deposit paying care recipients and those care recipients who choose to pay by daily payments.

Section 52F-5 Accommodation agreements for flexible care
This section provides that accommodation agreements for flexible care services do not need to deal with the parts of section 52F-3 that relate to accommodation contributions.

This is because care recipients in flexible care (provided in a residential setting such as in a Multi-Purpose Service) are not eligible for any accommodation supplement and therefore are not required to pay any accommodation contribution. Any provisions relating to the payment of accommodation contributions will not apply to care recipients in a flexible care service.

Section 52F-6 Accommodation agreements may be included in another agreement
This section states that accommodation agreements may be incorporated into other agreements, such as resident agreements.

Section 52F-7 Effect of accommodation agreements
This section provides that the accommodation agreement has effect subject to the *Aged Care Act 1997* and any other law of the Commonwealth.

Division 52G – Rules about accommodation payments and accommodation contributions

Section 52G-1 What this Division is about
This Division sets out the rules regarding how accommodation payments and accommodation contributions may be charged.

This Division has two subdivisions: 52G-A - Rules about accommodation payments; and 52G-B - Rules about accommodation contributions.

Subdivision 52G-A – Rules about accommodation payments

Section 52G-2 Rules about charging accommodation payments
This section establishes the circumstances under which a care recipient may be charged an accommodation payment in a residential care service or eligible flexible care service (in a residential setting).

This section amends the current rules regarding paying for accommodation by moving the focus from the care recipient's level of care upon entry, to whether the care recipient can afford to contribute to the cost of their accommodation.

This section provides that:

- the ability to charge accommodation payments must take into account the care recipient's means tested amount. The means tested amount must be equal to, or greater than, the maximum accommodation supplement for a person to be charged an accommodation payment. If the care recipient fails to provide enough information to enable means testing then they may be charged an accommodation payment;

- the care recipient cannot be charged an accommodation payment for respite care;

- the accommodation payment must not be greater than the maximum amount specified by the Minister (section 52G-3), or any higher amount approved by the Aged Care Pricing Commissioner (section 52G-4);

- an accommodation payment must not be charged if the charging of an accommodation payment is prohibited because a sanction is in place or because the service is not certified; and

- the approved provider must comply with all relevant rules relating to accommodation payments including any rules specified in the Fees and Payments Principles.

Section 52G-3 Minister may determine maximum amount of accommodation payment
This section deals with the value of the accommodation payments to be charged. The Minister may determine a maximum amount of accommodation payment that an approved provider may charge. This may be expressed as an amount or a method for working out an amount.

This does not preclude the approved provider from charging a care recipient less than the maximum amount specified by the Minister.

A Ministerial determination of the maximum amount of accommodation payment is a legislative instrument under the *Legislative Instruments Act 2003*.

Section 52G-4 Aged Care Pricing Commissioner may approve higher maximum amount of accommodation payment
Section 52G-4 provides that the Aged Care Pricing Commissioner may approve a higher amount of accommodation payment on application from an approved provider. The application must comply with the requirements set out in the Fees and Payments Principles, such as specifying the residential care service or the distinct part of such the service, to which the higher price would apply.

The section allows the Aged Care Pricing Commissioner to request further information from the approved provider in order to make a decision on the application for a higher amount of accommodation payment. If requested, the approved provider must provide the information within 28 days, or by another specified time. If this information is not provided to the Aged Care Pricing Commissioner within the time specified, the application for a higher amount of accommodation payment is deemed to be withdrawn.

The Aged Care Pricing Commissioner’s approval of any higher amount of accommodation payment must be made in writing and in accordance with the Fees and Payments Principles.

Any higher amount of accommodation payment approved applies only to new accommodation agreements for the stated accommodation, and where the care recipient does not enter the service until, or after, the date of the approval.

A subsequent application cannot be made within 12 months of a previous decision, made by the Aged Care Pricing Commissioner, in relation to the same service, or part of service. The exception to this is if a different time period is specified in the Fees and Payments Principles.

Decisions of the Aged Care Pricing Commissioner are reviewable which means that the approved provider may seek reconsideration of a decision and if the approved provider continues to be dissatisfied the provider may seek review by the Administrative Appeals Tribunal.

Subsection 52G-4(7) states that a determination made under this section is not a legislative instrument. This subsection is included to assist readers and clarify that the determination is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Section 52G-5 Accommodation payments must not be greater than amounts set out in accommodation agreements

Section 52G-5 states that in no circumstances can the amount of accommodation payment charged exceed the amount specified in the accommodation agreement. Nor can an approved provider accept an offer from a care recipient to pay a higher amount than is specified.

Subdivision 52G-B – Rules about accommodation contributions

Section 52G-6 Rules about charging accommodation contribution

This section establishes the circumstances under which a care recipient may be charged an accommodation contribution in a residential care service. An accommodation contribution refers to the amount a care recipient can be asked to pay when the approved provider is also receiving some accommodation supplement from the Government in respect of that care recipient's accommodation.

Like section 52G-2, this section amends the current rules regarding paying for accommodation by moving the focus from the care recipient's level of care upon entry, to whether the care recipient can afford to contribute towards the cost of their accommodation.

This section provides that:

- the amount of accommodation contribution payable by a care recipient takes into account the care recipient's means tested amount. The person's means tested amount, at their time of entry, must be less than the maximum accommodation supplement in order for a person to be charged an accommodation contribution. If their means tested amount at entry is equal to or greater than the maximum accommodation supplement amount, the person will be liable to pay an accommodation payment;

- a care recipient who does not provide sufficient information to determine whether they are eligible to pay an accommodation contribution may be charged an accommodation payment (rather than an accommodation contribution);

- the actual amount of accommodation contribution owing by the care recipient on any given day will be based on their means tested amount but cannot exceed the accommodation supplement applicable to the service for that day;

- a care recipient cannot be charged an accommodation contribution for respite care;

- an accommodation contribution must not be charged if it is prohibited from being charged because a sanction is in place or because the service is not certified; and

- an approved provider must comply with all relevant rules about charging accommodation contributions including any rules set out in the Fees and Payments Principles.

Division 52H – Rules about daily payments

This Division sets out rules related to daily payments of both accommodation payments and accommodation contributions.

Section 52H-1 Payment in advance
If a care recipient is paying by daily payment, payments can be made in advance. This section provides that advance payments can only be paid up to one month in advance.

Section 52H-2 When daily payments accrue
Daily payments only accrue during periods when the residential care service is certified (see Part 2.6 of the *Aged Care Act 1997*) and when the person is receiving residential or flexible care. The person is defined as receiving care as long as they are a care recipient, including any time that the care recipient is on leave (defined in section 42-2).

Section 52H-3 Charging interest
If daily payments have accrued, interest can be charged on any amount that has been outstanding for over one month.

The Minister may set the maximum rate of interest applicable to outstanding daily payments. The approved provider has the discretion to charge an interest rate up to the maximum set by the Minister.

The accommodation agreement must have provided that interest is payable in these circumstances. If it has not expressly provided for the charging of interest on accrued daily payments, then no interest may be charged.

Section 52H-4 The Fees and Payments Principles
Section 52H-4 provides that the Fees and Payments Principles may specify matters about daily payments, including when daily payments are to be made.

Division 52J – Rules about refundable deposits

This Division sets out the rules related to refundable deposits in relation to both accommodation payments and accommodation contributions.

Section 52J-2 When refundable deposits can be paid
After signing an accommodation payment agreement with an approved provider, the care recipient can choose to pay or add to their existing refundable deposit balance at any time. The maximum that can be paid as refundable deposit is the amount specified in the accommodation payment agreement. The care recipient has discretion over the amount and timing of refundable deposit payments, up to the maximum agreed.

Section 52J-3 The Fees and Payments Principles
This section provides that the Fees and Payments Principles may specify matters about refundable deposits, including how a choice to pay a refundable deposit may be made.

Section 52J-4 Residential care services that are not certified
Uncertified residential care services cannot require payment of a refundable deposit.

This section provides that a provider of a residential care service that is not certified must not require the payment of a refundable deposit within 6 months after the service is certified (or such other time specified in the Fees and Payments Principles).

If a care recipient paid a refundable deposit to an approved provider whose certification is subsequently revoked, the approved provider is not required to refund the refundable deposit but must instead pay interest on the refundable deposit balance for each day that the residential care service is uncertified.

Section 52J-5 Person must be left with minimum assets
Section 52J-5 provides that if a person commits to paying a refundable deposit within 28 days of entry to a service, then the provider can only accept the payment if it leaves the care recipient with assets at least equal to the minimum permissible asset value. If the person does not provide sufficient information to allow the person's means tested amount to be worked out, this obligation to leave the care recipient with the minimum permissible asset value does not apply.

The minimum permissible asset value is defined in subsection 52J-5(2) and is equivalent to 2.25 times the basic age pension amount or such other amount specified in the Fees and Payments Principles. It is intended to ensure care recipients are left with funds for discretionary spending while in aged care.

The value of the care recipient's assets is to be worked out in accordance with section 44-26A, with one exception. For the purposes of this section, the value of the principal residence, which is not occupied by a protected person, will not be capped. Rather its full value will be included as an asset.

Section 44-26C enables a care recipient to apply to the Secretary for a written valuation of their assets including for the purposes of section 52J-5. The application must be made in the approved form and include sufficient information to enable the Secretary to make the valuation.

Section 52J-6 Approved provider may retain income derived
Section 52J-6 states that the approved provider is entitled to retain income derived from a refundable deposit. Unlike the permitted uses for the refundable deposit, this income may be used for any purpose, as is currently the case.

Section 52J-7 Amounts to be deducted from refundable deposits
Section 52J-7 provides that if the care recipient requests, in writing, that daily payments be drawn down from the refundable deposit, the approved provider must action this request. Any other amounts as specified in the Fees and Payments Principles, or agreed in writing between the care recipient and approved provider,

may be deducted from the refundable deposit. This means that a care recipient may have their care fees deducted from their refundable deposit if both the approved provider and the care recipient agree to this.

Division 52K - Financial Hardship

Section 52K-1 Determining cases of financial hardship
A care recipient or approved provider is able to apply to the Secretary for a financial hardship determination in respect of a care recipient.

Section 52K-1 sets out the circumstances when the Secretary may determine that a care recipient is in financial hardship.

In accordance with the Fees and Payments Principles, the Secretary may determine that a care recipient cannot be charged an accommodation payment or accommodation contribution, or an accommodation payment or contribution above a specified amount, because doing so would cause the person financial hardship.

In deciding whether to make a determination (and in determining the specified amount) the Secretary must have regard to those matters specified in the Fees and Payments Principles. The Secretary may also request further information from the applicant. The application is taken to be withdrawn if the applicant does not respond within 28 days or such other time as is specified by the Secretary in the notice requesting further information.

The applicant must be notified of the Secretary's decision within 28 days of making the application or within 28 days of the Secretary receiving any additional information that has been requested.

The determination may specify a time or an event at which time the determination will cease to be in force.

Subsection 52K-1(9) states that a determination made under this section is not a legislative instrument. This subsection is included to assist readers and clarify that the determination is not a legislative instrument within the meaning of section 5 of the *Legislative Instruments Act 2003*.

Section 52K-2 Revocation of financial hardship determination
This section provides that the Secretary may revoke a financial hardship determination. However, before making such a decision the Secretary must notify the person and the approved provider that a revocation is being considered and provide both parties with a 28 day window to make a submission regarding the proposed revocation. If no submission is received, the revocation will take effect on the day after the last day for making submissions.

If the care recipient or provider makes a submission regarding the impending revocation, the Secretary must consider those submissions and has 28 days after receiving the submissions to make a decision and notify the parties.

A revocation of a determination will have effect from the day after care recipient and the approved provider both received the notice.

Part 3A. 3 – Managing refundable deposits, accommodation bonds and entry contributions

Division 52L – Introduction

Section 52L-1 What this Part is about
This section provides that refundable deposits, accommodation bonds and entry contributions must be managed in accordance with the prudential requirements made under Division 52M and the rules set out in Division 52N (permitted uses) and Division 52P (refunds).

Division 52M – Prudential requirements

Section 52M-1 Compliance with prudential requirements
This section provides that approved providers must comply with the Prudential Standards, set out in the Fees and Payments Principles. It is intended that these Standards will reflect those currently included in the User Rights Principles, with some changes as a consequence of other amendments under this Bill.

Division 52N – Permitted Uses

Section 52N-1 Refundable deposits and accommodation bonds to be used only for permitted purposes
This section provides that an approved provider can only use a refundable deposit or accommodation bond for permitted uses.

The permitted uses of refundable deposits and accommodation bonds, broadly fall into the categories of capital expenditure, investment in financial products, certain loans and repayments of debt, and refunding accommodation bond balances, entry contribution balances and refundable deposit balances. These permitted uses are those existing in the *Aged Care Act 1997* as at 30 June 2014.

The permitted uses are intended to reduce the risk of providers defaulting on obligations to repay refundable deposits and accommodation bonds, and clarify the intended purposes for refundable deposits and accommodation bonds – to provide a capital source of funding for investment in residential aged care infrastructure, for prudent financial investment and for refunding accommodation bond balances and refundable deposit balances.

Details regarding some permitted uses are outlined in the Fees and Payments Principles, such as permitted capital expenditure.

There are no restrictions on the use of income derived from investing refundable deposits, accommodation bonds or entry contributions (see section 52J-10 for the right of an approved provider to derive income).

Section 52N-2 Offences relating to non-permitted use of refundable deposits and accommodation bonds
This section outlines the offences that may apply to an approved provider or key personnel if there is a non-permitted use of a refundable deposit or accommodation bond and within 2 years after the non-permitted use the Guarantee scheme is triggered.

The Guarantee Scheme is triggered when the approved provider has an insolvency event and has at least one outstanding accommodation bond balance or refundable deposit balance that has not been refunded.

