13 May 2025

Department of Health and Aged Care

**New Aged Care Act Rules consultation – release 4b – remaining rules**

Ageing Australia welcomes the opportunity to provide feedback on the remaining rules in release 4b which focus on entering aged care and how places are allocated to people, rules for providers, workers and digital platforms, how to make a complaint, what information the government must or can share and accommodation costs.

Ageing Australia is the national peak body for aged care, representing providers of retirement living, seniors housing, residential care, home care and community services. We advocate for our members, providing expert advice, resources and tailored services to ensure they deliver exceptional care to older Australians.

Ageing Australia's recommendations and key messages are provided below. Specific comments on the release 4b rules are contained in **Appendix 1**. We have also provided comments on the meal obligation explainer document in **Appendix 2** and the process for managing complaints document in **Appendix 3**.

**Recommendations**

**R1 The Department of Health and Aged Care (Department) and/or Aged Care Quality and Safety Commission (Commission) should urgently release resources that map existing requirements to new requirements, clearly identifying any changes, and summarising which providers need to meet which requirements.**

**R2 The Department should urgently publish any rules that remain 'to be drafted'.**

**R3 That Government increase funding for providers to ensure they are adequately funded to meet any new requirements from the commencement of the new Aged Care Act, in addition to the prices recommended by the Independent Health and Aged Care Pricing Authority from 2025-26.**

**R4 Transitional arrangements should be implemented to allow sufficient implementation time for providers, particularly for new requirements.**

**R5 The Department should consider what requirements (particularly reporting requirements) can be streamlined, removed or further consulted on before implementation.**

**R6 Review of service agreement requirements in proposed subsections 148-65(7) and (8) should be removed as they are potentially onerous, unreasonable and unnecessary.**

**R7 The general requirements for service agreements in proposed subsection 148-65(3) should be amended consistent with our recommended changes in Appendix 1.**

**R8 Existing home care and Commonwealth Home Support Programme providers should be allowed 12 months to put in place new service agreements for existing clients.**

**R9 Home support providers should publish the most common price they intend to charge in the next six months (rather than the most frequently charged price during the previous two calendar months).**

**R10 A mechanism is introduced to ensure accommodation charges can be made by residential aged care providers while the Services Australia assessment for a resident is being completed.**

**R11 Requirements for meals delivered by providers registered in home and community services, and requirements for meals delivered by providers registered in personal and care support in the home and community, should be amended consistent with our recommended changes in Appendix 1.**

**R12 Address the feedback included in Appendices 1, 2 and 3.**

### Impacts of compressed timeframe on proper consideration and implementation

We are concerned by the magnitude of rules released in this consultation draft, and the inclusion of significant requirements that providers are expected to meet by 1 July 2025. We have provided extensive feedback, much of which indicates substantial barriers to successful implementation of components of the rules before 1 July 2025. We are highly concerned that, with less than two months to go, issues risk going unaddressed and thus unintended consequences are probable, if not likely.

We also note there are sections of the rules that are yet to be drafted. A lack of clarity is adding to the pressures providers are already facing in preparing for the commencement of the new Aged Care Act on 1 July 2025. Indeed, providers require the certainty of 'final' rules to enable their preparations (particularly training of staff, amending policies and procedures, and having standard templates developed).

To support providers to prepare, the Department and/or Commission should urgently release resources that map existing requirements to new requirements, clearly identifying any changes, and summarising which providers need to meet which requirements. The need for this has become even more apparent with this release of rules as it contains extensive reporting requirements for providers. We acknowledge that the Department intends to release, in June 2025 or soon after 1 July 2025, a Digital Provider Obligation Tool to support providers to understand and navigate requirements under the new Act and rules, which will be of assistance.

Any rules that remain 'to be drafted' and have not been included in any consultation drafts of the rules should also be urgently published. Providers need to be able to easily understand all the requirements they must comply with, including what is new.

To accompany the final rules, the Department should also produce tailored implementation guidance materials to support providers delivering services to people with specific needs, for example, culturally and linguistically diverse people, Aboriginal and Torres Strait Islander people, and people experiencing homelessness.

We also ask that any new requirements are adequately costed and funded with effect from commencement of the new Aged Care Act. This includes, for example, the new requirement for an annual assessment of meals by an accredited practising dietitian in proposed section 148-20. To not adequately cost and fund new requirements from commencement of the new Aged Care Act will put a sector already experiencing significant financial sustainability challenges further behind.

The acuteness of our concerns about some components of the rules could be allayed if transitional arrangements were implemented to allow sufficient implementation time for providers. For example, the new requirements in proposed section 148-20 for meals delivered by certain registered providers should commence no earlier than 1 July 2026 to allow sufficient implementation time for providers; and existing home care and

Commonwealth Home Support Programme (CHSP) providers should be allowed 12 months to put in place new service agreements for existing clients.

**Reporting and compliance burden**

There are various requirements in this rules release which will further exacerbate the already significant reporting and compliance burden for providers. The issue of compliance burden was evident in release 3 of the rules (and identified in our submission on that consultation, with examples such as the complaints reporting requirements) – this is further heightened by the requirements included in this rules release.

For example, we are concerned that the requirements for providers to notify changes relating to arrangements with associated providers (proposed section 167-55) may be particularly onerous and especially so for some Support at Home providers. This requirement should be limited to notification of changes where arrangements with associated providers materially affect a provider's ability to deliver care.

Another example of an excessive reporting requirement is the two monthly reporting period for pricing information under proposed section 166-1505. This should be changed to a six monthly reporting period to reduce reporting burden.

We are also unclear on the need for some of the reporting requirements, such as the requirement to prepare a service demographics report each financial year (proposed section 166-735). The child safety compliance statement (proposed section 166-628) is another example – this is new and would benefit from further consultation before commencement to determine the most cost efficient way to implement it.

Aligned to our feedback to release 3 of the rules, we recommend the Department consider what requirements can be streamlined, removed or further consulted on before implementation – in the context of reform of this magnitude, in the timeframe required, and the pressures associated with preparing for the new Aged Care Act.

**Service agreements**

We have a number of concerns with the proposed service agreement requirements.

<u>Review of service agreement - proposed subsections 148-65(7) and (8)</u>

These subsections, which require providers to review service agreements at least once every 12 months and upon request from individuals, should be removed as they are potentially onerous, unreasonable and unnecessary.

The idea that a contract should be subject to ongoing negotiation is inconsistent with standard contract law. In usual contractual arrangements, parties would only "review" a contract at a time when it is up for renewal and both parties have a chance to walk away, or, at the mutual agreement of both parties. Under the proposed arrangements, a provider would be required to regularly "review" a contract, yet there are only limited circumstances under the *Aged Care Act 2024* in which it is possible for a provider to exit that contract.

The obligation to "review" the contract is also vague. What obligation is there on the provider to change the terms if they don't wish to? What if the individual repeatedly asks for a price reduction, will the provider be in breach if they say no? If a provider repeatedly says no, would that constitute a breach of the requirement to "review" the agreement?

Also, it is onerous to require a provider to renegotiate a contract every time it is requested. Consumers will inevitably seek to exercise this right in the event of a dispute and the provider may incur significant legal costs in responding to these requests.

This requirement is also unnecessary. Individuals (unlike providers) have the right to exit at any time, for any reason, and have the right to go to other providers. Providers have an incentive to negotiate if it is reasonable but should not be forced to.

Requirements for service agreements – general – proposed subsection 148-65(3)

In **Appendix 1**, we have recommended a number of changes to these provisions including to change paragraph 148-65(3)(a) to read "the individual is involved in the preparation of the service agreement to the extent they are able to and proportionate to the individual's service complexity and wishes".

We have recommended this change as it is unclear how an individual can be involved in the "development" of a service agreement and its required content, and what this means where providers use template agreements. It is also likely to create excessive administrative burden for providers and individuals.

We are also concerned that indicating that the service agreement in its entirety can be negotiated is misleading. The provider should only be required to ensure that individuals are involved in the "preparation of the service agreement to the extent they are able to".

Further, it is unclear how the requirement as drafted is meant to be undertaken for services such as transport for CHSP without time provision for a sit-down meeting with the individual or care management. For this reason, we have recommended adding "proportionate to the individual's service complexity and wishes" to account for, as an example, a person with intermittent transport support to medical appointments with limited negotiation/preparation needs.

## Support at Home agreement transition

Providers are unable to offer or secure acceptance of new individual Support at Home service agreements before 1 July 2025 as well as meet the Statement of Rights and Principles in the new Aged Care Act. Enacting a requirement to have new service agreements in place for each individual transitioning to the Support at Home program on 1 July 2025 will result in either widespread non-compliance, despite minimal risk to individuals, or individuals ceasing services. Given the number of individuals transitioning, and in the absence of final rules, it would be extremely difficult to finalise service agreements by 1 July 2025.

Transitional provisions are essential to ensure continuity of care for individuals and other provisions in the Act to be upheld. We recommend provisions are included to enable providers to:

- seek consent on change to services, obligations and contributions through a letter as an addendum to the current agreement
- renegotiate formal agreement documents by 1 July 2026.

These provisions would increase the proportion of individuals consenting to the Support at Home program by 1 July 2025, and enable an extended period for more detailed conversations about agreement considerations.

## Commonwealth Home Support Programme (CHSP) transition

The draft 4b rules outline a number of new requirements for CHSP providers, including new requirements for service agreements and obligations for specific CHSP providers.

Given providers are still awaiting clear guidance from the Department on the new requirements, including in a CHSP Manual 2025-2027, it is vital that transitional arrangements are introduced for the many existing CHSP clients, to give providers sufficient time to implement any new requirements. We recommend a 12-month transitional period.

**Publication of information by home support providers**

Proposed section 155-80 requires home support providers to publish, every two months, the price for a service that the provider has most frequently charged during the previous two calendar months.

Using historical prices to publish a price is problematic and potentially misleading (particularly given providers will have to periodically increase fees to cover increased costs). Two monthly reporting is also overly onerous.

Instead, we recommend home support providers publish the most common price they intend to charge in the next six months. Separately, there could be a provision requiring providers to report to the Department, every six months, the most common price charged in the previous six months.

**Providers registered in home and community services or personal and care support in the home and community – requirements for meals**

We have a number of concerns with proposed section 148-20.

These new requirements should not commence before 1 July 2026 to allow sufficient implementation time for providers and accredited practising dietitians.

The requirement for an annual assessment of meals and refreshments, conducted by an accredited practising dietitian, is a new obligation. It will be essential, as noted earlier, that the Government appropriately funds providers to allow these assessments to be undertaken without having a negative impact on the delivering of other services.

It is unclear whether "refreshments" is intended to mean drinks and/or the provision of food other than meals. We recommend that the terminology used is consistent with the strengthened Aged Care Quality Standards which uses 'meals, drinks and snacks' (assuming this is what is intended for these new requirements).

In **Appendix 1**, we have highlighted other concerns with this section, along with recommended solutions.

**Residential care – residents waiting for their assessment from Services Australia**

There is a drafting gap in relation to what providers can charge residents while a resident waits for their assessment from Services Australia (or during the period before they receive a determination that they are "means not disclosed").

Paragraph 296(a) of the *Aged Care Act 2024* says that an individual must not be charged an accommodation payment unless:

i. the individual's daily means tested amount, at the individual's start day, is equal to or greater than the individual's maximum accommodation supplement amount for that day; or
ii. the individual has means not disclosed status at the individual's start day.

Under the *Aged Care Act 1997*, providers could charge the highest amount if "the person does not provide sufficient information to allow the person's means tested amount to be worked out". This did not stipulate who that information needed to be provided to, and as such providers could interpret this to mean that there was insufficient information provided to the provider. As a result, during this period providers could assume the resident was eligible to pay an accommodation payment. If this proved to be incorrect, they would then refund the overcharged amounts once they received the assessment from Services Australia.

The new Aged Care Act has a new concept of "means not disclosed" which must be specifically determined by the System Governor. As such, if a person has not provided sufficient information, they will not receive the System Governor's determination until the time period under the rules has elapsed. Given the significant impact on providers from not being able to charge in these circumstances, and potentially being unable to recoup if a resident refuses to pay once an assessment is made, we recommend a mechanism is introduced to ensure charges can be made while the Services Australia assessment is being completed.

For further feedback on the release 4b rules, the meal obligation explainer document and the process for managing complaints document, please see **Appendices 1, 2 and 3**.

Thank you again for the opportunity to provide feedback on these documents. Please contact Anne Liddell, Head of Strategic Policy at anne.liddell@ageingaustralia.asn.au and myself at jennifer.chynoweth@ageingaustralia.asn.au if you have any questions or would like to discuss our feedback.

**Yours sincerely,**

Jennifer Chynoweth
Head of Funding and Reform

**Attachments**

Appendix 1: Feedback on consultation draft rules – release 4b
Appendix 2: Feedback on meal obligation explainer document
Appendix 3: Feedback on the process for managing complaints document

Appendix 1


**CONSULTATION DRAFT**

# Aged Care Rules 2025

I, Anika Wells, Minister for Aged Care, make the following rules.

Dated 2025

Anika Wells **[DRAFT ONLY—NOT FOR SIGNATURE]**
Minister for Aged Care

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# Chapter 1—Introduction

## Part 1—Preliminary

### 1-5 Name

This instrument is the *Aged Care Rules 2025*.

### 2-5 Commencement

(1) Each provision of this instrument specified in column 1 of the table commences, or is taken to have commenced, in accordance with column 2 of the table. Any other statement in column 2 has effect according to its terms.

| **Commencement information** | | |
|---|---|---|
| **Column 1** | **Column 2** | **Column 3** |
| **Provisions** | **Commencement** | **Date/Details** |
| 1. The whole of this instrument | At the same time as the *Aged Care Act 2024* commences. | |

Note: This table relates only to the provisions of this instrument as originally made. It will not be amended to deal with any later amendments of this instrument.

(2) Any information in column 3 of the table is not part of this instrument. Information may be inserted in this column, or information in it may be edited, in any published version of this instrument.

### 3-5 Authority

This instrument is made under the *Aged Care Act 2024*.

### 4-5 Simplified outline of this instrument

[To be drafted.]

[Amounts in this draft are approximate and subject to change before 1 July 2025.]

Section 5-5

# Part 2—Definitions

### 5-5 Definitions

Note: The following expressions used in this instrument are defined in the Act:
(aa) associated provider;
(a) care and services plan;
(b) enrolled nurse;
(c) health service;
(d) means testing category;
(e) Multi-Purpose Service Program;
(f) National Law;
(g) nursing;
(h) nursing assistant;
(i) registered nurse;
(j) service agreement;
(k) specialist aged care program;
(l) subsidy basis;
(m) Transition Care Program;
(n) transition time.

In this instrument:

***accommodation bond agreement*** has the same meaning as in the *Aged Care (Transitional Provisions) Act 1997*, as in force immediately before the transition time.

***accommodation charge agreement*** has the same meaning as in the *Aged Care (Transitional Provisions) Act 1997*, as in force immediately before the transition time.

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

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

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

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

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

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

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

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

***Aged Care Assessment Manual*** means the Aged Care Assessment Manual, published by the Department, as existing on the day this instrument commences.

Note: The Aged Care Assessment Manual could in 2025 be viewed on the Department's website (https://www.health.gov.au).

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

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

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

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

Note: The AN-ACC Assessment Tool could in 2025 be viewed on the Department's website (https://www.health.gov.au).

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

Note: The AN-ACC Reference Manual could in 2025 be viewed on the Department's website (https://www.health.gov.au).

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

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

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

***authorised person***: see section 28 of the Act.

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

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

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

***complainant***: see subsection 361-10(1) of this instrument.

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

***current wait time***, for the allocation of a place for a classification type for a service group to an individual, on a day (the ***current day***) before the place is

allocated to the individual, means the time starting at the time the individual's access approval for the classification type for the service group was given and ending at the end of the day before the current day.

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

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

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

***entry contribution*** has the same meaning as in the old Act.

***entry contribution balance*** has the same meaning as in the old Act.

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

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

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

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

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

***home support compounding factors***: see section 81-7.

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

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

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

***income support payment*** has the same meaning as in the *Aged Care (Transitional Provisions) Act 1997*, as in force immediately before the transition time.

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

***Integrated Aged Care Module*** means the document of that name published by the Australian Commission on Safety and Quality in Health Care.

Note: The Integrated Aged Care Module could in 2025 be viewed on the website of the Australian Commission on Safety and Quality in Health Care (https://www.safetyandquality.gov.au).

[The Integrated Aged Care Module is the document currently named the Aged care module and User Guide for Multi-Purpose Services.]

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

Note: The Integrated Assessment Tool could in 2025 be viewed on the Department's website (https://www.health.gov.au).

***local region*** means [to be drafted].

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

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

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

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

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

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

Note: The National Safety and Quality Health Service Standards could in 2025 be viewed on the website of the Australian Commission on Safety and Quality in Health Care (https://www.safetyandquality.gov.au).

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

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

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

***pre-2014 accommodation balance***, in relation to a pre-2014 bond-related accommodation payment (other than a payment that is to be paid by periodic payments) is, at a particular time, an amount equal to the difference between:

(a) the payment; and
(b) any amounts that have been, or are permitted to be, deducted under this instrument as at that time.

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

(a) immediately before the transition time, any of the following were in effect for the individual:
  (i) a formal agreement (within the meaning of the old Act);
  (ii) an accommodation bond agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*);
  (iii) an accommodation charge agreement (within the meaning of the *Aged Care (Transitional Provisions) Act 1997*); and
(b) if, at the transition time, the individual is not accessing funded aged care services in an approved residential care home—the sum of the following periods is not more than 28 days:
  (i) the period (if any) immediately before the transition time during which the individual had ceased to be provided with residential care by a residential care service (other than because the person was on leave (within the meaning of the old Act));
  (ii) the period beginning at the transition time during which the individual does not access funded aged care services in an approved residential care home; and
(c) since the transition time, the individual has not:
  (i) elected, in the approved form, to cease being a member of the pre-2014 residential contribution class; and
  (ii) ceased accessing funded aged care services in an approved residential care home and started accessing funded aged care services in another approved residential care home.

***pre-2014 bond-related accommodation agreement*** means an agreement between an individual in the pre-2014 accommodation class and a registered provider in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider that meets the requirements set out in section 287-25.

***pre-2014 bond-related accommodation payment*** means an amount of money paid or payable in accordance with a pre-2014 bond-related accommodation agreement by an individual in the pre-2014 accommodation class to a registered provider.

***pre-2014 bond-related retention amount*** means an amount that a registered provider may deduct from a pre-2014 accommodation balance in accordance with section 287-95.

***pre-2014 charge-related accommodation agreement*** means an agreement between an individual in the pre-2014 accommodation class and a registered provider in relation to the delivery of ongoing funded aged care services to the individual through the service group residential care at an approved residential care home of the provider that meets the requirements set out in section 287-115.

***pre-2014 charge-related accommodation payment*** means an amount of money paid or payable in accordance with a pre-2014 charge-related accommodation agreement by an individual in the pre-2014 accommodation class to a registered provider.

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

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

***quality auditor*** means a person who is approved as a quality auditor under [to be drafted].

***queue rate*** means:

(a) for the priority category high for the classification type ongoing for the service group home support—0.25; or

(b) for the priority category medium for the classification type ongoing for the service group home support—1; or

(c) for the priority category standard for the classification type ongoing for the service group home support—1.25.

***refund period*** means the period within which a pre-2014 accommodation balance must be refunded in accordance with section 287-102.

***residential care compounding factors***: see section 81-8.

***restorative care partner***: see section 148-40.

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

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

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

(a) convicted of murder or sexual assault; or

(b) convicted of, and sentenced to imprisonment for, any other form of assault.