Offence provisions for the non-permitted use of refundable deposits and accommodation bonds are appropriate because of the misuse funds which have been essentially loaned to the approved provider by people in a vulnerable position. Specific offence provisions in the *Aged Care Act 1997* are necessary because, in the absence of fraud, non-permitted use of refundable deposits and accommodation bonds are not an offence under the Criminal Code or the various state and territory Crimes Acts.

Criminal penalties may apply to individuals who were in a position to influence how bonds were used by an approved provider, and who know about, or who were reckless or negligent regarding, non-permitted uses of bonds.

Each of the criminal penalties is based on those existing in the *Aged Care Act 1997* as at 30 June 2014. The offences have been changed to reflect the broader scope of responsibilities relating not just to accommodation bonds but also refundable deposits that may be paid by care recipients from 1 July 2014.

Division 52P – Refunds

This Division specifies the rules for refunding refundable deposit balances. These rules also apply to accommodation bonds.

Section 52P-1 Refunding refundable deposit balances
This section establishes the rules for refunding refundable deposit balances when a care recipient dies or ceases to be provided with care by the residential care service or flexible care service. The timing of the refund will vary, depending on whether the care recipient has notified the approved provider that they will be leaving, as set out in subsection 52P-1(4).

If the care recipient died, the refund is due 14 days after the day the approved provider sights the probate of the will or letters of administration of the care recipient's estate.

If the care recipient has notified the approved provider more than 14 days before they leave the residential care service or flexible care service, then the refund is due on the day that the care recipient leaves.

If the care recipient notified the approved provider 14 days or less before they leave, then the refund is due 14 days after the day after the notification was given.

If the care recipient did not notify the approved provider that they were leaving the residential care service or flexible care service, the refund is due 14 days after the day after the care recipient leaves.

The process for refunding deposit balances, including the rules for the payment of interest on any balance, is specified in the Fees and Payments Principles.

Section 52P-2 Refunding refundable deposit balances – former approved providers
This section imposes requirements for the repayment of refundable deposit balances on persons that were approved providers but have ceased to be approved providers ('former approved providers'). This section is intended to preserve the statutory obligations imposed on approved providers for refunding refundable deposit balances in circumstances in which an entity ceases to be an approved provider, for example because its approval as a provider has been revoked as a sanction under Part 4.4 of the *Aged Care Act 1997.*

The section provides that if a refundable deposit was paid to an approved provider for entry to a residential or flexible care service and the approved provider ceases to be an approved provider (of that service), the former approved provider must refund the refundable deposit balance to the care recipient.

The timeframes within which the refundable deposit balance must be refunded are set out in subsection (3) as follows:

- if the care recipient dies within 90 days after the day on which the former approved provider ceased to be an approved provider in respect of the service (the 90 day period) the refundable deposit balance must be repaid within 14 days after the day on which the former approved provider is shown the probate of the will of the care recipient or letters of administration of the estate of the care recipient; or

- if the care recipient is to enter another service to receive residential care within the 90 day period:

    - if the care recipient has notified the former approved provider of the move more than 14 days before the former approved provider ceased providing care to the care recipient, on the day the former approved provider ceased providing that care; or

    - if the care recipient notified the former approved provider within 14 days before the former approved provider ceased providing that care, within 14 days after the notice was given; or

    - if the care recipient did not notify the former approved provider before the former approved provider ceased providing that care, within 14 days after the former approved provider ceased providing that care; or

- in any other case, within the 90 day period.

Subsection 52P-2 specifies that a corporation commits an offence if it was required under this section to refund an amount on a particular day or within a particular period and did not do so. This offence is punishable by a penalty of 30 penalty units.

Section 52P-3 Payment of interest
This section provides that the Fees and Payments Principles may specify circumstances in which interest may be payable on a refundable deposit, accommodation bond or entry contribution balance. The Principles may also specify how any interest is to be worked out. This enables the Principles to describe interest arrangements when, for example, a refundable deposit is refunded after the time required by section 52P-1.

Section 52P-4 Delaying refunds to secure re-entry
This section specifies the conditions under which a care recipient and an approved provider may agree to delay the refund of a refundable deposit or accommodation bond in order to secure re-entry to the service or entry to an alternative service.

This situation may arise if an approved provider is temporarily closing one of its residential care services or flexible care services to refurbish it and once the service is operational again the former care recipient wishes to return to the same service. In this case, the care recipients who had paid a refundable deposit or accommodation bond may choose to have their refund delayed as they anticipate returning to the same service.

Items 150, 152, 156, 165 and 166
These items replace the words 'subsidy is payable under Chapter 3' with '*subsidy is payable' throughout the *Aged Care Act 1997*. The words are replaced in:

- section 53-1 (note)
- paragraphs 54-1(2)(a), 56-5(a), 63-1(2)(a); and
- subparagraph 63-1AA(9)(b)(i)

These changes ensure that any reference to subsidy includes both subsidy payable under the *Aged Care Act 1997* and subsidy payable under the *Aged Care Act (Transitional Provisions) Act 1997*.

Item 151
This item makes consequential changes to paragraph numbering in paragraph 54-1(1)(c) as the result of the changes to section 56 that are described in items 153 to 155.

Item 153
This amendment updates the list of approved provider responsibilities for residential care that are described in section 56-1 to reflect the changes made throughout the *Aged Care Act 1997*. The list of approved provider responsibilities applies to providers who are providing care to both care recipients who entered the residential care service before 1 July 2014 and those who entered on or after 1 July 2014.

Specifically the responsibilities of an approved provider are as follows.

- Paragraph 56-1(a) limits the amount that a non-continuing care recipient can be charged for the provision of care and services that it is the approved provider's responsibility to provide. It also requires compliance with rules relating to resident fees and accommodation payments and contributions.

- Similarly paragraph 56-1(b) limits the amount that a continuing care recipient can be charged for the provision of care and services, and requires compliance with rules regarding resident fees and accommodation that it is the approved provider's responsibility to provide as prescribed in the *Aged Care (Transitional Provisions) Act 1997*.

- Paragraph 56-1(c) requires that in relation to an entry contribution the provider comply with the requirements of the Prudential Standards and the *Aged Care (Transitional Provisions) Act 1997* in relation to entry contributions.

- Paragraph 56-1(d) requires that a provider charge no more, by way of booking fee for respite care, than any amount set out in the Fees and Payments Principles.

- Paragraph 56-1(e) requires that a care recipient cannot be charged any more than an amount agreed beforehand for the provision of care and services other than those the provider is required to provide. An itemised account of other care and services must be provided to the care recipient.

- Paragraph 56-1(f) requires providers to ensure security of tenure for the care recipients place, in accordance with the User Rights Principles.

- Paragraph 56-1(g) requires compliance with requirements relating to extra service agreements.

- Paragraph 56-1(h) requires the approved provider to offer a resident agreement and enter into such an agreement if that is what the care recipient wishes.

- Paragraphs 56-1(i) and 56-2(j) require providers to comply with rules relating to personal information and resolution of complaints.

- Paragraphs 56-1(k) and 56-1(l) set out responsibilities in regard to allowing access to the service for people acting for care recipients and for people acting for bodies that have received advocacy grants or community visitors grants. The User Right Principles will specify the access requirements.

- Paragraph 56-1(m) requires the approved provider to uphold the rights and responsibilities of care recipients as specified in the User Rights Principles.

- Paragraph 56-1(n) requires providers to comply with any other responsibilities set out in the User Rights Principles or the Fees and Payments Principles (for example responsibilities relating to the charging of fees and accommodation payments).

Item 154
This amendment updates the list of approved provider responsibilities for home care that are described in section 56-2, to reflect the changes made throughout the *Aged Care Act 1997*. The list of approved provider responsibilities applies to providers who are providing care to both care recipients who entered home care before 1 July 2014 and those who entered on or after 1 July 2014.

Specifically the responsibilities of an approved provider will include the following:

- Paragraph 56-2(a) prohibits the provider from charging for entry to a home care service.

- Paragraph 56-2(b) limits the amount that a non-continuing care recipient can be charged for the provision of care and services that it is the responsibility of the approved provider to provide, and also requires providers to comply with the rules relating to home care fees.

- Paragraph 56-2(c) limits the amount that a continuing care recipient can be charged for the provision of care and services that it is the responsibility of the approved provider to provide, and also requires providers to comply with the rules relating to home care fees as prescribed in the *Aged Care (Transitional Provisions) Act 1997*.

- Paragraph 56-2(d) requires that a provider charge no more for care or services provided in addition to those that it is the provider's responsibility to provide under s54-1(1)(a) than an amount agreed beforehand. An itemised account of other care and service must be provided to the care recipient.

- Paragraph 56-2(e) requires that a provider provide such other care and services described in paragraph 56-2(d) in accordance with the agreement between the approved provider and the care recipient.

- Paragraph 56-2(f) requires providers to ensure security of tenure for the care recipient's place in the service in accordance with the User Rights Principles.

- Paragraph 56-2(g) requires the approved provider to offer a home care agreement and enter into such an agreement if that is what the care recipient wishes.

- Paragraphs 56-2(h) and 56-2(i) require providers to comply with rules relating to personal information and resolution of complaints.

- Paragraph 56-2(j) requires providers to allow access to the service for people acting for bodies that have received advocacy grants.

- Paragraph 56-2(k) requires the approved provider to uphold the rights and responsibilities of care recipients as specified in the User Rights Principles.

- Paragraph 56-2(l) requires providers to comply with any other responsibilities set out in the User Rights Principles or Fees and Payments Principles.

Item 155
This amendment updates the list of approved provider responsibilities for flexible care that are described in section 56-3 to reflect the changes made throughout the *Aged Care Act 1997*. The list of approved provider responsibilities applies to providers who are providing care to both care recipients who entered flexible care before 1 July 2014 and those who entered on or after 1 July 2014.

Specifically the responsibilities of an approved provider will include the following:

- Paragraph 56-3(a) prohibits the provider from charging any more for the provision of care and services than is set out in the User Rights Principles.

- Paragraph 56-3(b) requires that if the care recipient entered flexible care on or after 1 July 2014, the provider must comply with the requirements in Part 3. 2A of the *Aged Care Act 1997* relating to accommodation payments (noting that flexible care services cannot charge accommodation contributions).

- Paragraph 56-3(c) requires that if the care recipient is a continuing care recipient (that is entered care before 1 July 2014) then if the care recipient paid an accommodation bond or is paying an accommodation charge the provider must comply with the requirements relating to bonds and charges that are described in the *Aged Care (Transitional Provisions) Act 1997*.

- Paragraph 56-3(d) requires that if the care recipient paid an entry contribution, the provider must comply with the formal agreement under which that entry contribution was paid and also the Prudential Standards and the requirements set out in the Aged Care (Transitional Provisions) Principles made under the *Aged Care (Transitional Provisions) Act 1997*.

- Paragraph 56-3(e) requires that a provider charge no more for any care or services than the amount agreed beforehand. An itemised account of other care and services must be provided to the care recipient.

- Paragraph 56-3(f) requires providers to ensure security of tenure for the care recipient's place in the service in accordance with the User Rights Principles.

- Paragraph 56-3(g) requires the approved provider to comply with any rules in the Fees and Payments Principles relating to offering an agreement and entering into such an agreement if that is what the care recipient wishes.

- Paragraphs 56-3(h) and 56-3(i) require providers to comply with rules relating to personal information and resolution of complaints.

- Paragraphs 56-3(j) and 56-3(k) require providers to allow people acting for the care recipient to have such access to the service as is specified in the User Rights Principles. Access must also be given to people acting for bodies paid advocacy grants.

- Paragraph 56-3(l) requires the approved provider to uphold the rights and responsibilities of care recipients as specified in the User Rights Principles.

- Paragraph 56-3(m) requires providers to comply with any other responsibilities set out in the User Rights Principles or Fees and Payments Principles.

Item 157
This item repeals Divisions 57, 57A and 58 that set out the responsibilities relating to accommodation bonds, entry contributions and resident fees.

For continuing care recipients, all of these rules will be preserved in the *Aged Care (Transitional Provisions) Act 1997*.

For care recipients entering care on or after 1 July 2014, the new arrangements relating to accommodation payments, accommodation contributions and resident fees are dealt with in the new Chapters 3 and 3A.

Item 158
Section 59-1 deals with requirements for resident agreements. One of the current requirements is that the approved provider must specify the levels of care and services that the provider has the capacity to provide the care recipient. This item amends this paragraph so that it simply refers to the care and services that the provider is able to provide rather than the levels (noting that from 1 July 2014 there will no longer be a distinction between high and low level residential care).

Item 159
This item amends the note at the end of subsection 59-1(3) about the requirements of resident agreements.

This is a change in terminology to reflect the replacement of accommodation bonds and accommodation charges with accommodation payments from 1 July 2014.

Item 160
This item repeals Division 60 which deals with approved provider responsibilities in relation to home care fees. All of the relevant responsibilities from this Division have been moved into Division 52D which deals with home care fees.

Items 161, 162, 163 and 164
Section 62-1 describes the approved provider responsibilities in relation to the protection of personal information.

The effect of these items is to amend section 62-1 so that it reflects provider responsibilities in relation to protection (and disclosure) of information relating to accommodation payments and contributions (so that the same protections exist as for accommodation bonds and charges) and to ensure that appropriate reference is made to the *Aged Care (Transitional Provisions) Act 1997* where obligations are now described in that Act, for continuing care recipients.

Items 167 and 168
These items amend the requirement of the Minister to report annually on the operation of the *Aged Care Act 1997*. Item 168 amends paragraph 63-2(2)(c) so that the report includes not just information about the extent to which providers are complying with their responsibilities under the *Aged Care Act 1997* but also the extent to which they are complying with their responsibilities under the *Aged Care (Transitional Provisions) Act 1997*.

Item 169 adds two new paragraphs (ca) and (cb) so that the annual report on the operation of the *Aged Care Act 1997* will also include information about the amounts of accommodation payments and accommodation contributions paid by care recipients and the amounts paid as refundable deposits and daily payments.

Items 170 and 171
Section 66-1 specifies the sanctions that may be imposed on an approved provider that has not complied, or is not complying, with one or more of its responsibilities under Part 4. 1, 4. 2 or 4. 3 of the *Aged Care Act 1997*.

From 1 July 2014, it is proposed that, consistent with the sanction in paragraph 66-1(j) relating to accommodation bonds, a new sanction relating to the new accommodation payments (proposed paragraph 66-1(ia)) be introduced. It is also proposed that three new sanctions be introduced to better align with the new requirements in the legislation:

- requiring the repayment of an amount (with interest) to a care recipient who has been charged an accommodation payment or accommodation contribution that is greater than the maximum amount permitted (paragraph 66-1(ja));

- requiring repayment of a refundable deposit balance, an accommodation bond balance or an entry contribution balance (with interest) where it has not been refunded as required under the *Aged Care Act 1997* (paragraph 66-1(jb)); and

- restricting, to one or more of the permitted uses under Division 52N, the use of refundable deposit balances, accommodation bond balances or entry contribution balances during the period specified in the sanction notice (paragraph 66-1(jc)).

These paragraphs allow the Secretary to enforce the rules around the charging, use and refunding of accommodation bond balances, entry contribution balances and refundable deposit balances.

Item 172
Subparagraph 67A-4(2)(a)(iv) requires the Secretary, in making a decision that a sanction should take effect at a later time, to have regard to (amongst other matters) the consequences under the *Aged Care Act 1997* of the imposition of the sanction. As the imposition of a sanction may have consequences under both the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*, this item inserts a reference to the *Aged Care (Transitional Provisions) Act 1997*.

Item 174
This item replaces the words 'Residential Care Grant Principles' with 'Grant Principles' in section 70-2.

Provisions currently included in the Residential Care Grant Principles will be consolidated into new Grant Principles, along with provisions in the Advocacy Grant Principle, Community Visitors Grant Principles and Other Grant Principles.

Item 178, 179 and 180
Subsection 81-3(1) (including the note) and paragraphs 81-4(1)(a) and (b) currently refer to the Advocacy Grant Principles. From 1 July 2014, the provisions currently included in the Advocacy Grant Principles will be consolidated into new Grant Principles, along with provisions from the Residential Care Grant Principles, Community Visitors Grant Principles and Other Grant Principles.

These items therefore change the references from 'Advocacy Grant Principles' to 'Grant Principles'.

Items 181, 182, 183 and 184
Subsection 82-2(3) (including the note), section 82-3 and paragraphs 82-4(1)(a) and (b) currently refer to the Community Visitors Grant Principles. From 1 July 2014 the provisions currently included in the Community Visitors Grant Principles will be consolidated into new Grant Principles, along with provisions from the Residential Care Grant Principles, Advocacy Grant Principles and Other Grant Principles.

These items therefore change the references from 'Community Visitors Grant Principles' to 'Grant Principles'.

Items 185, 186 and 187
Subsection 83-1(3) (including the note) and paragraphs 83-2(a) and (b) currently refer to the Other Grants Principles. From 1 July 2014, the provisions currently included in the Other Grant Principles will be consolidated into new Grant Principles, along with provisions from the Residential Care Grant Principles, Advocacy Grant Principles and Community Visitors Grant Principles.

These items therefore change the references from 'Other Grants Principles' to 'Grant Principles'.

Item 188, 189, 190, 191, 192 and 193
The *Aged Care Act 1997* allows certain decisions to be subject to internal reconsideration and to subsequent review by the Administrative Appeals Tribunal. Section 85-1 describes, in a table, those decisions that are reviewable decisions.

The amendments described in these items repeal from the table in section 85-1 those decisions that will no longer exist from 1 July 2014 and replaces the table items with new decisions that will be made from 1 July 2014.

Specifically:

- table item 39A currently provides that a decision to grant or refuse an application for a determination described in subsection 44-7(1A) or 44-8(1A) (which is relevant to a person's status as a concessional resident or an assisted resident) is a reviewable decision. Table item 39B provides that a decision to revoke a determination of a person's status as a concessional or assisted resident is also a reviewable decision. Care recipients who enter residential care from 1 July 2014 will not be eligible for a concessional resident or assisted resident status. Item 188 therefore repeals table items 39A and 39B as they will no longer apply after 1 July 2014. However, for care recipients who entered aged care before 1 July 2014 and were granted a concessional resident or assisted resident status, these decisions will continue to be reviewable decisions under the *Aged Care (Transitional Provisions) Act 1997.*

- table item 39C describes the decision to determine the value of a person's assets under subsection 44-8AB(1). From 1 July 2014, this decision will be made under a new subsection 44-26C(1) and included as table item 47. Similarly, table item 39D (a decision to revoke a determination of the value of a person's assets under subsection 44-8AB(4)) is being replaced with new table item 47A which relates to a decision to revoke a determination of the value of a person's assets under subsection 44-26C(4). Table items 39C and 39D will be set out as reviewable decisions in the *Aged Care (Transitional Provisions) Act 1997*.

- currently table items 40, 41 and 47 describe the decisions to refuse to make a determination that a care recipient is eligible for an oxygen supplement, enteral feeding supplement or that the approved provider is eligible for a viability supplement. As these decisions will be made under Principles from 1 July 2014, these table items are being repealed. A new table item inserted by Schedule 1 of this Bill will however ensure that decisions made in accordance with Principles will still be reviewable under section 85 of the *Aged Care Act 1997*, as will be the case for these decisions;

- under the new subsection 44-20A(4) the Secretary has the power to determine compensation payment reductions for a care recipient where the information or document is not given or produced within the specified period stated in a notice given by the Secretary. It is appropriate that this new decision be subject to reconsideration and review. Item 189 therefore inserts a new reviewable decision with regard to the Secretary's power to determine compensation payment reductions in respect of residential care subsidy when the care recipient has not provided the Secretary with information (new table item 44). New table items 50, 51 and 52 are also being added to the table of reviewable decisions to ensure that the decisions regarding compensation payment reductions in respect of home care subsidy are also reviewable;

- the current table item 44 describes the decision to refuse to make a determination that the daily income tested reduction is zero. This decision, made under new subsection 44-23(2), will now appear at table item 45. In addition, the decision to refuse to make a determination that the care subsidy reduction is zero in relation to home care subsidy will also be a reviewable decision. A decision made under new

subsection 48-8(2) will be therefore included in the table of reviewable decisions at table item 53 by item 193 of the Bill;

- table item 45 describes the decision to specify a period at the end of which a determination that the daily income tested reduction is zero ceases to have effect (currently section 44-22(3)). As the income tested reduction will, from 1 July 2014, be a care subsidy reduction and because the section under which the decision is being made has changed, this table item is being repealed and replaced with table item 45A, which describes the decision to specify a period at the end of which a determination that the care subsidy reduction is zero ceases to be in force. A decision to specify a period at the end of which a determination that the care subsidy reduction is zero ceases to be in force in relation to home care subsidy (made under subsection 48-8(3)) will be inserted in table item 53A by item 193 of the Bill;

- table item 48 describes the decision to refuse to make a determination that a care recipient is eligible for a hardship supplement without specifying the type of care to which the decision relates. This table item is being amended by item 191 of the Bill to make clear that the decision is in relation to residential care. This is due to the creation of a new reviewable decision in table item 53B describing a decision to refuse to make a determination that a care recipient is eligible for a hardship supplement in respect of home care. A new table item 49AA is also being added to describe a new decision which is a decision to revoke a determination that a care recipient is eligible for hardship supplement in respect of residential care. As hardship will also be available for home care, the relevant decisions regarding hardship determinations in home care have also been made reviewable decisions and are included in table items 53C and 53D;

- existing table items 51 to 53C, which describe reviewable decisions relating to determinations for financial hardship with respect to accommodation bonds and accommodation charges, are being repealed from the table in the *Aged Care Act 1997* but will be retained in the *Aged Care (Transitional Provisions) Act 1997*. The table items are being replaced with new table items (table items 53F to 53H) that ensure that decisions relating to hardship in relation to accommodation contributions and accommodation payments are reviewable;

- item 193 adds a new table item 53E to section 85-1. This ensures that a decision by the Aged Care Pricing Commissioner to refuse to approve a higher maximum amount of accommodation payment is a reviewable decision.

Items 194 and 195
These items amend section 85-2. Section 85-2 establishes deadlines for making reviewable decisions, including the circumstances in which the Secretary is taken, for the purposes of the *Aged Care Act 1997*, to have made a decision to reject the application for reconsideration. The section outlines that if: the Act provides for a person to apply to the Secretary to make a reviewable decision; and a period is specified under the Act for giving notice of the decision to the applicant; and the Secretary has not notified the applicant of the Secretary's decision within that period; the Secretary is taken, for the purposes of the Act, to have made a decision to reject the application.

These items add a new subsection (subsection 85-2(2)) that provides that if: the Act provides for a person to apply to the Aged Care Pricing Commissioner to make a reviewable decision; and a period is specified under the Act for giving notice of the decision to the applicant; and the Aged Care Pricing Commissioner has not notified the applicant of the Aged Care Pricing Commissioner's decision within that period; the Aged Care Pricing Commissioner is taken, for the purposes of the Act, to have made a decision to reject the application.

Item 196 and 197
These items amend section 85-3 which describes the requirement of the Secretary to give reasons for reviewable decisions. This section's heading is amended by removing the reference to the Secretary in order to broaden the application of this section to also include the Aged Care Pricing Commissioner. Subsections 85-3(1) and (2) are amended by establishing in relation to the Aged Care Pricing Commissioner, the same requirements of the Secretary to provide reasons for reviewable decisions.

Items 198, 199, 200, 201, 202, 203 and 204
These items amend section 85-4 which describes the ability of the Secretary to reconsider reviewable decisions. This section is amended by removing the references to the Secretary in order to broaden the application of this section to also include the Aged Care Pricing Commissioner.

Item 199 amends subsection 85-4(1) which describes when the Secretary may reconsider a reviewable decision. This subsection is amended to specify that the Secretary may reconsider a decision other than a reviewable decision under Division 35 or section 52G-4, which relate to decisions that may be reviewed by the Aged Care Pricing Commissioner. Division 35 relates to the power of the Aged Care Pricing Commissioner to determine the extra service fee and section 52G-4 relates to the power of the Aged Care Pricing Commissioner to approve an amount of accommodation payment that is higher than the maximum determined by the Minister under section 52G-3.

Item 200 amends subsection 85-4(1) by inserting subsection 85-4(1A) which describes that the Aged Care Pricing Commissioner may reconsider a reviewable decision under Division 35 or section 52G-4 if they are satisfied that there is sufficient reason to reconsider the decision.

Items 201, 202, 203 and 204 amend subsections 85-4(3), 85-4(4), 85-4(5) and 85-4(6) by inserting the reference to the Aged Care Pricing Commissioner to grant the Aged

Care Pricing Commissioner the same powers and responsibilities as the Secretary when reconsidering a reviewable decision.

Items 205 to 212
Section 85-5 currently provides that a person whose interests are affected by a reviewable decision may request the Secretary to reconsider the decision. However, from 1 July 2014, the Aged Care Pricing Commissioner may also make decisions that are reviewable decisions.

These items provide that a person may request the Aged Care Pricing Commissioner to reconsider a reviewable decision that he or she has made in relation to extra service fees or the maximum amount of accommodation payment.

The person's request must be made in writing to the Aged Care Pricing Commissioner within 28 days, or such longer period as the Aged Care Pricing Commissioner allows, after the day on which the person first received notice of the decision.

The notice must set out the reasons for making the request.

After receiving the request, the Aged Care Pricing Commissioner must reconsider the decision and:

- confirm the decision;
- vary the decision; or
- set the decision aside and substitute a new decision.

The Aged Care Pricing Commissioner's decision to confirm, vary or set aside the decision takes effect on the day specified in the decision on review or if the day is not specified – on the day on which the decision on review was made.

The Aged Care Pricing Commissioner is taken to have confirmed the decision if he or she does not give notice of a decision to the person within 90 days after receiving the person's request.

If a committee has been established to provide advice to the Aged Care Pricing Commissioner in relation to his or her reconsideration of a particular kind of reviewable decision, he or she:

- may refer a reviewable decision of that kind to the committee for advice; and
- must, in reconsidering the decision, take account of any advice provided by the committee in relation to the decision.

Item 213
Section 86-1 provides a definition of protected information.

This item inserts references to the *Aged Care (Transitional Provisions) Act 1997* so that information collected under that Act in relation to continuing care recipients

continues to be defined as protected information and continues to be able to be used and disclosed for the same purposes as information collected under the *Aged Care Act 1997*.

Items 214 and 215
Section 86-2 sets out the uses of protected information and the penalties that apply when the information is not used for the purpose for which it is intended.

These items insert references to the *Aged Care (Transitional Provisions) Act 1997* so that information collected under that Act in relation to continuing care recipients continues to be defined as protected information and continues to be able to be used for the same purposes as protected information collected under the *Aged Care Act 1997*.

Item 216
Section 86-9 describes the information that the Secretary may make publicly available about an aged care service. This item amends paragraph 86-9(1)(e) to extend the information the Secretary may make publicly available to include information about accommodation payments and accommodation contributions in the same way that the Secretary may make publicly available information about accommodation bonds and accommodation charges.

Item 217
Section 86-9 sets out the information that the Secretary may make publicly available about an aged care service. This item inserts in paragraph 86-9(1)(h) a reference to the *Aged Care (Transitional Provisions) Act 1997* to enable the Secretary to make publicly available information regarding the amounts of funding received by a service under that Act or under the *Aged Care Act 1997*.