***significant compounding factors***:

(a) for a classification assessment for an individual for a classification type for the service group home support—the individual has ***significant compounding factors*** if the home support compounding factors for the individual, considered together, indicate that the individual has significantly higher care needs relative to the needs of other individuals with similar home support functional independence scores and home support needs met scores; and

(b) for a classification assessment for an individual for the classification type ongoing for the service group residential care—an individual mentioned in an item of the table in section 81-8 has ***significant compounding factors*** if the residential care compounding factors for the individual, considered together, indicate that the individual has significantly higher care needs relative to the needs of other individuals mentioned in that item.

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

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

(a) for the priority category urgent—1 month; or

(b) for the priority category high, medium or standard—the result of multiplying the wait time factor on the day by the queue rate for the priority category.

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

(a) has an access approval in effect for the classification type for the service group; and

(b) has been assigned the priority category for the classification type for the service group; and

(c) has not been allocated a place for the classification type for the service group.

***wait time factor***: see section 93-13.

***wraparound services*** means non-clinical wraparound services and clinical wraparound services.

### 7-8 Approved needs assessors

*Approving entities*

(1) For the purposes of paragraph (a) of the definition of ***approved needs assessor*** in section 7 of the Act, the kind of entity is an entity to which the System Governor has, under subsection 567(3) of the Act, delegated the System Governor's function under section 78 of the Act.

*Criteria*

(2) For the purposes of paragraph (b) of the definition of ***approved needs assessor*** in section 7 of the Act, the criteria for a person are that the person is an individual who:

(a) is employed or otherwise engaged by an entity prescribed by subsection (1); and

(b) has completed the minimum mandatory learning goals specified in the My Aged Care Workforce Learning Strategy 2025 published by the Department, as existing on the day this instrument commences.

Note 1: For paragraph (a), an individual engaged by an entity includes an independent contractor.

Note 2: The My Aged Care Workforce Learning Strategy 2025 could in 2025 be viewed on the Department's website (https://www.health.gov.au).

# Chapter 2—Entry to the Commonwealth aged care system

## Part 1—Introduction

### 55-5 Simplified outline of this Chapter

[To be drafted.]

# Part 2—Eligibility for entry

## Division 1—Applying for access to funded aged care services

### 56-5 Classes of persons who may apply on behalf of individuals

For the purposes of subsection 56(1) of the Act, the following classes of persons are prescribed in relation to an individual:

(a) supporters of the individual;
(b) health professionals;
(c) allied health professionals;
(d) aged care workers of registered providers;
(e) registered providers;
(f) social workers (however described);
(g) individuals employed or engaged as care finders under the care finder program funded by the Department;
(h) individuals employed or engaged as elder care supporters under the elder care support program funded by the Department;
(i) family members, friends, advocates and carers of the individual.

### 57-5 Period for deciding whether to make eligibility determinations

For the purposes of subsection 57(2) of the Act, the period for making a decision under subsection 57(1) of the Act on an application for access to funded aged care services is 28 days after receiving the application.

**Commented [A1]:** To support consumers and their care needs, recommend change to 14 days as the decision time should only have a minor impact on the wait time for being able to access funded aged care services.

### 58-5 Information to be provided for eligibility determinations

For the purposes of paragraph 58(b) of the Act, each of the following is prescribed as a kind of information relating to an individual's care needs:

(a) a declaration by the individual, made orally or in writing, that the individual has care needs;
(b) a written statement by a person in a class of persons referred to in section 56-5 of this instrument that sets out the individual's care needs;
(c) written medical records of the individual's care needs.

Note: For the definition of ***care needs***, see section 7 of the Act.

## Division 2—Aged care needs assessments and reassessments

### Subdivision A—Aged care needs assessments

#### 62-5 Assessment tool

For the purposes of subsection 62(1) of the Act, the Integrated Assessment Tool is prescribed.

### Subdivision B—Aged care needs reassessments

#### 64-5 Significant changes in circumstances

For the purposes of subparagraph 64(1)(c)(i) of the Act, each of the following is prescribed as a significant change in circumstances in relation to an individual who is accessing funded aged care services other than through the service group residential care:

(a) a carer for the individual has permanently ceased to provide some or all care to the individual;

(b) an application for a classification reassessment has been made by the individual, or a registered provider on behalf of the individual, under section 82 of the Act because the individual has experienced an event, or a decline in their condition, that is likely to mean that the individual will require:

(i) more frequent access to a funded aged care service that is covered by the individual's access approval and that the individual has been accessing; or

(ii) access to a funded aged care service that is covered by the individual's access approval but that the individual has not been accessing; or

(iii) access to a funded aged care service that is not covered by the individual's access approval.

#### 64-10 Other circumstances

For the purposes of subparagraph 64(1)(c)(ii) of the Act, each of the following is prescribed as other circumstances in relation to an individual who is accessing funded aged care services other than through the service group residential care:

(a) a carer for the individual has temporarily ceased to provide some or all care to the individual;

(b) both:

(i) the individual has experienced an event, or a decline in their condition, that is likely to mean that the individual will require access to a funded aged care service that is not covered by the individual's access approval; and

(ii) an application for a classification reassessment has not been made by the individual, or a registered provider on behalf of the individual, under section 82 of the Act following that event or decline.

### 64-15 Information for reassessments in other circumstances

For the purposes of paragraph 64(2)(b) of the Act, each of the following is prescribed as a kind of information in relation to an individual:

(a) information provided, orally or in writing, by any of the following about the individual's need for funded aged care services:
  (i) a health professional;
  (ii) an allied health professional;
  (iii) a registered provider delivering the funded aged care service home support care management or home support restorative care management to the individual;

(b) information provided, orally or in writing, by an approved needs assessor following a review by the assessor of the report of the most recent aged care needs assessment for the individual;

(c) information in the most recent application for a classification reassessment for the individual;

(d) information referred to in paragraph 76-15(2)(b) of this instrument (classification assessment for classification type short-term for service groups home support and assistive technology—end-of-life).

**Commented [A2]:** Include, Information provided by the individual and supporter, and other carer parties.

## Division 3—Approval of access to funded aged care services

### Subdivision A—General

#### 65-5 Approval of services in service types for individuals

For the purposes of subparagraph 65(2)(b)(ii) of the Act, the following service types are prescribed:

(a) allied health and therapy;

(b) therapeutic services for independent living.

#### 65-10 Eligibility requirements—service group home support

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service group home support for an individual are that:

(a) the individual has a total score of less than 20 for the questions in the Integrated Assessment Tool with the following headings:

(i) "Climb stairs";

(ii) "Eating";

(iii) "Dressing";

(iv) "Take a bath or shower";

(v) "Grooming";

(vi) "Transfers";

(vii) "Toilet use";

(viii) "Toileting – bladder";

(ix) "Toileting – bowels";

(x) "Walk";

(xi) "Wheelchair Mobility"; or

(b) the individual has a total score of less than 14 for the questions in the Integrated Assessment Tool with the following headings:

(i) "Get to places out of walking distance";

(ii) "Undertake housework (heavy/moderate)";

(iii) "Go shopping (assuming transportation)";

(iv) "Prepare meals";

(v) "Take medicine";

(vi) "Handle money";

(vii) "Use the telephone"; or

(c) the individual has a score of greater than zero for the questions in the sections of the Integrated Assessment Tool headed "Cognition" and "Medical and Medications"; or

(d) the individual has a score of greater than zero for the questions in the sections of the Integrated Assessment Tool headed "Psychological"; or

(e) the individual has a score of greater than zero for the questions in the section of the Integrated Assessment Tool headed "Physical, Personal Health and Frailty".

### 65-15 Eligibility requirements—service groups assistive technology and home modifications

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service groups assistive technology and home modifications for an individual is that the service group home support is approved for the individual.

### 65-20 Eligibility requirements—service group residential care

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service group residential care for an individual is that the individual is incapable of living in a home or community setting without support.

**Commented [A3]:** It is unclear how this definition interacts in relation to individuals who are eligible for home support. Does it mean, for example, that all individuals who are eligible for home support are also eligible for residential care? Should it instead be something along the lines of the description used on My Aged Care (i.e. the individual can no longer live at home and needs ongoing help with everyday tasks or health care)?

### 65-30 Period for making decisions

For the purposes of subsection 65(5) of the Act, the period for making decisions under subsections 65(1) and (2) of the Act for an individual is 14 days after receiving an assessment report for the individual provided under section 63 of the Act, or information relating to the individual that is provided to the System Governor in accordance with paragraph 64(2)(b) of the Act, as applicable.

## Subdivision B—Period of effect of approval

### 71-5 Alternative entry—when access approval takes effect—circumstances and period for making application

For the purposes of paragraph 71(3)(b) of the Act, the following circumstances and period are prescribed for an individual:

(a) the circumstances are that a registered provider that delivers funded aged care services under the MPSP or the NATSIFACP is delivering aged care services to the individual;

(b) the period is 30 days after the first day an aged care service covered by the individual's access approval was delivered to the individual by the provider.

**Commented [A4]:** Clarification is needed about the implications of this section.

# Part 3—Classification

## Division 1—Classification assessments

### 75-5 Circumstances in which classification assessment not required

For the purposes of paragraph 75(5)(a) of the Act, the circumstances in which a classification assessment otherwise required under paragraph 75(1)(b) or subsection 75(2) of the Act in relation to an individual for a classification type for a service group is not required to be undertaken are that:

(a) the classification type is ongoing or short-term for the service group residential care; and

(b) the individual is accessing funded aged care services under a specialist aged care program in an approved residential care home.

### 76-10 Assessment tools and other requirements for classification assessments required under subsection 75(1) or (2) of the Act and carried out by approved needs assessors

(1) This section is made for the purposes of subparagraphs 76(1)(a)(i) and (b)(i) of the Act.