Item 221
Section 90-4 gives authorised officers the power to monitor approved providers to ensure that they are meeting their responsibilities under the *Aged Care Act 1997*. This item amends paragraph 90-4(3)(d) to insert a reference to the *Aged Care (Transitional Provisions) Act 1997.* This will enable an authorised officer to also monitor whether claims for payment under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997*, or other payments under that Act, have also been made properly. Such claims would include, for example, claims for payment of subsidy and supplements in respect of continuing care recipients.

Items 222 and 223
Section 91-1 gives an authorised officer the power to enter an aged care service at any time of the day or night, and to enter other premises between 9 am and 5 pm on a business day, and exercise monitoring powers. An authorised officer may do this to the extent that is reasonably necessary for various purposes specified in subsection 91-1(2), which include assessing whether an approved provider's claims for payment under Chapter 3 or other payments under the *Aged Care Act 1997* have been properly made.

Item 222 amends paragraph 91-1(2)(b) to enable an authorised officer to also enter a premises to assess whether an approved provider's claims for payment under

Chapter 3 the *Aged Care (Transitional Provisions) Act 1997* have been made properly. This amendment ensures that an authorised officer can monitor payments being made under the *Aged Care Act 1997* in respect of care recipients entering care on or after 1 July 2014 and payments being made under the *Aged Care (Transitional Provisions) Act 1997* for continuing care recipients.

As well as making applications under the *Aged Care Act 1997*, an approved provider might also make applications under the *Aged Care (Transitional Provisions) Act 1997* in relation to care recipients in care on 30 June 2014. Therefore item 223 amends paragraph 91-1(2)(f) to enable an authorised officer to also enter a premises to assess any application made under the *Aged Care (Transitional Provisions) Act 1997*.

Item 224 and 225
Section 92-1 sets out the circumstances in which an authorised officer may exercise his or her monitoring powers without the approved provider's consent. Section 92-2 sets out the circumstances in which an authorised officer may apply to a magistrate for a monitoring warrant and the circumstances in which the warrant may be issued.

Item 224 amends paragraph 92-1(b) to remove the reference to Chapter 3 and refer the reader to the definition of the word 'subsidy' in the Dictionary in Schedule 1 to the *Aged Care Act 1997*. The definition, as amended by this Bill (once enacted) provides that subsidy is paid under Chapter 3 of the *Aged Care Act 1997* and under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997*. This amendment ensures that an authorised officer can exercise the powers granted under Division 92 in circumstances relating to the payment of subsidy in respect of care recipients entering care on or after 1 July 2014 as well as in respect of continuing care recipients.

Item 225 amends paragraph 92-2(2)(b) to provide that a magistrate may also issue a monitoring warrant to give an authorised officer access to premises to assess whether an approved provider's claims for payment under Chapter 3 the *Aged Care (Transitional Provisions) Act 1997* and other payments under that Act have been made properly. This amendment recognises that after 1 July 2014 payments will be made under the *Aged Care Act 1997* for care recipients who enter care on or after 1 July 2014 as well as under the *Aged Care (Transitional Provisions) Act 1997* for continuing care recipients.

Item 226 and 227
Section 93-1 sets out the circumstances in which the Secretary has the power to require a person to attend before an authorised officer at a specified time and place to answer questions and provide documents that relate to a specified matter. These items amend the list of specified matters.

Item 226 amends paragraph 92-2(2)(b) to also list as a specified matter an assessment of whether an approved provider's claims for payment under Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997* have been made properly. This amendment recognises that after 1 July 2014 payments will be made under the *Aged Care Act 1997* for care recipients who enter care on or after 1 July 2014 as well as under the *Aged Care (Transitional Provisions) Act 1997* for continuing care recipients.

As well as making applications under the *Aged Care Act 1997*, an approved provider might also make applications under the *Aged Care (Transitional Provisions) Act 1997* in relation to care recipients in care on 30 June 2014. Therefore item 227 amends paragraph 92-2(2)(f) to enable an authorised officer to require a person to attend at a specified time and place to answer questions and produce documents to assess any application made under the *Aged Care (Transitional Provisions) Act 1997.*

Item 233
Section 95-3 provides that where an approved provider is liable to pay a recoverable amount, as defined in the Dictionary in Schedule 1 to the *Aged Care Act 1997*, the amount can be deducted from other amounts payable to the approved provider. The current drafting of section 95-3 provides that it only applies in relation to payments made under the *Aged Care Act 1997*.

This item inserts a reference to the *Aged Care (Transitional Provisions) Act 1997* to provide that the treatment of recoverable amounts also applies to payments made under that Act from 1 July 2014.

Item 234
Section 95-4 provides that where an approved provider is liable to pay a recoverable amount because of an overpayment in respect of an aged care service and all the allocated places included in the aged care service have been transferred to a new provider, the recoverable amount is deductible from payments to the new provider. Section 95-4 currently relates only to overpayments made under the *Aged Care Act 1997.* This item inserts a reference to the *Aged Care (Transitional Provisions) Act 1997* to provide that the treatment of recoverable amounts also applies to overpayments made under that Act.

Items 235 to 238
These items amend section 96-1. Section 96-1 sets out the Principles that may be made by the Minister.

The effect of the changes to the table of Principles in section 96-1 is that from 1 July 2014:

- there will no longer be any Advocacy Grant Principles, Community Visitors Grant Principles, Other Grants Principles or Residential Care Grant Principles. These will be consolidated into one set of Grant Principles; and

- there will no longer be any Community Care Subsidy Principles, Flexible Care Subsidy Principles or Residential Care Subsidy Principles. These will be combined into one set of Subsidy Principles that are relevant to care recipients who enter care on or after 1 July 2014. Matters relating to subsidy for recipients who entered care before this date will be dealt with in the Aged Care (Transitional Provisions) Principles.

Items 239, 240, 241, 242, 243, 244 and 245
Section 96-2 relates to delegations of the Secretary's powers and functions. These items make consequential changes to section 96-2 so that where the powers of the Secretary have been changed (or the location of these powers moved) and there are

cross-references to these powers and provisions in section 96-2 the cross-references are accurate.

Item 246
Subsection 96-3(1) enables the Minister to establish committees for the purposes of the *Aged Care Act 1997*. This item amends this section so that committees may also be established for the purpose of the *Aged Care (Transitional Provisions) Act 1997.*

Item 247
Section 96-5 describes the circumstances under which another person can enter into specified agreements under the *Aged Care Act 1997* on behalf of a care recipient. This item amends the note to remove the former terminologies for accommodation bond agreements and accommodation charge agreements and replace them with the new terminology of accommodation agreement.

Item 248
Section 96-10 provides that subsidies payable under Chapter 3, and amounts payable under subsection 44-8A(6) are payable out of the Consolidated Revenue Fund, which is appropriated accordingly.

This item amends that section so that subsidies payable under Chapter 3 of the *Aged Care Act 1997* and subsidies payable under the *Aged Care (Transitional Provisions) Act 1997* are both appropriated and payable from Consolidated Revenue.

Items 249 to 289
These items amend Clause 1 Schedule 1 of the Dictionary to the *Aged Care Act 1997* to reflect the changes being made throughout the Act.

The items insert new definitions such as:

- ‘accommodation agreement’, which means an agreement that meets the requirements of section 52F-3. Accommodation agreements set out information relating to accommodation payments and contributions and how a person may choose to pay their accommodation payments or contributions;

- ‘accommodation contribution’, which means a contribution paid for accommodation provided with residential care;

- ‘accommodation payment’, which means payment for accommodation provided with residential or flexible care;

- ‘accommodation supplement’, which means the supplement referred to in section 44-28;

- ‘combined care subsidy reduction’, which means a care subsidy reduction under section 44-21 (residential care) or section 48-7 (home care);

- continuing care recipient means:

    - a continuing flexible care recipient; or

- a continuing home care recipient; or
- a continuing residential care recipient;

- 'continuing flexible care recipient' means a person who entered a flexible care service before 1 July 2014 and has not:
  - ceased to be provided with flexible care by a flexible care service for a continuous period of more than 28 days (other than because the person is on leave); or
  - before moving to another flexible care service, made a written choice, in accordance with the Fees and Payments Principles, to be covered by Chapters 3 and 3A of the *Aged Care Act 1997* in relation to the other service;

- 'continuing home care recipient' refers to a person who has entered a home care service before 1 July 2014 and has not:
  - ceased to be provided with home care by a home care service for a continuous period of more than 28 days (other than because the person is on leave); or
  - before moving to another home care service, made a written choice, in accordance with the Fees and Payments Principles, to be covered by Chapters 3 and 3A of the *Aged Care Act 1997* in relation to the other service;

- 'continuing residential care recipient' refers to a person who has entered a residential care service before 1 July 2014 and has not:
  - ceased to be provided with flexible care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave); or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles, to be covered by Chapters 3 and 3A of the *Aged Care Act 1997* in relation to the other service;

- 'daily accommodation contribution', which means an accommodation contribution that accrues daily and is paid by periodic payment. This contrasts a refundable accommodation contribution which does not accrue daily and is paid by lump sum;

- 'daily accommodation payment', which means an accommodation payment that accrues daily and is paid by periodic payment. This contrasts a refundable accommodation deposit which does not accrue daily and is paid by lump sum;

- 'daily payment', which is the collective term used in the *Aged Care Act 1997* to refer to both a daily accommodation payment and a daily accommodation contribution;

- 'eligible flexible care service', which has the meaning given by subsection 52F-1(2) which is a provider of a flexible care service that is permitted to charge care recipients an accommodation payment because the service is specified as an eligible flexible care service under the Fees and Payment Principles. For example it is proposed that the Principles would prescribe Multi-Purpose Services (MPS) (which is a type of flexible care service) as an eligible flexible care service. This is consistent with current arrangements whereby MPS's may charge accommodation bonds;

- ‘maximum accommodation supplement amount’ has the meaning given by subsection 44-21(6) which is, for a day, the highest of the amounts determined by the Minister by legislative instrument as the maximum amounts of accommodation supplement payable for residential care services for that day;

- ‘maximum home value’ has the meaning given by section 44-26B which is the amount determined by the Minister by legislative instrument;

- ‘means tested amount’ has the meaning given by section 44-22. Section 44-22 includes a ten step calculator for working out the means tested amount for a care recipient;

- ‘refundable accommodation contribution’ means an accommodation contribution that does not accrue daily and is paid as a lump sum;

- ‘refundable accommodation deposit’ means an accommodation payment that does not accrue daily and is paid as a lump sum;

- ‘refundable deposit’ is the collective term used to describe both a refundable accommodation deposit and a refundable accommodation contribution;

- ‘refundable deposit balance’ means a refundable deposit less any allowable deductions that are permitted to be deducted in accordance with the *Aged Care Act 1997;*

- ‘start-date year’ is a term used to refer to the date and year which a care recipient first entered an aged care service, or an anniversary of that day;

- ‘subsidy’ means a subsidy payment made under Chapter 3 of the *Aged Care Act 1997* or Chapter 3 of the *Aged Care (Transitional Provisions) Act 1997;*

The items also amend existing definitions such as the definitions of:

- ‘accommodation bond’ and ‘accommodation charge’. Notes are added to these definitions to refer the reader to the rules in the *Aged Care (Transitional Provisions) Act 1997;*

- ‘accommodation bond balance’ to make reference to amounts deducted in accordance with both the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997;*

- ‘permitted’ to include permitted uses of refundable deposits in the same way as the term applies to accommodation bonds as outlined in section 52N-1;

- ‘close relation’, ‘dependent child’, ‘homeowner’, ‘member of a couple’, ‘partner’ and ‘pre-entry leave’ to change the section cross references within those definitions; and

- 'unregulated lump sum' and 'unregulated lump sum balance' so as to change cross references to the *Aged Care (Bond Security) Act 2006* to the *Aged Care (Accommodation Payment Security) Act 2006.*

The items also repeal redundant definitions such as the definitions of:

- accommodation bond agreement;
- accommodation charge agreement;
- assisted resident;
- charge exempt resident;
- concessional resident;
- daily income tested reduction;
- high level of residential care;
- low level of residential care;
- pensioner supplement;
- post-2008 reform resident, post-September 2009 resident, pre-2008 reform resident and pre-September 2009 resident;
- protected resident;
- standard resident contribution; and
- supported resident.

While these terms are no longer used in the *Aged Care Act 1997* they continue to be used in the *Aged Care (Transitional Provisions) Act 1997* and will be defined in that Act.

Part 2 – Transitional and savings provisions

Item 290

This item inserts two new definitions – 'commencement time' and 'old law' which are terms used in item 285.

The term 'commencement time' refers to the time when this Schedule commences (1 July 2014).

The term 'old law' means the *Aged Care Act 1997* as in force immediately before 1 July 2014.

Item 291
This item provides that an approval to receive residential care that was limited to a low level of residential care and given under Part 2. 3 of the *Aged Care Act 1997* as it existed on 30 June 2014 (and in force at that time) is taken, from 1 July 2014, to have been given without being limited to a low level of residential care.

The effect of this provision is that an approval for residential care that is still in force as at 30 June 2014 will enable the care recipient to access the care that they need without being limited to low level care.

Schedule 4 – Amendments of other Acts

Part 1 – Amendments commencing on 1 July 2013

A New Tax System (Goods and Services Tax) Act 1999

Item 1
This item replaces a reference to Community in the heading of section 38-30 of the *A New Tax System (Goods and Services Tax) Act 1999,* with a reference to Home. This is because, from 1 July 2013, community care in the *Aged Care Act 1997* will be replaced with a new form of care, home care.

Item 2
This item replaces references to community care with references to home care in subsection 38-30(1) of the *A New Tax System (Goods and Services Tax) Act 1999*. This is because from 1 July 2013 community care in the *Aged Care Act 1997* will be replaced with a new form of care, home care. This amendment ensures that a supply of home care is GST-free if home care subsidy is payable under Part 3. 2 of the *Aged Care Act 1997*, thereby treating a supply of home care from 1 July 2013 in the same way as a supply of community care is currently treated for GST purposes.

Item 3
This item replaces a reference to community care with a reference to home care in subsection 30-30(3) of the *A New Tax System (Goods and Services Tax) Act 1999*. This is because from 1 July 2013 community care in the *Aged Care Act 1997* will be replaced with a new form of care, home care. This amendment ensures that from 1 July 2013 a supply of home care is GST-free in the same way that a supply of community care is under the current arrangements. That is, a supply of home care will be GST-free if the supply is of services:

- that are provided to one or more aged or disabled people; and
- that are of a kind covered by item 2. 1 (daily living activities assistance) of Part 2 of Schedule 1 to the Quality of Care Principles.

Item 4
This item repeals the definition of community care in section 195-1 of the *A New Tax System (Goods and Services Tax) Act 1999*, which is defined by reference to the *Aged Care Act 1997*, as community care in the *Aged Care Act 1997* will be replaced with home care from 1 July 2013.

Item 5
This item inserts in section 195-1 of the *A New Tax System (Goods and Services Tax) Act 1999* the definition of home care by reference to the definition of home care in the *Aged Care Act 1997*. This is because community care in the *Aged Care Act 1997* will be replaced with home care from 1 July 2013.

Part 2 – Amendments commencing on 1 July 2014

A New Tax System (Goods and Services Tax) Act 1999

Item 6
This item inserts a reference to Part 3. 2 of the *Aged Care (Transitional Provisions) Act 1997* in subsection 38-30(1) of the *A New Tax System (Goods and Services Tax) Act 1999*. This amendment ensures that a supply of home care is GST-free if home care subsidy is payable under Part 3. 2 of the *Aged Care Act 1997* or Part 3. 2 of the *Aged Care (Transitional Provisions) Act 1997*, thereby treating a supply of home care funded under either Act in the same way for GST purposes.

Item 7
This item inserts a reference to Part 3. 3 of the *Aged Care (Transitional Provisions) Act 1997* in section 38-35 of the *A New Tax System (Goods and Services Tax) Act 1999*. This amendment ensures that a supply of flexible care is GST-free if flexible care subsidy is payable under Part 3. 3 of the *Aged Care Act 1997* or Part 3. 3 of the *Aged Care (Transitional Provisions) Act 1997*, thereby treating a supply of flexible care funded under either Act in the same way for GST purposes.

Health and Other Services (Compensation) Act 1995

Item 8
Section 3 of the *Health and Other Services (Compensation) Act 1995* currently defines 'residential care subsidy' as having the same meaning as in the *Aged Care Act 1997*. With the implementation of the *Living Longer Living Better* reforms, residential care subsidy will be paid under two Acts – the *Aged Care Act 1997* and a new *Aged Care (Transitional Provisions) Act 1997* which will be created by Schedule 5 of the Aged Care Living Longer Living Better) Bill 2013.

The *Aged Care Act 1997* will deal with the payment of subsidy for care recipients who enter care on or after 1 July 2014 and the *Aged Care (Transitional Provisions) Act 1997* will deal with payment of subsidy for care recipients who entered care before 1 July 2014 and have not subsequently left care for more than 28 days or, on moving services, elected to be subject to the new law (continuing care recipients). This item therefore amends the definition of residential care in the *Health and Other Services (Compensation) Act 1995* to refer to subsidy paid under either Act.

Item 9
Section 9 of the *Health and Other Services (Compensation) Act 1995* relates to reimbursement of amounts payable for nursing home care or residential care. This item amends section 9 so that references to the *Aged Care Act 1997* in subsection 9(2A) also include a reference to the *Aged Care (Transitional Provisions) Act 1997*.

The effect of this is that, despite Part 3.1 of the *Aged Care Act 1997* and Part 3.1 of the *Aged Care (Transitional Provisions) Act 1997*, residential care subsidy will not be payable in respect of residential care if, under the reimbursement arrangement, the whole or any part of the amount payable for residential care has already been reimbursed before a claim for residential care subsidy in respect of the residential care has been submitted.

Item 10
Section 42 of the *Health and Other Services (Compensation) Act 1995* provides for the Chief Executive Medicare to obtain information or require the production of a document in certain circumstances. These circumstances include those described in paragraph 42(1)(f), where the information or documents may be relevant to whether the Secretary of the Department of Health and Ageing should make a determination in relation to a compensation payment reduction for a care recipient under subsections 44-20(5) or (6) of the *Aged Care Act 1997*.

From 1 July 2014, determinations regarding compensation payment reductions will be made:

- under subsections 44-20(5) and (6) of the *Aged Care Act 1997* for care recipients who enter residential care on, or after, 1 July 2014;

- under subsections 44-20(5) and (6) of the *Aged Care (Transitional Provisions) Act 1997* for continuing care recipients who were in residential care on 30 June 2014; or

- under new subsections 48-5(5) and (6) of the *Aged Care Act 1997* for home care recipients who commence receiving home care on or after 1 July 2014 (there are no equivalent provisions for existing home care recipients).

This item therefore amends section 42 to reflect these decision points under the aged care legislation.

Human Services (Medicare) Act 1973

Item 11
Section 41G of the *Human Services (Medicare) Act 1973* currently provides that for the purposes of a law of the Commonwealth, a medicare program includes services, benefits, programs or facilities that are provided for under the *Aged Care Act 1997*. With the implementation of the *Living Longer Living Better* reforms, aged care services and benefits will be provided for under two Acts – the *Aged Care Act 1997* and a new *Aged Care (Transitional Provisions) Act 1997* which will be created by Schedule 5 of the Aged Care Living Longer Living Better) Bill 2013.

The *Aged Care Act 1997* will deal with the payment of subsidy and fees for care recipients who enter care on or after 1 July 2014 and the *Aged Care (Transitional Provisions) Act 1997* will deal with continuing care recipients.

In order to ensure that services, benefits, programs or facilities that are provided for under aged care transitional arrangements are treated in the same way as those that are

provided for under the *Aged Care Act 1997*, this item adds a new subparagraph to section 41G which provides that a medicare program includes services, benefits, programs or facilities that are provided for under the *Aged Care (Transitional Provisions) Act 1997*.

Social Security Act 1991

Item 12
This item amends section 4 of the *Social Security Act 1991* which defines *approved respite care*. This amendment is intended to provide for transitional arrangements, so that *approved respite care* is defined by supplements that may be payable under the *Aged Care Act 1997* or under the *Aged Care (Transitional Provisions) Act 1997*. Paragraph 4(9)(a) provides that a person is in approved respite care on a particular day if the person is eligible for a respite care supplement in respect of that day under the Subsidy Principles made for the purposes of section 44-5(1)(a)(i) of the *Aged Care Act 1997*. Paragraph 4(9)(b) provides that a person is in approved respite care in respect of a day if the person is eligible for a respite supplement under section 44-12 of the *Aged Care (Transitional Provisions) Act 1997*. This amendment clarifies that if a care recipient is receiving respite care on 30 June 2014 and the episode of respite care continues on 1 July 2014, the whole episode of respite care is approved respite care for the purposes of the *Social Security Act 1991*.

Item 13
This item adds two notes after subsection 8(8) of the *Social Security Act 1991*. The notes refer the reader to subsection 13(2) for definitions of rent and clarify that under subsections 11A(8) and (9) (which deal with the definition of principal home for the purpose of the assets test) the principal home of a person in a care situation may be a place other than the place where the person receives care.

Item 14
This item inserts a new paragraph 8(8)(znaa) of the *Social Security Act 1991* which excludes from the definition of income any rent from the person's principal home that the person, or the person's partner, earns, derives or receives from another person while the person is liable to make daily accommodation payments or daily accommodation contributions in respect of their accommodation in a residential aged care service. This ensures that any rent earned, derived or received from the person's principal home while the person is liable to make such daily payments for their accommodation in a residential aged care service is treated consistently with the way rent is treated if a person is liable to make daily payments in the form of an accommodation charge or is paying an accommodation bond by periodic payments.

Item 15
Subsection 9(1D) of the *Social Security Act 1991* currently provides that, to avoid doubt, neither an accommodation bond nor an accommodation bond balance is a financial investment for the purposes of the *Social Security Act 1991*. With the changes being made to the *Aged Care Act 1997*, there will be two new types of lump sum accommodation payment – refundable accommodation deposits and refundable accommodation contributions. These are collectively defined in the *Aged Care Act 1997* as refundable deposits. Refundable deposit balances are amounts remaining from accommodations deposits after any allowable deductions have been made. This

item repeals subsection 9(1D) and replaces it with a new subsection that provides that, to avoid doubt, accommodation bonds and accommodation bond balances, are not financial investments for the purposes of the *Social Security Act 1991*. This ensures that all lump sum payments (and subsequent balances) made under the *Aged Care Act 1997* in respect of accommodation in residential aged care are treated in the same way for the purposes of determining the meaning of the term 'financial investment'.

Item 16
Section 11 of the *Social Security Act 1991* sets out assets test definitions. This item amends the definition of 'charge exempt resident' to provide that the meaning of charge exempt resident is as defined in the *Aged Care (Transitional Provisions) Act 1997*. This amendment is consequential to transitional arrangements for care recipients who occupied an approved nursing home bed in a nursing home approved under section 40AA of the *National Health Act 1953* (as then in force) on 30 September 1997 and who are receiving care (not on a respite basis) in a residential care service on 30 June 2014. A care recipient receiving the specified form of care on both of those days will continue to be a charge exempt resident under the *Aged Care (Transitional Provisions) Act 1997*, whether or not they have been receiving care continuously between 30 September 1997 and 30 June 2014. A care recipient who was receiving the specified form of care on 30 September 1997, but who is not receiving the specified form of care on 30 June 2014, will not be a charge exempt resident.

Item 17
Section 11 of the *Social Security Act 1991* sets out assets test definitions. This item inserts definitions of daily accommodation contributions and daily accommodation payments, which have the same meaning as in the *Aged Care Act 1997*.

Item 18
Section 11 of the *Social Security Act 1991* sets out assets test definitions. This item inserts definitions of refundable deposit and refundable deposit balance, which have the same meaning as in the *Aged Care Act 1997*. A refundable deposit is, under the *Aged Care Act 1997*, a collective term for refundable accommodation deposits and refundable accommodation contributions.

Item 19
This item inserts a new subsection 11(3AA) of the *Social Security Act 1991* which provides that a refundable deposit balance in respect of a refundable deposit paid by a person is taken to be an asset of the person for the purposes of the *Social Security Act 1991*. This ensures that the current treatment of an accommodation bond balance also applies to a refundable deposit balance. Subsection 11(3B) of the *Social Security Act 1991* provides that an accommodation bond balance in respect of an accommodation bond paid by a person which is taken to be an asset of the person for the purposes of the *Social Security Act 1991*.

Item 20
This item amends note 2 below paragraph 11(8)(a) of the *Social Security Act 1991*. Paragraph 11(8)(a) specifies the periods during which a residence of a person is taken to be the person's *principal home* for the purposes of the assets test under the *Social Security Act 1991*. The amendment to note 2 is a result of transitional

arrangements for continuing care recipients. From 1 July 2014, a continuing care recipient can only be charged an accommodation charge in accordance with the conditions in Division 57A of the *Aged Care (Transitional Provisions) Act 1997*.

Item 21

This item inserts a new paragraph 11A(8)(ba) in the *Social Security Act 1991* expanding the definition of 'principal home' for the purpose of the assets test. The new provision ensures that from 1 July 2014 the definition of principal home continues to operate in accordance with current arrangements regarding a liability to pay a daily payment for accommodation in residential aged care, where a person left their principal home for the purpose of going into a care situation and the person (or the person's partner) is earning, deriving or receiving rent for the residence from another person. That is, a residence of a person is taken to be the person's principal home in the circumstances described in subsection 11A(8) whether they are liable to pay an accommodation charge, an accommodation bond by periodic payments, a daily accommodation payment or a daily accommodation contribution.

Item 22

This item amends paragraph 11A(8)(c) of the *Social Security Act 1991* to expand the specified periods during which the residence of a person is taken to be the person's principal home to include any period during which the residence is, because of new paragraph 11A(8)(ba), the principal home of the person's partner. This change is consequential to the change described at item 21.

Item 23

Section 1099E sets out the scope of Division 1D of the *Social Security Act 1991*. Division 1D relates to care recipients who were eligible to pay an accommodation bond for entry to a residential care service on or after 1 October 1997, but became eligible to pay an accommodation charge instead of an accommodation bond on 6 November 1997 as the result of a change in government policy and subsequently chose to pay an accommodation charge. The amendments made by this item are consequential to transitional arrangements for care recipients who entered care before 1 July 2014 and have not had more than 28 days out of care or elected, on moving service to be covered by the new arrangements (continuing care recipients). From 1 July 2014, a person can only be charged an accommodation charge in accordance with the conditions in Division 57A of the *Aged Care (Transitional Provisions) Act 1997*. Division 57A of the *Aged Care Act 1997* will be repealed with effect from 1 July 2014.

Items 24 and 25

Section 1099J sets out the scope of Division 1E of the *Social Security Act 1991*. Division 1E relates to refunds to charge exempt residents. These items amend subsections 1099J(1) and 1099J(2) so that the provisions of the *Aged Care Act 1997* to which these subsections refer are the provisions in the *Aged Care Act 1997* as in force before 1 July 2014. With effect from 1 July 2014, paragraphs 44-8A(6)(b), 56-1(kc) and 56-3(ic) of the *Aged Care Act 1997* will be repealed and paragraph 44-8A(6)(b) will become paragraph 44-8A(6)(b) of the *Aged Care (Transitional Provisions) Act 1997*.