*Service groups home support, assistive technology and home modifications*

(2) For an assessment for an individual for a classification type for the service group home support, assistive technology or home modifications:

(a) the assessment tool is the Integrated Assessment Tool; and

(b) the other requirements are that the assessment must be carried out in accordance with the Aged Care Assessment Manual.

*Classification type ongoing for service group residential care*

(3) For an assessment for an individual for the classification type ongoing for the service group residential care:

(a) the assessment tool is the AN-ACC Assessment Tool; and

(b) the other requirements are that the assessment must be carried out in accordance with the AN-ACC Reference Manual.

*Classification type short-term for service group residential care*

(4) For an assessment for an individual for the classification type short-term for the service group residential care:

(a) the assessment tool is the De Morton Mobility Index assessment item; and

(b) the other requirements are that the assessment must be carried out in accordance with the part of the AN-ACC Reference Manual that relates to that item.

### 76-15 Circumstances and information for classification assessments required under paragraph 75(1)(a) or subsection 75(2) of the Act and carried out by the System Governor

(1) This section is made for the purposes of subparagraph 76(1)(a)(ii) of the Act for an assessment for an individual for a classification type for a service group.

*Classification type short-term for service groups home support and assistive technology—end-of-life*

(2) The following circumstances and kind of information are prescribed for the classification type short-term for the service groups home support and assistive technology:

(a) the circumstances are that on the date of the individual's application for access to funded aged care services, there were reasonable grounds to believe that the individual had:

(i) a prognosis of a life expectancy of 3 months or less; and

(ii) an AKPS score of 40 or less;

(b) the kind of information is information that provides evidence of the matter mentioned in paragraph (a).

*Classification type short-term for service group assistive technology—repairs or maintenance for AT-HM products*

(3) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) the individual has a classification level in effect for the classification type ongoing for the service group home support; and

(ii) repairs or maintenance are required for a product listed in the AT-HM List that the individual owns or has been loaned under a Commonwealth aged care program (including under the old Act);

(b) the kind of information is information that provides evidence of the matter mentioned in subparagraph (a)(ii).

*Classification type short-term for service groups assistive technology and home modifications—progressive conditions*

(4) The following circumstances and kind of information are prescribed for the classification type short-term for the service groups assistive technology and home modifications:

(a) the circumstances are that:

(i) the individual has a classification level in effect for the classification type ongoing for the service group home support; and

(ii) the individual has a condition referred to in subsection 211-10(2) of this instrument;

(b) the kind of information is information that provides evidence of the matter mentioned in subparagraph (a)(ii).

*Classification type short-term for service groups assistive technology and home modifications—aged care needs reassessments in certain circumstances*

(5) The following circumstances and kinds of information are prescribed for the classification type short-term for the service groups assistive technology and home modifications:

(a) the circumstances are that:

(i) the individual has a classification level in effect for the classification type short-term for the service group home support; and

(ii) the circumstances referred to in paragraph 64-10(b) of this instrument (aged care needs reassessments in certain circumstances) apply to the individual;

(b) the kinds of information are the kinds of information referred to in paragraphs 64-15(a), (b) and (c) of this instrument.

*Classification type ongoing for service group residential care—palliative care pathway*

(6) The following circumstances and kind of information are prescribed for the classification type ongoing for the service group residential care, for an individual accessing funded aged care services in the form of palliative care in an approved residential care home of a registered provider:

(a) the circumstances are that:

(i) on and after the individual's start day for the home, the provider has delivered funded aged care services in the form of palliative care to the individual in the home; and

(ii) on the individual's start day for the home, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less; and

(iii) the provider gives the System Governor a notice in the approved form containing the kind of information referred to in paragraph (b) within 14 days, or such longer period as is agreed in writing between the System Governor and the provider, after the provider gives the System Governor a start notification for the individual;

(b) the kind of information is information that provides evidence of the matters mentioned in subparagraph (a)(ii).

**Commented [A5]:** Clarification is needed about what would constitute reasonable grounds. E.g. does this need to be based on the opinion of one (or more) doctors? Would the opinion of a nurse or nurse practitioner be sufficient? Would the doctor or nurse need to be independent of the residential aged care home?

**Commented [A6]:** As per earlier comment, further clarity is needed about what would be considered sufficient evidence. E.g. Would you need written evidence of a doctor's assessment? Recommend amending this provision to state examples of what this could include.

**76-20 Circumstances and information for classification assessments required under paragraph 75(1)(b) of the Act (on application for classification reassessment) and carried out by the System Governor**

(1) This section is made for the purposes of subparagraph 76(1)(b)(ii) of the Act for an assessment for an individual for a classification type for a service group.

*Classification type short-term for service group home support [to be drafted if required]*

(2) The following circumstances and kind of information are prescribed for the classification type short-term for the service group home support:

(a) the circumstances are [to be drafted if required];

(b) the kind of information is [to be drafted if required].

*Classification type short-term for service group assistive technology—end-of-life*

(3) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that on the date of the individual's application for classification reassessment, there were reasonable grounds to believe that the individual had:

(i) a prognosis of a life expectancy of 3 months or less; and

(ii) an AKPS score of 40 or less;

(b) the kind of information is information that provides evidence of the matters mentioned in paragraph (a).

*Classification type short-term for service group assistive technology—aged care needs reassessments in certain significant changes in circumstances*

(4) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) the individual has a classification level for the classification type short-term for the service group assistive technology other than AT high; and

(ii) the circumstances referred to in paragraph 64-5(b) of this instrument (aged care needs reassessments in certain significant changes in circumstances) apply to the individual;

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

*Classification type short-term for service group assistive technology—individuals with transitional classification levels*

(5) The following circumstances and kind of information are prescribed for the classification type short-term for the service group assistive technology:

(a) the circumstances are that:

(i) the individual has the classification level AT transitional for the classification type short-term for the service group assistive technology; and

(ii) subsection (6) applies to the individual;

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

(6) This subsection applies to the individual if:

(a) the individual has an assistance dog; or

(b) the individual has a condition referred to in subsection 211-10(2) of this instrument; or

(c) the System Governor has reviewed the report of the most recent aged care needs assessment for the individual and considers that the individual needs assistive technology to mitigate functional decline or impairment and

enable them to safely live in their home and community (see paragraph (a) in column 2 of items 1 to 3 of the table in subsection 81-25(1) of this instrument (criteria for the classification levels AT low, AT medium and AT high)).

*Classification type short-term for service group home modifications—aged care needs reassessments in certain significant changes in circumstances*

(7) The following circumstances and kind of information are prescribed for the classification type short-term for the service group home modifications:

(a) the circumstances are that:

(i) the individual has a classification level for the classification type short-term for the service group home modifications other than HM high; and

(ii) the circumstances referred to in paragraph 64-5(b) of this instrument (aged care needs reassessments in certain significant changes in circumstances) apply to the individual;

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

*Classification type short-term for service group home modifications—individuals with transitional classification levels*

(8) The following circumstances and kind of information are prescribed for the classification type short-term for the service group home modifications:

(a) the circumstances are that:

(i) the individual has the classification level HM transitional for the classification type short-term for the service group home modifications; and

(ii) the System Governor has reviewed the report of the most recent aged care needs assessment for the individual and considers that the individual needs home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community (see paragraph (a) in column 2 of items 1 to 3 of the table in subsection 81-30(1) of this instrument (criteria for the classification levels HM low, HM medium and HM high));

(b) the kind of information is information that provides evidence of the circumstances mentioned in subparagraph (a)(ii).

**Commented [A7]:** Recommend need for reassessment if the most recent aged care needs assessment was undertaken some time beforehand or if there has been indication of changing needs.

*Classification type ongoing for service group residential care—palliative care pathway*

(9) The following circumstances and kind of information are prescribed for the classification type ongoing for the service group residential care, for an individual accessing funded aged care services in the form of palliative care in an approved residential care home of a registered provider:

(a) the circumstances are that:

(i) on and after the individual's start day for the home, the provider has delivered funded aged care services in the form of palliative care to the individual in the home; and

(ii) on the individual's start day for the home, there were reasonable grounds to believe that the individual had a prognosis of a life expectancy of 3 months or less and an AKPS score of 40 or less; and

(iii) the provider gives the System Governor a notice in the approved form containing the kind of information referred to in paragraph (b) within 14 days, or such longer period as is agreed in writing between the System Governor and the provider, after the date of the application for classification reassessment for the individual;

(b) the kind of information is information that provides evidence of the matters mentioned in subparagraph (a)(ii).

**Commented [A8]:** Comments above about subsection 76-15(6) also applicable here as these provisions seem to be the same

### 76-25 Classification assessments for classification type ongoing for service group residential care—skills, qualifications and other requirements for approved needs assessors

*Skills and qualifications*

(1) For the purposes of paragraph 76(2)(a) of the Act, the skills and qualifications for an approved needs assessor are that the assessor is a registered nurse, occupational therapist or physiotherapist.

*Other requirements*

(2) For the purposes of paragraph 76(2)(b) of the Act, the other requirements for an approved needs assessor are the following:

(a) the assessor has at least 5 years of clinical experience in the delivery of aged care services or related health services as a registered nurse, occupational therapist or physiotherapist (as the case requires);

(b) a police certificate issued for the assessor within the last 3 years does not record that the assessor has a serious offence conviction in Australia;

(c) if, at any time after turning 16, the assessor has been a citizen or permanent resident of a country other than Australia—the assessor has made a statutory declaration that the assessor does not have a serious offence conviction in that country;

(d) when carrying out a classification assessment for the classification type ongoing for the service group residential care, the assessor must:

(i) at all times, carry the assessor's identity card issued under section [to be drafted]; and

(ii) if a person who apparently represents a registered provider requests the assessor to show the assessor's identity card—do so when requested, or, if it is not reasonably practicable to do so when requested, do so as soon as reasonably practicable after that.

**Commented [A9]:** In what circumstances would this be applicable?

## Division 2—Classification decisions

### Subdivision A—Period for making classification decisions

#### 78-5 Period for making classification decisions

For the purposes of subsection 78(4) of the Act, the period for making a decision under subsection 78(1) of the Act to establish a classification level for an individual for a classification type for a service group is 14 days after the occurrence of whichever of the events referred to in subsection 78(1) of the Act is applicable for the individual.

### Subdivision B—Period of effect of classification levels

#### 80-5 Purpose of this Subdivision

For the purposes of subsection 80(1) of the Act, this Subdivision prescribes, subject to subsection 80(3) of the Act, the period of effect for a classification level for a classification type for a service group that has been established under section 78 of the Act for an individual.

#### 80-10 Service group home support—classification type ongoing

*CHSP class*

(1) For the classification level CHSP class for the classification type ongoing for the service group home support, established for an individual by a classification decision, the period of effect:
  (a) starts at the start of the day the classification decision is made; and
  (b) ends at the end of the earlier of the following (as applicable):
    (i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
    (ii) the day the individual dies.

*SAH class 1, 2, 3, 4, 5, 6, 7 or 8*

(2) For the classification level SAH class 1, 2, 3, 4, 5, 6, 7 or 8 for the classification type ongoing for the service group home support, established for an individual by a classification decision, the period of effect:
  (a) starts at the start of the day the individual gives the System Governor an acceptance of a place for the classification type under subsection 92(5) of the Act; and
  (b) ends at the end of the earlier of the following (as applicable):
    (i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
    (ii) the day the individual dies.

*HCP class 1, 2 3 or 4*

(3) For the classification level HCP class 1, 2, 3 or 4 for the classification type ongoing for the service group home support, taken to be established for an individual by [the determination to be drafted under subitem 4(1) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*] the period of effect:
  (a) starts at the transition time; and
  (b) ends at the end of the earlier of the following (as applicable):
    (i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
    (ii) the day the individual dies.

### 80-15 Service group home support—classification type short-term

*SAH restorative care pathway [1]*

(1) For the classification level SAH restorative care pathway [1] for the classification type short-term for the service group home support, established for an individual by a classification decision:
  (a) the classification level does not take effect if the individual does not give the System Governor an acceptance of a place for the classification level under subsection 92(5) of the Act within the period prescribed by paragraph 92-5(b) of this instrument; and
  (b) the period of effect for the classification level starts at the start of the latest of the following:
    (i) the day the individual gives the System Governor an acceptance of a place for the classification level under subsection 92(5) of the Act;
    (ii) if the individual has previously had the classification level in effect—the day after the end of 90 days after the previous classification level ceased to be in effect;
    (iii) if the individual has had the classification level in effect twice in a period of 12 months—the day after the end of 12 months starting on the first day of the period of effect of the first of the 2 previous classification levels;
    (iv) the start day for the individual for the classification level (as specified in the start notification for the individual under section 149-10 of this instrument); and
  (c) the period of effect for the classification level ends at the earliest of the following (as applicable):
    (i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
    (ii) the end of the day the individual starts accessing funded aged care services under the TCP;
    (iii) the end of the maximum period effect for the classification level (see section80-55);
    (iv) the end of the day the individual dies.

**Commented [A10]:** Add provision 'the end of the day of the individual's request'

*SAH restorative care pathway 2 [to be drafted if required]*

(2) [to be drafted if required]

*SAH end-of-life pathway*

(3) For the classification level SAH end-of-life pathway for the classification type short-term for the service group home support, established for an individual by a classification decision:

(a) the classification level does not take effect if the individual does not give the System Governor an acceptance of a place for the classification level under subsection 92(5) of the Act within the period prescribed by paragraph 92-5(b) of this instrument; and

(b) the period of effect for the classification level starts at the start of the later of the following:

(i) the day the individual gives the System Governor an acceptance of a place for the classification level under subsection 92(5) of the Act;

(ii) the start day for the individual for the classification level (as specified in the start notification for the individual under section 149-10 of this instrument); and

(c) the period of effect for the classification level ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the end of the maximum period effect for the classification level (see section 80-57);

(iii) the end of the day the individual dies.

**Commented [A11]:** Add provision: to end if the person is reassessed as not palliative. This may be required if they need to access the program at another time.

*STRC class*

(4) For the classification level STRC class for the classification type short-term for the service group home support, taken to be established for an individual by [the determination to be drafted under subitem 4(1) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*] the period of effect:

(a) starts at the transition time; and

(b) ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the end of the episode of short-term restorative care (within the meaning of the *Subsidy Principles 2014*) that began for the individual before the transition time;

(iii) the end of the day the individual dies.

**Commented [A12]:** Add provision 'the end of the day of the individual's request'

### 80-20 Service group assistive technology—classification type ongoing

For the classification level assistance dogs for the classification type ongoing for the service group assistive technology, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the day the individual gives the System Governor an acceptance of a place for the classification level under subsection 92(5) of the Act; and

(b) ends at the end of the earlier of the following (as applicable):

(i) the day that the individual ceases to have an assistance dog;

(ii) the day the individual dies.

### 80-25 Service group assistive technology—classification type short-term

*AT CHSP*

(1) For the classification level AT CHSP for the classification type short-term for the service group assistive technology, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the day the classification decision is made; and

(b) ends at the end of the earlier of the following (as applicable):

(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the day the individual dies.

*AT low, AT medium and AT high*

(2) For the classification level AT low, AT medium or AT high for the classification type short-term for the service group assistive technology, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the start day for the individual for the classification level (as specified in the start notification for the individual under section 149-10 of this instrument); and

(b) ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the end of the account period for the individual's notional assistive technology account established in respect of that classification level;

(iii) the end of the day the individual dies.

*AT transitional*

(3) For the classification level AT transitional for the classification type short-term for the service group assistive technology, taken to be established for an individual by [the determination to be drafted under subitem 4(1) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*] the period of effect:

(a) starts at the transition time; and

(b) ends at the earliest of the following (as applicable):
(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
(ii) the later of the following:
(A) the end of 12 months after the transition time;
(B) when the individual's notional home care account ceases under subsection 226E(9) of the Act;
(iii) the end of the day the individual dies.

### 80-30 Service group home modifications—classification type short-term

*HM CHSP*

(1) For the classification level HM CHSP for the classification type short-term for the service group home modifications, established for an individual by a classification decision, the period of effect:
(a) starts at the start of the day the classification decision is made; and
(b) ends at the end of the earlier of the following (as applicable):
(i) the later of the following:
(A) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
(B) if the System Governor determines a later time than the time mentioned in sub-subparagraph (A) for the individual under subsection (7)—that later time;
(ii) the day the individual dies.

**Commented [A13]:** Add provision 'the end of the day of the individual's request'

*HM low, HM medium and HM high*

(2) For the classification level HM low, HM medium or HM high for the classification type short-term for the service group home modifications, established for an individual by a classification decision, the period of effect:
(a) starts at the start of the start day for the individual for the classification level (as specified in the start notification for the individual under section 149-10 of this instrument); and
(b) ends at the earlier of the following (as applicable):
(i) the latest of the following:
(A) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;
(B) the end of the account period for the individual's notional home modifications account established in respect of that classification level;
(C) if the System Governor determines a later time than the time mentioned in sub-subparagraph (A) or (B) for the individual under subsection (7)—that later time;
(ii) the end of the day the individual dies.

**Commented [A14]:** Add provision 'the end of the day of the individual's request'

*HM transitional*

(3) For the classification level HM transitional for the classification type short-term for the service group home modifications, taken to be established for an individual by [the determination to be drafted under subitem 4(1) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*] the period of effect:

(a) starts at the transition time; and

(b) ends at the earlier of the following (as applicable):

(i) the latest of the following:

(A) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(B) the end of 12 months after the transition time;

(C) when the individual's notional home care account ceases under subsection 226E(9) of the Act;

(D) if the System Governor determines a later time than the time mentioned in sub-subparagraph (A), (B) or (C) for the individual under subsection (7)—that later time;

(ii) the end of the day the individual dies.

*Extension of period of effect for services scheduled for delivery*

(4) A registered provider may apply to the System Governor for a determination of a later time for an individual under subsection (7).

(5) An application under subsection (4) in relation to a classification level established or taken to be established for an individual must be made:

(a) in the approved form; and

(b) within the account period for the individual's notional home modifications account established in respect of that classification level.

(6) The System Governor must consider an application under subsection (4) and decide whether to determine a longer period under subsection (7).

(7) The System Governor may determine a later time for an individual if the System Governor is satisfied that a service in the service group home modifications to be delivered by the registered provider to the individual has been scheduled for delivery, and is in progress, but will not be delivered before the time that would otherwise apply under subparagraph (1)(b)(i), (2)(b)(i) or (3)(b)(i) (as applicable).

(8) The System Governor must give written notice to the registered provider of the System Governor's decision within 28 days after the application was made.

**Commented [A15]:** Recommend decision is required to be made within 14 days rather than 28 days.

**80-35 Service group residential care—classification type ongoing**

*Class 0*

(1) For the classification level class 0 for the classification type ongoing for the service group residential care, established in accordance with section 81-42 of this instrument for an individual to whom paragraph 78(1)(c) of the Act applies:

(a) subject to paragraph (b), the period of effect:

(i) starts at the start of the entry day for the classification type for the service group for the individual; and

(ii) ends at the end of the earlier of the following:

(A) the day the individual starts accessing funded aged care services under a specialist aged care program other than the TCP;

(B) the day the individual dies; and

(b) if the classification level class 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 or 13 (the ***higher classification level***) is in effect for the individual on a day under subsection (2), the classification level class 0:

(i) is not in effect for the individual on the day; and

(ii) does not resume being in effect if the higher classification level ceases to be in effect for the individual.