Item 26
Section 1118 provides for certain assets to be disregarded in calculating the value of a person's assets for the purposes of the *Social Security Act 1991*. Paragraph 1118(1)(u) currently provides for the amount of any accommodation bond balance in respect of an accommodation bond paid by the person to be disregarded. This item extends the list of assets to be disregarded to include the amount of any refundable deposit balance in respect of a refundable deposit paid by the person. The effect of this amendment is that lump sums paid in respect of accommodation will be treated consistently for the purposes of the *Social Security Act 1991*, whether the payment is a refundable deposit under the *Aged Care Act 1997* or an accommodation bond under the *Aged Care (Transitional Provisions) Act 1997*.

Social Security (Administration) Act 1999

Items 27 and 28
Section 126 of the *Social Security (Administration) Act 1999* deals with own motion review of decisions by the Secretary of the Department administered by the Minister who administers the *Social Security Act 1999*. These items amend subsection 126(1) to include a new paragraph (f). Paragraph 126(1)(f) will enable decisions regarding a care recipient's total assessable income made under section 44-24 of the *Aged Care (Transitional Provisions) Act 1997* to be reviewed in the same way as decisions regarding a care recipient's total assessable income made under section 44-24 of the *Aged Care Act 1997* are reviewed.

Items 29 and 30
Section 129 of the *Social Security (Administration) Act 1999* enables a person to apply to the Secretary for review of certain decisions including a decision under section 44-24 of the *Aged Care Act 1997*. These items amend section 129 to add a new paragraph 129(1)(f) to ensure that a person may also apply to the Secretary for review of a decision under section 44-24 of the *Aged Care (Transitional Provisions) Act 1997*. This ensures that decisions regarding a care recipient's total assessable income made in respect of care recipients in care on 30 June 2014 and care recipients who enter care on or after 1 July 2014 are treated consistently under Division 3.

Item 31
Section 140 is about the application of Division 3 of the *Social Security (Administration) Act 1999* regarding review by the Social Security Appeals Tribunal. Subsection 140(1) provides that the Division applies to all decisions under section 44-24 of the *Aged Care Act 1997*. This item extends the application of subsection (1) to include a new paragraph which provides that the Division also applies to all decisions under section 44-24 of the *Aged Care (Transitional Provisions) Act 1997*. This ensures that decisions regarding a care recipient's total assessable income made in respect of care recipients in care on 30 June 2014 and care recipients who enter care on or after 1 July 2014 are treated consistently under Division 3.

Item 32
Section 178 is about the application of Division 5 of the *Social Security (Administration) Act 1999* regarding review by the Administrative Appeals Tribunal. Subsection 178(1) provides that the Division applies to all decisions under

section 44-24 of the *Aged Care Act 1997*. This item extends the application of subsection (1) to include a new paragraph which provides that the Division also applies to all decisions under section 44-24 of the *Aged Care (Transitional Provisions) Act 1997*. This ensures that decisions regarding a care recipient's total assessable income made in respect of care recipients in care on 30 June 2014 and care recipients who enter care on or after 1 July 2014 are treated consistently under Division 5.

Veterans' Entitlements Act 1986

Item 33
Section 5 sets out the index of definitions for the purposes of the *Veterans' Entitlements Act 1986*. This item inserts the term 'accommodation bond balance' into the index of definitions. Although 'accommodation bond balance' is currently used within the *Veterans' Entitlements Act 1986*, the term has not previously been listed in the index in section 5.

Item 34
Section 5 sets out the index of definitions for the purposes of the *Veterans' Entitlements Act 1986*. This item inserts the terms 'daily accommodation contribution' and 'daily accommodation payment' into the index of definitions. Daily accommodation contributions and daily accommodation payments are new forms of daily payments under the *Aged Care Act 1997* that a care recipient, if eligible, may pay to an approved provider of aged care services in respect of their accommodation in residential aged care.

Item 35
Section 5 sets out the index of definitions for the purposes of the *Veterans' Entitlements Act 1986*. This item inserts the terms 'refundable deposit' and 'refundable deposit balance' into the index of definitions. These terms provide for new forms of lump sum payments under the *Aged Care Act 1997* known as refundable accommodation payments and refundable accommodation contributions (collectively known as 'refundable deposits').

Item 36
Section 5H sets out income test definitions for the purposes of the *Veterans' Entitlements Act 1986*. Subsection 5H(8) lists amounts that are not income in relation to a person for the purposes of the *Veterans' Entitlements Act 1986*. This item inserts in paragraph 5H(8)(na) a reference to a payment of a subsidy under Part 3.1 of the *Aged Care (Transitional Provisions) Act 1997*. This amendment ensures that the payment of subsidy under the transitional legislation is treated as an excluded amount the same way as the payment of subsidy under Part 3. 1 of the *Aged Care Act 1997* is treated for the purposes of section 5H of the *Veterans' Entitlements Act 1986*.

Item 37
Section 5H sets out income test definitions for the purposes of the *Veterans' Entitlements Act 1986*. Subsection 5H(8) is about amounts that are not income in relation to a person for the purposes of that Act.

This item inserts into subsection 5H(8) amounts that are not income for the purposes of the income test. The amounts currently set out in subsection 5H(8), include:

- an accommodation bond balance refunded to the person under the *Aged Care Act 1997*;
- any rent from the person's principal home that the person, or the person's partner, earns, derives or receives from another person while the person is liable to pay an accommodation charge; or
- any rent from the person's principal home that the person, or the person's partner, earns, derives or receives from another person while a person is liable to pay an accommodation bond by periodic payments.

The following amounts will be added to the subsection and will therefore also not be treated as income for the purposes of the *Veterans' Entitlements Act 1986* from 1 July 2014:

- a refundable accommodation deposit balance or a refundable accommodation contribution balance refunded to the person under the *Aged Care Act 1997*; and
- any rent from the person's principal home that the person, or the person's partner, earns, derives or receives from another person while a person is liable to pay a daily accommodation payment or daily accommodation contribution.

This ensures that all amounts paid for the purposes of accommodation in residential aged care are treated in the same way for the purposes of the income test under the *Veterans' Entitlements Act 1986.*

Item 38
Section 5J of the *Veterans' Entitlements Act 1986* sets out financial assets and income streams definitions. This item amends subsection 5J(2C) to provide that all forms of lump sums paid for the purposes of accommodation in residential aged care and the balance of those lump sums are not a financial investment for the purposes of the *Veterans' Entitlements Act 1986*. This amendment ensures that refundable deposits paid under the *Aged Care Act 1997* and accommodation bonds paid under the *Aged Care (Transitional Provisions) Act 1997* are treated consistently for the purposes of the *Veterans' Entitlements Act 1986*.

Item 39
This item inserts a definition of 'accommodation bond balance' in section 5L containing assets test definitions. The term is defined by reference to its meaning in the *Aged Care Act 1997*.

Item 40
This item inserts definitions of 'daily accommodation contribution' and 'daily accommodation payment' into subsection 5L(1) containing assets test definitions. The terms are defined by reference to their meaning in the *Aged Care Act 1997*.

Item 41
This item inserts definitions of 'refundable deposit' and 'refundable deposit balance' into section 5L containing assets test definitions. The terms are defined by reference to their meaning in the *Aged Care Act 1997*.

Item 42
Section 5L describes the assets test definitions for the purposes of the *Veterans' Entitlements Act 1986*.

Subsection 5L(3B) currently provides that, to avoid doubt, an accommodation bond balance (within the meaning of the *Aged Care Act 1997*) in respect of an accommodation bond paid by a person is taken to be an asset of the person.

In order to ensure that consistent rules apply to the new forms of refundable deposits being introduced from 1 July 2014, this item inserts a new subsection 5L(3BA) that provides that a refundable deposit balance (within the meaning of the *Aged Care Act 1997*) in respect of a refundable deposit paid by a person is taken to be an asset of the person. This amendment ensures that all lump sum balances in respect of lump sums paid to an approved provider under the *Aged Care Act 1997* or the *Aged Care (Transitional Provisions) Act 1997* for the purpose of accommodation in residential aged care are treated consistently.

Item 43
Section 5LA of the *Veterans' Entitlements Act 1986* defines 'principal home' for the purposes of that Act. Subsection 5LA(8) deals with the effects of absences from the principal home. This item inserts in subsection 5LA(8) a new paragraph regarding the principal home definition for the purpose of the assets test. The new provision ensures that from 1 July 2014 the definition of principal home continues to operate in accordance with current arrangements regarding a liability to pay a daily payment for accommodation in residential aged care, where a person left their principal home for the purpose of going into a care situation and the person (or the person's partner) is earning, deriving or receiving rent for the residence from another person. That is, a residence of a person is taken to be the person's principal home in the circumstances described in subsection 5LA(8) whether they are liable to pay an accommodation charge, an accommodation bond by periodic payments, a daily accommodation payment or a daily accommodation contribution.

Item 44
This item makes consequential changes to paragraph 5LA(8)(c) to reflect the inclusion of new paragraph 5LA(8)(b)(item 43).

Item 45
This item amends note 4 in subsection 5LA(8) of the *Veterans' Entitlements Act 1986* to account for transitional arrangements by replacing the reference to the *Aged Care Act 1997* with a reference to the *Aged Care (Transitional Provisions) Act 1997*. From 1 July 2014, a person can only be charged an accommodation charge in accordance with the conditions in Division 57A of the *Aged Care (Transitional Provisions) Act 1997*.

Item 46
Subsection 5NC(8) of the *Veterans' Entitlements Act 1986* defines circumstances when a person is 'in respite care' for the purposes of that Act. This item amends the definition to provide for transitional arrangements, so that 'in respite care' is defined by supplements that may be payable either under the *Aged Care Act 1997* or under the *Aged Care (Transitional Provisions) Act 1997*. This amendment clarifies that if a care recipient is receiving respite care on 30 June 2014 and the episode of respite care continues on 1 July 2014, the care recipient is in respite care throughout the episode of care.

Item 47
Section 52 of the *Veterans' Entitlements Act 1986* provides for certain assets to be disregarded in calculating the value of a person's assets for certain purposes under that Act. Paragraph 52(1)(p) currently provides for the amount of any accommodation bond balance, in respect of an accommodation bond paid by the person, to be disregarded. This item extends the list of assets to be disregarded to include the amount of any refundable deposit balance, in respect of a refundable deposit paid by the person. The effect of this amendment is that lump sums paid for accommodation will be treated consistently for the purposes of the *Veterans' Entitlements Act 1986*, whether the payment is a refundable deposit under the *Aged Care Act 1997* or an accommodation bond under the *Aged Care (Transitional Provisions) Act 1997*.

Item 48
Schedule 5 to the *Veterans' Entitlements Act 1986* contains savings and transitional provisions. Part 2 of Schedule 5 sets out transitional arrangements for care recipients who were eligible to pay an accommodation bond for entry to a residential care service on or after 1 October 1997, but became eligible to pay an accommodation charge instead of an accommodation bond on 6 November 1997 as the result of a change in government policy and subsequently chose to pay an accommodation charge. This item amends paragraph 13(1)(b) of Schedule 5 to the *Veterans' Entitlements Act 1986* by replacing a reference to the *Aged Care Act 1997* with a reference to the *Aged Care (Transitional Provisions) Act 1997*. From 1 July 2014, section 44-8B and Division 57A of the *Aged Care Act 1997* will be repealed and these provisions will become section 44-8B and Division 57A of the *Aged Care (Transitional Provisions) Act 1997*.

Item 49
This item repeals the note in subclause 13(1) of Part 2 of Schedule 5 to the *Veterans' Entitlements Act 1986* and replaces it with two new notes. Note 1 provides that 'accommodation bond' and 'accommodation charge' have the same meanings as in the *Aged Care Act 1997*. Note 2 provides that 'charge exempt residents' has the same meaning as the *Aged Care (Transitional Provisions) Act 1997*.

Item 50
Schedule 5 to the *Veterans' Entitlements Act 1986* contains savings and transitional provisions. Clause 13 of the *Veterans' Entitlements Act 1986* sets out the scope of Part 2 of Schedule 5 and lists those persons to which Part 2 applies. This item amends paragraph 13(2)(b) of the *Veterans' Entitlements Act 1986* by inserting a reference to the *Aged Care (Transitional Provisions) Act 1997*. This amendment provides for transitional arrangements under which legislation regarding charge exempt residents

will be contained in the *Aged Care (Transitional Provisions) Act 1997* and not the *Aged Care Act 1997*.

Item 51
This item repeals the note below subclause 13(2) of Part 2 of Schedule 5 to the *Veterans' Entitlements Act 1986* and replaces it with two new notes. Note 1 provides that 'accommodation bond' and accommodation charge' have the same meanings as in the *Aged Care Act 1997.* Note 2 provides that 'charge exempt resident' has the same meaning as in the *Aged Care (Transitional Provisions) Act 1997*.

Item 52
This item amends the heading of Part 2A in Schedule 5 to the *Veterans' Entitlements Act 1986* to reflect that from 1 July 2014 'charge exempt resident' will be defined and dealt with under the *Aged Care (Transitional Provisions) Act 1997* and not the *Aged Care Act 1997*. The heading of Part 2A has therefore been changed to 'Part2A-charge exempt residents under the *Aged Care (Transitional Provisions) Act 1997.'*

Item 53
This item amends the current definition of 'charge exempt resident' under the *Veterans' Entitlements Act 1986* to reflect the meaning under the Aged *Care (Transitional Provisions) Act 1997*. From 1 July 2014, as part of the aged care transitional arrangements, charge exempt residents will be defined and dealt with under the *Aged Care (Transitional Provisions) Act 1997* and not the *Aged Care Act 1997*.

Items 54 and 55
Clause 17B of Schedule 5 to the *Veterans' Entitlements Act 1986* provides for refunds of accommodation charges. Subclause 17B(1) sets out that a 'refunded amount' is an amount that is refunded as mentioned in paragraph 56-1(kc) or 56-3(ic) of the *Aged Care Act 1997.* This item amends subclause 17B(1) so that these paragraphs of the *Aged Care Act 1997* apply as in force before 1 July 2014. These provisions will not appear in the *Aged Care Act 1997* or in transitional provisions after 1 July 2014.