*Classes 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13*

(2) For the classification level class 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 or 13 for the classification type ongoing for the service group residential care, established for an individual by a classification decision, the period of effect:

(a) starts:

(i) unless subparagraph (ii), (iii) or (iv) applies—at the start of the entry day for the classification type for the service group for the individual; or

(ii) unless subparagraph (iii) or (iv) applies—if, before the day the classification decision is made:

(A) the classification level class 0 is in effect for the individual under subsection (1); and

(B) the individual started accessing funded aged care services in an approved residential care home; and

(C) the individual did not cease to access funded aged care services in that home for a period of more than 28 days;

—at the start of the individual's start day for that home; or

(iii) unless subparagraph (iv) applies—if, before the day the classification decision is made:

(A) the classification level class 0 is in effect for the individual under subsection (1); and

(B) the individual started accessing funded aged care services in an approved residential care home; and

(C) the individual ceased to access funded aged care services in that home for a period of more than 28 days;

**Commented [A16]:** This section is particularly complicated and difficult to understand. Recommend it be rewritten.

**Commented [A17]:** How does this work if the individual takes extended leave?

—at the start of the day after the end of that period when the individual resumed accessing ongoing funded aged care services in an approved residential care home; or

(iv) if the classification decision relates to a classification assessment undertaken in accordance with paragraph 75(1)(b) of the Act (that is, following an application for classification reassessment)—the day the application for classification reassessment was made; and

(b) ends at the end of the earlier of the following:

(i) the day the individual starts accessing funded aged care services under a specialist aged care program other than the TCP;

(ii) the day the individual dies.

### 80-40 Service group residential care—classification type short-term

*Respite class 0*

(1) For the classification level respite class 0 for the classification type short-term for the service group residential care, established in accordance with section 81-42 of this instrument for an individual to whom paragraph 78(1)(c) of the Act applies:

(a) subject to paragraphs (b) and (c)—the period of effect consists of each day on or after the entry day for the classification type for the service group for the individual on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group at an approved residential care home of the provider (other than under a specialist aged care program); and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group at an approved residential care home (other than under a specialist aged care program) during the financial year in which the day occurred is less than the maximum period of effect for the classification level (see section 80-60); and

(b) if the classification level respite class 1, 2 or 3 (the ***higher classification level***) is in effect for the individual on a day under subsection (2), the classification level respite class 0:

(i) is not in effect for the individual on the day; and

(ii) does not resume being in effect for the individual if the higher classification level ceases to be in effect for the individual; and

(c) the period of effect ends at the end of the earliest of the following (as applicable):

(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the day the individual starts accessing funded aged care services under a specialist aged care program;

(iii) the day the individual dies.

*Respite classes 1, 2 and 3*

(2) For the classification level respite class 1, 2 or 3 for the classification type short-term for the service group residential care, established for an individual by a classification decision:

(a) subject to paragraphs (b) and (c)—the period of effect consists of each day on or after the entry day for the classification type for the service group for the individual on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group at an approved residential care home of the provider (other than under a specialist aged care program); and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group at an approved residential care home (other than under a specialist aged care program) during the financial year in which the day occurred is less than the maximum period of effect for the classification level (see section 80-60); and

(b) if the classification decision relates to a classification assessment undertaken in accordance with paragraph 75(1)(b) of the Act (that is, following an application for classification reassessment)—the period of effect consists of each day on or after the day the application for classification reassessment was made on which:

(i) a registered provider delivers funded aged care services to the individual for the classification type for the service group at an approved residential care home of the provider (other than under a specialist aged care program); and

(ii) the number of days on which the individual had previously accessed funded aged care services for the classification type for the service group at an approved residential care home (other than under a specialist aged care program) during the financial year in which the day occurred is less than the maximum period of effect for the classification level (see section 80-60); and

(c) the period of effect ends at the end of the earliest of the following (as applicable):

(i) the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the day the individual starts accessing funded aged care services under a specialist aged care program;

(iii) the day the individual dies.

### 80-45 Service group home support, assistive technology or residential care—classification type hospital transition

*Service group home support*

(1) For the classification level HS HT class for the classification type hospital transition for the service group home support, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the start day for the individual for the classification level; and

(b) ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the end of the maximum period effect for the classification level (see section 80-65);

(iii) the end of the day the individual dies.

**Commented [A18]:** Add provision 'the end of the day of the individual's request'

*Service group assistive technology*

(2) For the classification level AT HT class for the classification type hospital transition for the service group assistive technology, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the start day for the individual for the classification level; and

(b) ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the end of the maximum period effect for the classification level (see section 80-65);

(iii) the end of the day the individual dies.

*Service group residential care*

(3) For the classification level RC HT class for the classification type hospital transition for the service group residential care, established for an individual by a classification decision, the period of effect:

(a) starts at the start of the start day for the individual for the classification level; and

(b) ends at the earliest of the following (as applicable):

(i) the end of the day a classification level for the classification type ongoing for the service group residential care takes effect for the individual;

(ii) the end of the maximum period effect for the classification level (see section 80-65);

(iii) the end of the day the individual dies.

## Subdivision C—Maximum period of effect of classification levels

### 80-50 Purpose of this Subdivision

For the purposes of subsection 80(1) of the Act, this Subdivision prescribes, for certain classification levels, the maximum period of effect for the classification level.

### 80-55 Service group home support—classification type short-term—classification level SAH restorative care pathway [1]

(1) For the classification level SAH restorative care pathway [1] for the classification type short-term for the service group home support, the maximum period of effect for an individual is:

(a) 84 days; or

(b) if the System Governor determines a longer period for the classification level for the individual under subsection (5)—that longer period.

*Extension of maximum period of effect*

(2) A registered provider may apply to the System Governor for a determination of a longer period for the classification level SAH restorative care pathway [1] for an individual under subsection (5).

(3) An application under subsection (2) must be made:

(a) in writing; and

(b) within the period mentioned in paragraph (1)(a).

(4) The System Governor must consider an application under subsection (2) and decide whether to determine a longer period under subsection (5).

(5) The System Governor may determine a period of more than 84 days but not more than 112 days for the classification level SAH restorative care pathway [1] for the individual if the System Governor is satisfied that the individual requires access to funded aged care services for that level for that period.

(6) The System Governor must give written notice to the registered provider of the System Governor's decision within 28 days after the application was made.

**Commented [A19]:** Recommend change 28 days to 14 days as 28 days is too lengthy for a reablement service. It may not be identifiable that the person needs longer until 8 weeks and then planning needs to occur.

### 80-57 Service group home support—classification type short-term—classification level SAH end-of-life pathway

For the classification level SAH end-of-life pathway for the classification type short-term for the service group home support, the maximum period of effect for an individual is 112 days.

### 80-60 Service group residential care—classification type short-term

(1) For a classification level for the classification type short-term for the service group residential care, the maximum period of effect is:

(a) 63 days; or

(b) if the System Governor has increased the number of days for the classification level for the individual under subsection (5)—the number of days as so increased (or as most recently increased).

*Increase in number of days for classification levels for individuals*

(2) A registered provider may apply to the System Governor for a determination of an increased number of days for the classification level for an individual under subsection (5).

(3) An application under subsection (2) must be made in the approved form.

(4) The System Governor must consider an application under subsection (2) and decide whether to determine an increased number of days under subsection (5).

(5) The System Governor may increase the number of days for the classification level for the individual by up to 21 if the System Governor is satisfied that an increase in the number of days is necessary because of any of the following:
   (a) carer stress;
   (b) severity of the individual's condition;
   (c) absence of the individual's carer;
   (d) any other relevant matter.

(6) The System Governor must give written notice to the registered provider of the System Governor's decision within 28 days after the application was made.

**Commented [A20]:** What happens if the decision is communicated to the provider after the end of the previously approved period?

(7) An increase under subsection (5) may be made more than once.

### 80-65 Service group home support, assistive technology or residential care—classification type hospital transition

(1) For a classification level for the classification type hospital transition for the service group home support, assistive technology or residential care, the maximum period of effect is:
   (a) 84 days; or
   (b) if the System Governor determines one or more additional periods for the classification level for the individual under subsection (5)—84 days plus those additional periods.

*Extension of maximum period of effect for classification levels for individuals*

(2) A registered provider may apply to the System Governor for a determination of an additional period for the classification level for an individual under subsection (5).

(3) An application under subsection (2) must be made:
   (a) in the approved form; and
   (b) within:
      (i) the period referred to in paragraph (1)(a); or
      (ii) if an additional period has been determined for the classification level for the individual under subsection (5)—that additional period.

(4) The System Governor must consider an application under subsection (2) and decide whether to determine an additional period under subsection (5).

(5) The System Governor may determine one or more additional periods, together totalling not more than 42 days, for the classification level for the individual if the System Governor is satisfied that the individual requires access to funded aged care services for that level for the additional periods.

(6) The System Governor must give written notice to the registered provider of a decision under subsection (5) within 28 days after the application was made.

**Commented [A21]:** What happens if the decision is communicated to the provider after the end of the previously approved period?

## Division 3—Classification levels and procedures

### Subdivision A—Introduction

#### 81-5 Purpose of this Division

For the purposes of section 81 of the Act, this Division prescribes:

(a) classification levels for classification types for service groups; and

(b) for certain classification levels—criteria that are to be used in establishing the classification level of an individual for a classification type for a service group; and

(c) for certain classification levels—methods or procedures that the System Governor must follow in deciding classification levels for an individual for a classification type for a service group; and

(d) for the service groups home support, assistive technology and home modifications—compounding factors (based on [results against relevant assessment items mentioned in subsection 77(2) of the Act]) that will be used to establish an individual's classification level; and

(e) for the service group residential care:

(i) compounding factors (based on results against relevant assessment items mentioned in subsection 77(2) of the Act) that will be used to establish an individual's classification level; and

(ii) the scientific population study that will be used by the System Governor to derive a method for establishing when these compounding factors, taken together, are significant because they indicate the individual has significantly higher care needs relative to the needs of other individuals.

#### *81-7* Meaning of *home support compounding factors*

The home support compounding factors, for an individual, means the individual's scores for the following groups of questions in the Integrated Assessment Tool:

(a) the questions in the sections headed "Cognition" and "Medical and Medications";

(b) the questions in the section headed "Social";

(c) the questions under the headings "Toileting - Bladder" and "Toileting - Bowels";

(d) the questions in the section headed "Carer Profile";

(e) the questions in the section headed "Psychological";

(f) the questions in the section headed "Physical, Personal Health and Frailty".

**Commented [A22]:** Clarity is needed about how these scores (including a 0 score) will be taken into account.

#### *81-8* Meaning of *residential care compounding factors*

The following table sets out the ***residential care compounding factors*** for individuals.

**Residential care compounding factors for individuals**

| Item | Column 1<br>For an individual who ... | Column 2<br>the residential care compounding factors are the following ... |
|---|---|---|
| 1 | is independently mobile | (a) the individual's AFM cognition score;<br>(b) the individual's agitation score;<br>(c) the individual's AKPS score;<br>(d) the individual's RUG total score;<br>(e) whether the individual requires daily injections. |
| 2 | is mobile only with assistance and has higher cognitive ability | (a) the individual's AFM motor score;<br>(b) the individual's AFM social cognition score;<br>(c) the individual's AKPS score;<br>(d) the individual's Braden activity score;<br>(e) whether the individual has fallen in the last 12 months;<br>(f) whether the individual requires daily injections. |
| 3 | is mobile only with assistance and has medium cognitive ability | (a) the individual's AFM communication score;<br>(b) the individual's disruptiveness score;<br>(c) the individual's Rockwood Frailty Score;<br>(d) the individual's RUG total score;<br>(e) whether the individual requires complex wound management;<br>(f) whether the individual requires daily injections. |
| 4 | is not mobile and has higher function | (a) the individual's AFM transfers score;<br>(b) the individual's Braden total score;<br>(c) the individual's disruptiveness score;<br>(d) whether the individual requires complex wound management;<br>(e) whether the individual requires daily injections. |
| 5 | is not mobile and has lower function and higher pressure sore risk | (a) the individual's AFM eating score;<br>(b) the individual's disruptiveness score;<br>(c) whether the individual has fallen in the last 12 months;<br>(d) whether the individual has lost more than 10% of their body weight in the last 12 months;<br>(e) whether the individual requires daily injections. |

### 81-9 Scientific population study for residential care compounding factors

The scientific population study to be used as mentioned in paragraph 81(4)(b) of the Act is the Resource Utilisation and Classification Study undertaken by the Australian Health Services Research Institute at the University of Wollongong.

Note: The reports of the Resource Utilisation and Classification Study could in 2025 be viewed on the Department's website (https://www.health.gov.au).

## Subdivision B—Classification levels and criteria

### 81-10 Service group home support—classification type ongoing

*Non-transitional classification levels and criteria*

(1) The following table sets out the non-transitional classification levels for the classification type ongoing for the service group home support and the criteria for those classification levels.

**Classification levels and criteria**

| Item | Column 1<br>Classification level | Column 2<br>Criteria |
|---|---|---|
| 1 | CHSP class | Any of the following:<br>(a) the individual:<br>(i) has a functional independence score of 42-48; and<br>(ii) has a needs met score of 35 or 36;<br>(b) the individual:<br>(i) has a functional independence score of 42-48; and<br>(ii) has a needs met score of 0-34;<br>(c) the individual:<br>(i) has a functional independence score of 35-41; and<br>(ii) has a needs met score of 31-36;<br>(d) the individual:<br>(i) has a functional independence score of 35-41; and<br>(ii) has a needs met score of 0-30; and<br>(iii) does not have significant compounding factors |
| 2 | SAH class 1 | Either:<br>(a) the individual:<br>(i) has a functional independence score of 35-41; and<br>(ii) has a needs met score of 0-30; and<br>(iii) has significant compounding factors; or<br>(b) the individual:<br>(i) has a functional independence score of 30-34; and<br>(ii) has a needs met score of 30-36; and<br>(iii) does not have significant compounding factors |
| 3 | SAH class 2 | Either:<br>(a) the individual:<br>(i) has a functional independence score of 30-34; and<br>(ii) has a needs met score of 30-36; and<br>(iii) has significant compounding factors; or<br>(b) the individual:<br>(i) has a functional independence score of 30-34; and<br>(ii) has a needs met score of 0-29; and<br>(iii) does not have significant compounding factors |
| 4 | SAH class 3 | Either:<br>(a) the individual:<br>(i) has a functional independence score of 30-34; and |

**Commented [A23]:** Add note that this does not apply to access to services in emergency provisions.

**Commented [A24]:** Clarity is needed about whether an individual with a higher need can stay in CHSP if they want to.

**Classification levels and criteria**

| Item | Column 1<br>Classification level | Column 2<br>Criteria |
|---|---|---|
| | | (ii) has a needs met score of 0-29; and<br>(iii) has significant compounding factors; or<br>(b) the individual:<br>(i) has a functional independence score of 25-29; and<br>(ii) has a needs met score of 28-36; and<br>(iii) does not have significant compounding factors |
| 5 | SAH class 4 | Either:<br>(a) the individual:<br>(i) has a functional independence score of 25-29; and<br>(ii) has a needs met score of 28-36; and<br>(iii) has significant compounding factors; or<br>(b) the individual:<br>(i) has a functional independence score of 25-29; and<br>(ii) has a needs met score of 0-27; and<br>(iii) does not have significant compounding factors |
| 6 | SAH class 5 | Either:<br>(a) the individual:<br>(i) has a functional independence score of 25-29; and<br>(ii) has a needs met score of 0-27; and<br>(iii) has significant compounding factors; or<br>(b) the individual:<br>(i) has a functional independence score of 0-24; and<br>(ii) has a needs met score of 29-36; and<br>(iii) does not have significant compounding factors |
| 7 | SAH class 6 | Either:<br>(a) the individual:<br>(i) has a functional independence score of 0-24; and<br>(ii) has a needs met score of 29-36; and<br>(iii) has significant compounding factors; or<br>(b) the individual:<br>(i) has a functional independence score of 0-24; and<br>(ii) has a needs met score of 23-28; and<br>(iii) does not have significant compounding factors |
| 8 | SAH class 7 | Either:<br>(a) the individual:<br>(i) has a functional independence score of 0-24; and<br>(ii) has a needs met score of 23-28; and<br>(iii) has significant compounding factors; or<br>(b) the individual:<br>(i) has a functional independence score of 0-24; and<br>(ii) has a needs met score of 0-22; and<br>(iii) does not have significant compounding factors |
| 9 | SAH class 8 | The individual:<br>(a) has a functional independence score of 0-24; and<br>(b) has a needs met score of 0-22; and |

| Classification levels and criteria | | |
|---|---|---|
| **Item** | **Column 1<br>Classification level** | **Column 2<br>Criteria** |
| | | (c) has significant compounding factors |

*Transitional classification levels*

(2) The transitional classification levels for the classification type ongoing for the service group home support are the following:

(a) HCP class 1;

(b) HCP class 2;

(c) HCP class 3;

(d) HCP class 4.

Note: Transitional classification levels for the classification type ongoing for the service group home support are established for classes of individuals to whom [subsection 2(2)] of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the [name of determination under subitem 4(1) of that Schedule].

### 81-15 Service group home support—classification type short-term

*Non-transitional classification levels and criteria*

(1) The following table sets out the non-transitional classification levels for the classification type short-term for the service group home support and the criteria for the classification levels.

| Classification levels and criteria | | |
|---|---|---|
| **Item** | **Column 1<br>Classification level** | **Column 2<br>Criteria** |
| 1 | SAH restorative care pathway [1] | The individual:<br>(a) does not meet the criteria for the classification level SAH end-of-life pathway [or SAH restorative care pathway 2]; and<br>(b) is residing in a home or community setting; and<br>(c) needs restorative care to prevent or delay the individual from needing to access ongoing funded aged care services in the service group home support; and<br>(d) has goals in line with restorative care outcomes (for example improving function and being independent) |
| 2 | SAH restorative care pathway 2 [if required] | [to be drafted if required] |
| 3 | SAH end-of-life pathway | The individual:<br>(a) has a prognosis of a life expectancy of 3 months or less; and<br>(b) has an AKPS score of 40 or less; and<br>(c) has not previously had the classification level SAH end-of-life pathway in effect |

**Commented [A25]:** This seems to imply that a person should not be receiving STRC if they are on ongoing funding under SAH. Is this intended?

*Transitional classification level*

(2) The transitional classification level for the classification type short-term for the service group home support is STRC class.

Note: The transitional classification level for the classification type short-term for the service group home support is established for [classes] of individuals to whom [subsection 2(2)] of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the [name of determination under subitem 4(1) of that Schedule].

### 81-17 Service group home support—classification type hospital transition

The following table sets out the classification levels for the classification type hospital transition for the service group home support and the criteria for the classification levels.

**Classification levels and criteria**

| Item | Column 1<br>Classification level | Column 2<br>Criteria |
|---|---|---|
| 1 | HS HT class | The individual:<br>(a) has an access approval that includes the service type assistance with transition care; and<br>(b) is in the concluding stage of a hospital episode; and<br>(c) is medically stable; and<br>(d) has the potential to benefit from accessing funded aged care services delivered through the service group home support under the TCP; and<br>(e) was admitted to a hospital at the time the aged care needs assessment was carried out |

### 81-20 Service group assistive technology—classification type ongoing

The following table sets out the classification levels for the classification type ongoing for the service group assistive technology and the criteria for the classification levels.

**Classification levels and criteria**

| Item | Column 1<br>Classification level | Column 2<br>Criteria |
|---|---|---|
| 1 | Assistance dogs | The individual:<br>(a) has an assistance dog; and<br>(b) is unable to access assistance under the Assistance Dogs Australia program for people with physical disabilities |

## 81-25 Service group assistive technology—classification type short-term

*Non-transitional classification levels and criteria*

(1) The following table sets out the classification levels for the classification type short-term for the service group assistive technology and the criteria for the classification levels.