In addition, subclause 17B(2) is amended to reference the *Aged Care (Transitional Provisions) Act 1997*. This is because charge exempt residents will from 1 July 2014 be dealt with under the *Aged Care (Transitional Provisions) Act 1997* and not the *Aged Care Act 1997*.

Schedule 5 – Aged Care (Transitional Provisions) Act 1997

Part 1 – Enactment

Item 1
Part 1 creates a new version of the *Aged Care Act 1997*. This new version is to be known as the *Aged Care (Transitional Provisions) Act 1997* and it will operate alongside the *Aged Care Act 1997* as amended by Schedules 1, 2 and 3 of the Aged Care (Living Longer Living Better) Bill 2013 (once enacted).

This new version will be amended by Part 2 of this Schedule. The intent of this new version is to provide for 'continuing care recipients'. In summary, continuing care

recipients are those who were in care before 1 July 2014 and have not since 1 July 2014 left care for more than 28 days or have not moved services and elected to be subject to the new arrangements. Further information about the concept of ‘continuing care recipients’ is included in item 4.

The *Aged Care (Transitional Provisions) Act 1997* provides only for those parts of the *Aged Care Act 1997* that deal with arrangements for fees, subsidies and payments which are required to be preserved for continuing care recipients. All other provisions which apply consistently to both continuing care recipients and care recipients who enter the aged care system on or after 1 July 2014 will be contained only within the *Aged Care Act 1997*.

Throughout this Act there will be references to the fact that this Act should be used in conjunction with the *Aged Care Act 1997*, as this Act covers only those legislative arrangements which are different for continuing care recipients.

Part 2 – Amendments

Aged Care (Transitional Provisions) Act 1997

Item 2
This item amends the long title of this Act to reflect that this new version of the *Aged Care Act 1997* deals with matters of a transitional nature in connection with the *Aged Care (Living Longer Living Better) Act 2013*. The long title of this Act will be: An Act to deal with transitional matters in connection with the enactment of the *Aged Care (Living Longer Living Better) Act 2013*.

Item 3
This item amends the short title as specified in section 1-1, changing it from the *Aged Care Act 1997* to the *Aged Care (Transitional Provisions) Act 1997.*

Item 4
This item repeals section 1-2 and replaces it with two new sections.

Section 1-2 Commencement
This new section provides that the *Aged Care (Transitional Provisions) Act 1997* commences on 1 July 2014.

Section 1-2A Act applies to continuing care recipients
This new section provides that the *Aged Care (Transitional Provisions) Act 1997* applies only to continuing care recipients, as defined in the *Aged Care Act 1997.*

A continuing care recipient means:

- a continuing flexible care recipient; or
- a continuing home care recipient; or
- a continuing residential care recipient.

Each of these terms is further defined in the *Aged Care Act 1997*. In summary:

- a continuing flexible care recipient refers to a person who has entered a flexible care service before 1 July 2014 and has not:
  - ceased to be provided with flexible care for a continuous period of more than 28 days (other than because the person is on leave); or
  - before moving to another flexible care service, made a written choice to be covered by Chapters 3 and 3A of the *Aged Care Act 1997* (rather than the *Aged Care (Transitional Provisions) Act 1997*)
- continuing home care recipient refers to a person who has entered a home care service before 1 July 2014 and has not:
  - ceased to be provided with home care for a continuous period of more than 28 days (other than because the person is on leave); or
  - before moving to another home care service, made a written choice to be covered by Chapters 3 and 3A of the *Aged Care Act 1997* (rather than the *Aged Care (Transitional Provisions) Act 1997)*
- continuing residential care recipient refers to a person who has entered a residential care service before 1 July 2014 and has not:
  - ceased to be provided with residential care for a continuous period of more than 28 days (other than because the person is on leave); or
  - before moving to another residential care service, made a written choice to be covered by Chapters 3 and 3A of the *Aged Care Act 1997* (rather than the *Aged Care (Transitional Provisions) Act 1997)*

The effect of these definitions is that:

- if, on or after 1 July 2014, a continuing care recipient discontinues receiving home care and moves into a residential care service, or moves from a residential care service to a home care service, the person will no longer be a continuing care recipient. From the day the care recipient begins to receive a new type of care, the person's subsidy, fees and accommodation payments (if any) will be worked out in accordance with the *Aged Care Act 1997*, not the *Aged Care (Transitional Provisions) Act 1997*;
- if, on or after 1 July 2014, a continuing care recipient moves between services of the same type (for example, between two home care services or between two residential care services or between two flexible care services) they will continue to be treated as a continuing care recipient unless either there is a gap of more than 28 days between the day they leave the first service and the day they enter the second service, or they elect, before they move into the second service, to be covered by the *Aged Care Act 1997*. The election must be in writing and must be in accordance with any rules set out in the Fees and Payments Principles; and

- if, on or after 1 July 2014, a continuing care recipient begins receiving a different level of home care they will remain a continuing care recipient.

Items 5 and 6
Section 2-1 describes the objects of the *Aged Care (Transitional Provisions) Act 1997*. These items amend this section to describe the objects of this Act as operating in conjunction with the *Aged Care Act 1997.*

Items 7, 8, 9 and 10
Section 3-1 provides general overview information for the *Aged Care (Transitional Provisions) Act 1997*. The amendments under these items acknowledge that the provisions of this Act are to be read in conjunction with the *Aged Care Act 1997*.

Items 11 to 15
Preliminary matters relating to subsidies are described in section 3-2 and the circumstances in which different types of subsidy may be paid are described in section 3-3.

These items amend these sections so that it is clear that:

- preliminary matters relating to subsidies, such as approval of providers, allocation of places and approval of care recipients, will continue to be dealt with under Chapter 2 of the *Aged Care Act 1997* and not the *Aged Care (Transitional Provisions) Act 1997*;

- similarly, matters that have an impact on the payment of subsidy, such as accreditation, will also continue to be dealt with under the *Aged Care Act 1997*; and

- the payment of subsidy for continuing care recipients will be under the *Aged Care (Transitional Provisions) Act 1997.*

Items 16, 17, and 18
Responsibilities of approved providers are described in section 3-4. These items amend that section so that it is clear that approved providers have responsibilities under both the *Aged Care (Transitional Provisions) Act 1997* (in respect of continuing care recipients) and under the *Aged Care Act 1997* (in respect of both continuing care recipients and other care recipients).

Failure to meet responsibilities under either Act may lead to the imposition of sanctions under the *Aged Care Act 1997.*

Items 19 and 20
Section 3-5 describes grants. These items amend the current section to refer to grants as set out in Chapter 5 of the *Aged Care Act 1997*. There is no need to provide for grants under the *Aged Care (Transitional Provisions) Act 1997*.

Items 21, 22 and 23
Subsection 4-1 describes the application of the *Aged Care (Transitional Provisions) Act 1997*. Consequential changes are made to the section, noting that some of the

Parts mentioned in the section (Parts 2.2 and 2.5) will not appear in this Act. The *Aged Care (Transitional Provisions) Act 1997* has the same application as the *Aged Care Act 1997.*

Items 24, 30, 31, 33 to 35, 44, 45, 48, 51 to 53, 55, 58, 62, 74, 76, 83 to 85, 96, 100 to 102, 108, 109, 111, 113, 142 and 156

Chapter 2 of the current Act describes preliminary matters relating to subsidies, including approval of providers, allocation of places, approval and classification of care recipients, extra service places and certification of residential care services.

Item 24 repeals Chapter 2 from the *Aged Care (Transitional Provisions) Act 1997*. The provisions required for these matters will be the same regardless of when a care recipient entered the aged care system. The provisions are therefore contained only within the *Aged Care Act 1997* and are not replicated in this Act.

This means that any reference to Chapter 2 or its Parts, Divisions, sections or subsections (such as in subsections 42-1(1), 42-1(4), 43-6(1), 43-6(2), 43-8(1), 44-3(3), 44-5A(2), 44-6(2), 44-8A(2), 44-12(2), 44-12(4), 44-18(1), 44-18(2), 44-30(4), 46-1(1), 46-1(2), 50-1(1), 50-1(2), paragraph 58-5(a), and subparagraph 57A-2(1)(a)(ii)) will refer to the *Aged Care Act 1997*, not to the *Aged Care (Transitional Provisions) Act 1997*.

Items 25, 26 and 27

These items amend section 40-1 which explains that Chapter 3 provides for subsidies. The amendments to this section clarify that a number of approvals and other decisions may need to have been made under Chapter 2 of the *Aged Care Act 1997* before a particular kind of payment can be made (see section 5-2 of the *Aged Care Act 1997*). For example, the provider needs to be an approved provider under Part 2.1 of the *Aged Care Act 1997*. Further, receipt of payments under Chapter 3 of this Act gives rise to certain approved provider responsibilities that are dealt with in Chapter 4 of both this Act and the *Aged Care Act 1997.*

Item 28

This item repeals section 41-2 which provides that residential care subsidy is dealt with in the Residential Care Subsidy Principles.

This item replaces section 41-2 with a new section.

Section 41-2 Residential care subsidy also dealt with in Aged Care (Transitional Provisions) Principles

This replacement section provides that residential care subsidy payable under this Part will also, where indicated, be dealt with in the Aged Care (Transitional Provisions) Principles, made by the Minister under section 96-1. The Aged Care (Transitional Provisions) Principles will set out provisions that are required to be different from those set out in Principles made under the *Aged Care Act 1997* because they relate to circumstances particular to continuing care recipients and which differ from circumstances for care recipients entering the aged care system on or after 1 July 2014.

Items 29, 37, 38, 40, 41, 42, 46, 47, 49, 54, 56, 57, 59, 60, 61, 63 to 73, 75, 77 to 82, 86 to 95 and 97

These items replace all references to the 'Residential Care Subsidy Principles' with the 'Aged Care (Transitional Provisions) Principles' as per item 28.

Changes are made to sections 41-3, 42-2, 42-3, , 43-1, 43-2, 43-3, 43-6, 43-8, 44-3, 44-5A, 44-5B, 44-6, 44-7, 44-8, 44-8A, 44-10, 44-11, 44-12, 44-13, 44-14, 44-16, 44-20, 44-22, 44-24, 44-27, 44-28, 44-29, 44-30, and 44-31.

Items 32 and 39

Sections 42-4, 42-5 and 42-6 describe accreditation requirements, determinations allowing for exceptional circumstances and revocation of determinations relating to exceptional circumstances. These issues are consistent regardless of the time of entry of a care recipient to the aged care system and are therefore being repealed (item 39) from the *Aged Care (Transitional Provisions) Act 1997* and described only in the *Aged Care Act 1997.*

Paragraph 42-1(1)(c) provides that in order to be eligible for subsidy under the *Aged Care (Transitional Provisions) Act 1997*, the residential care service must be accredited. The section refers the reader to section 42-4. Item 32 amends this reference so that it is clear that accreditation is dealt with under section 42-4 of the *Aged Care Act 1997* and is not dealt with under the *Aged Care (Transitional Provisions) Act 1997.*

The effect of this change is that accreditation continues to be a pre-requisite to the payment of subsidy regardless of whether the subsidy is being paid under the *Aged Care (Transitional Provisions) Act 1997* (in respect of continuing care recipients) or under the *Aged Care Act 1997* in respect of non-continuing care recipients.

Items 36, 43, 50, 106, 116 to 118, 127, 136, 140, 153, 157, 158, 161 to 163, 167, 170 and 173

These items repeal the following provisions because the provisions required for these matters will be consistent regardless of when the care recipient entered the aged care system:

- Division 53 (which is the introduction to Chapter 4) deals with the responsibilities of approved providers. As well as introducing the Chapter, Division 53 also provides that failure of approved providers to meet responsibilities does not have consequences apart from under the *Aged Care Act 1997*;

- Part 4.1 which outlines quality of care provisions for approved providers;

- Divisions 55 and 56. Division 55 provides an introduction to user rights, whilst Division 56 provides for the general responsibilities relating to user rights, in particular the responsibilities of approved providers of residential care, home care and flexible care; the complaints resolution mechanism; and the extent to which responsibilities apply;

- Subdivision 57-B which deals with prudential requirements, particularly compliance and prudential standards;

- Subdivision 57-EA which provides for permitted uses of accommodation bonds and offences relating to their non-permitted usage;

- Subdivision 57-G which deals with rules relating to approved providers and former approved providers refunding accommodation bond balances; as well as the payment of interest on accommodation bond balances and entry contribution balances; and rules regarding the delaying of refunding accommodation bond balances so as to secure re-entry;

- Division 59 which provides for the requirements for resident agreements;

- Divisions 61 and 62 which describe, respectively, the requirements for home care agreements, and the responsibilities of approved providers relating to the protection of personal information of aged care recipients;

- Parts 4.3 and 4.4 which deal with accountability and consequences of non-compliance, respectively. As Item 162 repeals Parts 4.3 and 4.4, Item 36 ensures that reference to subsection 42-2(1) refers to this section 67A-5 as contained within the *Aged Care Act 1997;*

- Chapter 5 which describes the provisions for grants made by the Commonwealth to contribute to costs associated with aged care;

- Parts 6.2 to 6.7 which deal with protection of information, record keeping, powers of officers, complaints, recovery of overpayments, the Aged Care Commissioner and the Aged Care Pricing Commissioner;

- section 96-3 which deals with the establishment of committees in regard to the *Aged Care Act 1997*; and

- sections 96-8, 96-9 and 96-10 which deal with matters relating to protection for reporting reportable assaults, application of the *Criminal Code*, and appropriation, respectively.

All of the provisions described above will appear only in the *Aged Care Act 1997* but will be equally applicable to providers providing care to continuing care recipients and to people who enter the aged care system on or after 1 July 2014.

Where any of these repealed provisions are referenced in other parts of this Act, items 36, 43, 50, 106, 153, 158 ensure that these references refer to these provisions as contained within the *Aged Care Act 1997*.

Item 98
This item repeals section 45-2 which provides that home care subsidy is dealt with in the Home Care Subsidy Principles.

This item replaces section 45-2 with a new section.

Section 45-2 Home care subsidy also dealt with in Aged Care (Transitional Provisions) Principles

This replacement section provides that home care subsidy payable under this Part will also, where indicated, be dealt with in the Aged Care (Transitional Provisions) Principles, made by the Minister under section 96-1. The Aged Care (Transitional Provisions) Principles will describe matters which are required to be different from those described in Principles under the *Aged Care Act 1997* because they relate to circumstances particular to continuing care recipients and which differ from circumstances for care recipients entering the aged care system on or after 1 July 2014.

Items 99 and 103 to 105

These items replace all references to the 'Home Care Subsidy Principles' with the 'Aged Care (Transitional Provisions) Principles' as per item 98 in the following sections respectively: sections 45-3, 46-2, 47-2 and 47-3.

Item 107

This item repeals section 49-2 which provides that flexible care subsidy is dealt with in the Flexible Care Subsidy Principles.

This item replaces section 49-2 with a new section.

Section 49-2 Flexible care subsidy also dealt with in Aged Care (Transitional Provisions) Principles

This replacement section provides that flexible care subsidy payable under this Part will also, where indicated, be dealt with in the Aged Care (Transitional Provisions) Principles, made by the Minister under section 96-1. The Aged Care (Transitional Provisions) Principles will describe matters which are required to be different from those described in Principles made under the *Aged Care Act 1997* because they relate to circumstances particular to continuing care recipients and which differ from circumstances for care recipients entering the aged care system on or after 1 July 2014.

Items 110, 112, 114 and 115

These items replace all references to the 'Flexible Care Subsidy Principles' with the 'Aged Care (Transitional Provisions) Principles' as per item 107 in sections 50-1, 50-2 and 51-1.

Item 119

This item amends the heading of Division 57. Currently the heading is 'What are the responsibilities relating to accommodation bonds and entry contributions?'. This item amends the heading to remove the reference to entry contributions. This is because amended Division 57 will no longer contain any reference to entry contributions. The only references to accommodation charges that are in the existing Act relate to payment of interest on refunds and prudential requirements. All prudential interest and refund obligations will be dealt with in the *Aged Care Act 1997*.

Item 120

Item 120 amends section 57-1. Section 57-1 describes the function of Division 57 which sets out approved provider responsibilities relating to accommodation bonds and entry contributions. The section is amended to indicate that rules regarding prudential arrangements and payment of interest on entry contribution balances are set out in Part 3A.3 of the *Aged Care Act 1997*. Part 3A.3 of the *Aged Care Act 1997* will set out rules for managing refundable deposits, accommodation bonds and entry contributions.

Items 121 and 123 to 125

These items amend paragraphs 57-2(1)(c), (k), (ka) and (o). Subsection 57-2(1) describes the rules for charging a person an accommodation bond for entry, as a care recipient, into a residential care service or flexible care service.

The amendments in paragraphs (c), (k) and (ka) relate to references to prudential requirements and permitted uses of accommodation bonds. Prudential requirements and permitted uses will be described in Part 3A.3 of the *Aged Care Act 1997* for both accommodation bonds and the new types of refundable deposits paid from 1 July 2014 under the *Aged Care Act 1997*.

Items 121, 123 and 124 ensure that the references to sections relating to permitted uses and prudential requirements are the relevant new references in the *Aged Care Act 1997.*

The amendment to paragraph (o) made by item 125 provides that an approved provider must not charge an accommodation bond if prohibited under Part 4.4 of the *Aged Care Act 1997* from doing so. The *Aged Care Act 1997* will continue to deal with sanctions for all non-compliance with both the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997.*

Items 122, 126, 128, 129, 130, 132, 133, 134, 135, 137, 138, 139, 143 to 152, 154, 155, 159 and 160

These items replace all reference to the 'User Rights Principles' with the 'Aged Care (Transitional Provisions) Principles' in the following provisions:

- sections 58-1, 58-2 (step 5);
- subsections 57-14(1) and (2), 57-15(1), 57-17(2) and (3), 57-18(3), (4) and (5), 57-20(1), (2), (4), (6) and (7), 57A-2(2), 57A-3(2), 57A-9(1) and (2), 57A-10(1), 57A-12(2), 60-2(1) and (2);
- paragraphs 57-2(1)(d), 57-2(1)(p), 57-9(1)(l), 57-12(1)(c), 57-16(1)(a), 57-16(2)(a), 57-19(1)(c), 57A-2(1)(d), 57A-2(1)(n), 57A-3(1)(g), 57A-6(1)(c), 60-1(d); and
- subparagraphs 57-12(3)(a)(ii) and (b)(ii).

Whilst the User Rights Principles will continue to exist under the *Aged Care Act 1997*, and will in some circumstances be relevant for all care recipients, certain matters relating to user rights are particular to continuing care recipients. For example, rights in relation to retention amounts from accommodation bonds. In these

cases these matters will be dealt with in the Aged Care (Transitional Provisions) Principles. The Aged Care (Transitional Provisions) Principles will set out provisions which are required to be different from those described in Principles under the *Aged Care Act 1997* because they relate to circumstances particular to continuing care recipients and which differ from circumstances for care recipients entering the aged care system from 1 July 2014.

Items 131 and 141
These items amend section 57-13 and paragraph 57-23(2)(b). Section 57-13 describes rules regarding the maximum amount of accommodation bond if the care recipient moves between residential aged care services. Paragraph 57-23(2)(b) provides for charging an accommodation bond instead of an accommodation charge.

The amendments to these sections relate to the calculation of the maximum amount of accommodation bond that a care recipient can be asked to pay if the care recipient moves from a residential care service to another residential care service on or after 1 July 2014.

The amendments made by these items ensure that the refund provisions described in Division 52P of the *Aged Care Act 1997*, where the rules for refunds for all care recipients are set out, apply in respect of continuing care recipients.

Item 144
This item amends paragraph 57A-2(1)(m) which provides that an approved provider must not charge an accommodation charge if prohibited from doing so. The amendment in this paragraph refers to a sanction that may be imposed prohibiting an approved provider from charging an accommodation charge for the period of the sanction. This sanction is described in Part 4.4 paragraph 66-1(j) of the *Aged Care Act 1997*.

Item 164
Item 164 repeals section 84-1 which describes Chapter 6 as dealing with matters relating to the administration of the *Aged Care (Transitional Provisions) Act 1997*. Many of the matters currently listed in this section will remain pertinent to all care recipients and therefore will appear only in the *Aged Care Act 1997*.

Chapter 6 of this Act only needs to deal with one issue - the reconsideration and administrative review of decisions, Part 6.1.

As well as repealing existing section 84-1, item 164 creates a new section to provide for this.

Section 84-1 What this Chapter is about
This new section provides that Chapter 6 deals only with reconsideration and administrative review of decisions made under the *Aged Care (Transitional Provisions) Act 1997.*

Items 165 and 166
Section 85-1 provides a table of reviewable decisions.

These items repeal table items 1 to 39 and table items 54 to 59. These table items describe reviewable decisions which will continue to exist under the *Aged Care Act 1997* (as amended on 1 July 2014 by the Aged Care (Living Longer Living Better) Bill 2013) but do not need to be replicated in this Act because these decisions relate to matters dealt with only in the *Aged Care Act 1997.*

Table items 39AA to 53C remain in the *Aged Care (Transitional Provisions) Act 1997* as the decisions described in these table items will relate to continuing care recipients. For example, decisions to:

- determine the value of a person's assets;
- refuse to make a determination about eligibility for various supplements; and
- refuse to extend a period within which to make a variation of a claim for subsidy.

Item 166 also inserts a new item into the table of reviewable decisions (table item 54) which provides that a decision under the Aged Care (Transitional Provisions) Principles, where it is specified in those Principles to be a decision reviewable under section 85-1, is reviewable.

Item 168
Section 96-1 includes a table that sets out all of the different Aged Care Principles that the Minister may make.

This item repeals that section and replaces it with a new section that allows the making of Aged Care (Transitional Provisions) Principles.

Section 96-1 Aged Care (Transitional Provisions) Principles
This new section provides that the Minister may, by legislative instrument, make Aged Care (Transitional Provisions) Principles providing for matters required or permitted by this Act or necessary or convenient in order to carry out or give effect to this Act.

The effect of this is that only one set of Principles will be made under this Act. These Principles will deal with all matters relating to continuing care recipients. The content of these Principles will be drawn from, for example, the User Rights Principles and the Residential Care Subsidy Principles where these Principles describe matters that are specific to continuing care recipients (such as matters relating to accommodation bonds and payment of supplements that are only relevant to continuing care recipients).

Item 169
This item repeals subsections 96-2(5) and (6).

Subsection 96-2(5) provides that the Secretary may delegate to a person making an assessment of the care needs of an applicant for approval as a care recipient, all or any of the Secretary's functions under Part 2.3 and all or any of the Secretary's functions under the Residential Care Subsidy Principles that relate to respite supplement. These functions of the Secretary will be performed under the *Aged Care Act 1997* and under

Principles made under that Act, not under the *Aged Care (Transitional Provisions) Act 1997*.

Subsection 96-2(6) provides that the Secretary may delegate to the CEO of the Quality Agency any functions of the Secretary that the Secretary considers necessary for the purposes of the functions of the CEO. This will continue to occur under the *Aged Care Act 1997*.

Item 171
The note under section 96-4 provides that where care is provided by another person, on behalf of an approved provider, the approved provider will still be responsible for the care provided by the other person under Chapter 4. This item amends the note to acknowledge that responsibilities exist under Chapter 4 of both the *Aged Care (Transitional Provisions) Act 1997* and the *Aged Care Act 1997*.

Item 172
This item amends the note under section 96-5 which currently describes the range of agreements provided for in the *Aged Care Act 1997*. The effect of the amendment is to describe only those agreements provided for under this Act - specifically accommodation bond agreements and accommodation charge agreements.

Any other agreements that may be applicable to both continuing care recipients and people who enter care on or after 1 July 2014 are described in the *Aged Care Act 1997.*

Items 178, 179, 181, 182, 183, 184, 187, 189, 190, 192, 196, 199, 202, 205, 206, 207, 209, 210, 212, 213 and 214
These items repeal the definitions listed below. These definitions are not required in this Act as they relate to material that has been repealed and is no longer in this Act. These definitions, where relevant, will remain in the *Aged Care Act 1997*.

The definitions of the following terms in Clause 1 of Schedule 1 are repealed in this Act:
advocacy grant, Aged Care Commissioner, *Aged Care Pricing Commissioner*, *authorised officer*, *available for allocation*, *capital expenditure*, *capital works costs*, *community visitors grant*, *corporation*, *disqualified individual*, *entry contribution balance*, *expiry date*, *formal agreement*, *key personnel*, *Military Rehabilitation and Compensation Commission*, *monitoring powers, operator*, *personal information, pre-allocation lump sum, protected information, provisional allocation period, provisionally allocated, recoverable amount, region, relinquish, reportable assault, residential care grant, section 67-5 notice time, unregulated lump sum*, *unregulated lump sum balance,*

Items 174, 175, 176, 177, 180, 185, 186, 191, 193, 194, 195, 198, 200, 203, 204, 208 and 211
These items repeal certain definitions and make substitutions as described below to ensure that these definitions are relevant to the terms contained in the *Aged Care (Transitional Provisions) Act 1997* and are consistent with their definitions in the *Aged Care Act 1997*.

The definitions of the following terms in Clause 1 of Schedule 1 are repealed in this Act and replaced with their definitions as in the *Aged Care Act 1997*: *accommodation bond, accommodation bond balance, accommodation charge, accreditation requirement, approved provider, certified, classification level, distinct part, extra service agreement, extra service place, extra service status, home care agreement, lowest applicable classification level, people with special needs, permitted, provisional allocation, resident agreement.*

Item 188
This item inserts a new definition for continuing care recipient into the *Aged Care (Transitional Provisions) Act 1997*. The term has the same meaning as in the *Aged Care Act 1997* (see Schedule 3 item 261).

Items 197 and 201
These items remove reference to the Classifications Principles within the definitions of *high level of residential care* and *low level of residential care*. The references are replaced with references to the Aged Care (Transitional Provisions) Principles. The Aged Care (Transitional Provisions) Principles will set out provisions which are required to be different from those described in Principles made under the *Aged Care Act 1997* because they relate to circumstances particular to continuing care recipients and which differ from circumstances for care recipients entering the aged care system from 1 July 2014.

Part 3 – Transitional and savings provisions

Item 215
This item inserts a new definition of ***commencement time*** which means 1 July 2014.

Item 216
This item provides that if an instrument is in force under a provision of the *Aged Care Act 1997* on 30 June 2014 and there is a provision in the *Aged Care (Transitional Provisions) Act 1997* that corresponds to the provision of the *Aged Care Act 1997* under which the instrument was made, the instrument is also taken to have been made under that corresponding provision of the *Aged Care (Transitional Provisions) Act 1997.*

For example if the Secretary has made a hardship determination in respect of a continuing care recipient under the *Aged Care Act 1997*, this hardship determination continues under the *Aged Care (Transitional Provisions) Act 1997.*

Item 217
This item provides that where a process or application or request has been commenced (but not completed) under a provision of the *Aged Care Act 1997* and there is a provision in the *Aged Care (Transitional Provisions) Act 1997* that corresponds to the provision of the *Aged Care Act 1997* under which the process or application or request was commenced, then from the commencement of this Act that process is deemed to have been commenced under this Act. This enables the process to continue uninterrupted under the *Aged Care (Transitional Provisions) Act 1997.*

For example, if a person submitted an application for a hardship determination on 20 June 2014, but a decision had not been made by 30 June 2014, the application could continue to be processed on and after 1 July 2014.