**Classification levels and criteria**

| Item | Column 1<br>Classification level | Column 2<br>Criteria |
|---|---|---|
| 1 | AT low | The individual:<br>(a) needs low cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and<br>(b) has any of the following classification levels in effect:<br>(i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8;<br>(ii) for the classification type short-term for the service group home support—SAH restorative care pathway [1] [, SAH restorative care pathway 2] or SAH end-of-life pathway |
| 2 | AT medium | The individual:<br>(a) needs medium cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and<br>(b) has any of the following classification levels in effect:<br>(i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8;<br>(ii) for the classification type short-term for the service group home support—SAH restorative care pathway [1] [, SAH restorative care pathway 2] or SAH end-of-life pathway |
| 3 | AT high | The individual:<br>(a) needs high cost assistive technology to mitigate functional decline or impairment and enable them to safely live in their home and community; and<br>(b) has any of the following classification levels in effect:<br>(i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8;<br>(ii) for the classification type short-term for the service group home support—SAH restorative care pathway [1] [, SAH restorative care pathway 2] or SAH end-of-life pathway |
| 4 | AT CHSP | The individual has the classification level CHSP class in effect for the classification type ongoing for the service group home support |

**Commented [A26]:** Change to 'or enable'. The AT may not enable the individual to live at home, it could be a combination of services and technology that 'enables' this.

Comment also applies to item 2 and 3

*Transitional classification levels*

(2) The transitional classification level for the classification type short-term for the service group assistive technology is AT transitional.

Note: The transitional classification levels for the classification type short-term for the service group assistive technology are established for classes of individuals to whom [subsection 2(2)] of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the [name of determination under subitem 4(1) of that Schedule].

### 81-27 Service group assistive technology—classification type hospital transition

The following table sets out the classification levels for the classification type hospital transition for the service group assistive technology and the criteria for the classification levels.

| **Classification levels and criteria** | | |
|---|---|---|
| **Item** | **Column 1**<br>**Classification level** | **Column 2**<br>**Criteria** |
| 1 | AT HT class | The individual:<br>(a) has an access approval that includes the service type assistance with transition care; and<br>(b) is in the concluding stage of a hospital episode; and<br>(c) is medically stable; and<br>(d) has the potential to benefit from accessing funded aged care services delivered through the service group assistive technology under the TCP; and<br>(e) was admitted to a hospital at the time the aged care needs assessment was carried out |

### 81-30 Service group home modifications—classification type short-term

*Non-transitional classification levels and criteria*

(1) The following table sets out the classification levels for the classification type short-term for the service group home modifications and the criteria for the classification levels.

| **Classification levels and criteria** | | |
|---|---|---|
| **Item** | **Column 1**<br>**Classification level** | **Column 2**<br>**Criteria** |
| 1 | HM low | The individual:<br>(a) needs low cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and<br>(b) has any of the following classification levels in effect:<br>(i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8; |

**Commented [A27]:** Change to ‘or enable’. The AT may not enable the individual to live at home, it could be a combination of services and technology that ‘enables’ this.

Comment also applies to item 2 and 3

**Classification levels and criteria**

| Item | Column 1<br>Classification level | Column 2<br>Criteria |
|---|---|---|
| | | (ii) for the classification type short-term for the service group home support—SAH restorative care pathway [1] [or SAH restorative care pathway 2] |
| 2 | HM medium | The individual:<br>(a) needs medium cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and<br>(b) has any of the following classification levels in effect:<br>(i) for the classification type ongoing for the service group home support—SAH class 1, 2, 3, 4, 5, 6, 7 or 8;<br>(ii) for the classification type short-term for the service group home support—SAH restorative care pathway [1] [or SAH restorative care pathway 2] |
| 3 | HM high | The individual:<br>(a) needs high cost home modifications to mitigate functional decline or impairment and enable them to safely live in their home and community; and<br>(b) has any of the classification levels SAH class 1, 2, 3, 4, 5, 6, 7 or 8 in effect for the classification type ongoing for the service group home support |
| 4 | HM CHSP | The individual has any of the classification level CHSP class in effect for the classification type ongoing for the service group home support |

*Transitional classification levels*

(2) The transitional classification level for the classification type short-term for the service group home modifications is HM transitional.

Note: The transitional classification levels for the classification type short-term for the service group home modifications are established for classes of individuals to whom [subsection 2(2)] of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024* applies—see the [determination to be drafted under subitem 4(1) of that Schedule].

### 81-35 Service group residential care—classification type ongoing

(1) The classification levels for the classification type ongoing for the service group residential care are as follows:
(a) class 0; and
(b) the classification levels set out in the following table.

(2) The following table sets out the criteria for the classification levels set out in the table.

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**Classification levels and criteria**

| Item | Column 1<br>Classification level | Column 2<br>Criteria |
|---|---|---|
| 1 | Class 1 | The circumstances referred to in paragraph 76-15(6)(a) of this instrument (palliative care pathway) apply to the individual |
| 2 | Class 2 | The individual:<br>(a) is independently mobile; and<br>(b) does not have significant compounding factors |
| 3 | Class 3 | The individual:<br>(a) is independently mobile; and<br>(b) has significant compounding factors |
| 4 | Class 4 | The individual:<br>(a) is mobile only with assistance; and<br>(b) has higher cognitive ability; and<br>(c) does not have significant compounding factors |
| 5 | Class 5 | The individual:<br>(a) is mobile only with assistance; and<br>(b) has higher cognitive ability; and<br>(c) has significant compounding factors |
| 6 | Class 6 | The individual:<br>(a) is mobile only with assistance; and<br>(b) has medium cognitive ability; and<br>(c) does not have significant compounding factors |
| 7 | Class 7 | The individual:<br>(a) is mobile only with assistance; and<br>(b) has medium cognitive ability; and<br>(c) has significant compounding factors |
| 8 | Class 8 | The individual:<br>(a) is mobile only with assistance; and<br>(b) has lower cognitive ability |
| 9 | Class 9 | The individual:<br>(a) is not mobile; and<br>(b) has higher function; and<br>(c) does not have significant compounding factors |
| 10 | Class 10 | The individual:<br>(a) is not mobile; and<br>(b) has higher function; and<br>(c) has significant compounding factors |
| 11 | Class 11 | The individual:<br>(a) is not mobile; and<br>(b) has lower function; and<br>(c) has lower pressure sore risk |
| 12 | Class 12 | The individual:<br>(a) is not mobile; and |

| Classification levels and criteria | | |
|---|---|---|
| **Item** | **Column 1<br>Classification level** | **Column 2<br>Criteria** |
| | | (b) has lower function; and<br>(c) has higher pressure sore risk; and<br>(d) does not have significant compounding factors |
| 13 | Class 13 | The individual:<br>(a) is not mobile; and<br>(b) has lower function; and<br>(c) has higher pressure sore risk; and<br>(d) has significant compounding factors |

### 81-40 Service group residential care—classification type short-term

(1) The classification levels for the classification type short-term for the service group residential care are as follows:
   (a) respite class 0; and
   (b) the classification levels set out in the following table.

(2) The following table sets out the criteria for the classification levels set out in the table.

| Classification levels and criteria | | |
|---|---|---|
| **Item** | **Column 1<br>Classification level** | **Column 2<br>Criteria** |
| 1 | Respite class 1 | The individual is independently mobile |
| 2 | Respite class 2 | The individual is mobile only with assistance |
| 3 | Respite class 3 | The individual is not mobile |

### 81-42 Procedure for deciding initial classification levels for individuals for the classification types ongoing and short-term for the service group residential care

*Classification type ongoing*

(1) The procedure for establishing a classification level for an individual to whom paragraph 78(1)(c) of the Act applies for the classification type ongoing for the service group residential care is to establish the classification level class 0 for the individual.

*Classification type short-term*

(2) The procedure for establishing a classification level for an individual to whom paragraph 78(1)(c) of the Act applies for the classification type ongoing for the service group residential care is to establish the classification level respite class 0 for the individual.

### 81-45 Service group residential care—classification type hospital transition

The following table sets out the classification levels for the classification type hospital transition for the service group residential care and the criteria for the classification levels.

**Classification levels and criteria**

| Item | Column 1<br>Classification level | Column 2<br>Criteria |
|---|---|---|
| 1 | RC HT class | The individual:<br>(a) has an access approval that includes the service type assistance with transition care; and<br>(b) is in the concluding stage of a hospital episode; and<br>(c) is medically stable; and<br>(d) has the potential to benefit from accessing funded aged care services delivered through the service group residential care under the TCP; and<br>(e) was admitted to a hospital at the time the aged care needs assessment was carried out |

# Part 4—Prioritisation

## Division 1—Priority category decisions

### 86-5 All service groups—period in which priority category decisions must be made

For the purposes of subsection 86(3) of the Act, the period of 14 days after the day on which the System Governor is given a prioritisation report under section 85 of the Act for an individual is prescribed.

### 86-10 Service group residential care—priority category 1—areas

For the purposes of subparagraph 86(5)(a)(ii) of the Act, an area with a 2019 MM category known as MM 5, MM 6 or MM 7 is prescribed.

## Division 2—Priority categories for classification types for service groups

### Subdivision A—Service group home support

#### 87-5 Priority categories and eligibility criteria for classification type ongoing

(1) For the purposes of subsection 87(1) of the Act:

(a) column 1 of the following table prescribes the priority categories for the classification type ongoing for the service group home support; and

(b) column 2 of the following table prescribes eligibility criteria for each of those priority categories.

| Classification type ongoing for service group home support | | |
|---|---|---|
| **Item** | **Column 1<br>Priority categories** | **Column 2<br>Eligibility criteria** |
| 1 | Urgent | The individual has 5 or more points determined in accordance with subsection (2) |
| 2 | High | The individual has 4 points determined in accordance with subsection (2) |
| 3 | Medium | The individual has 2 or 3 points determined in accordance with subsection (2) |
| 4 | Standard | The individual has 1 point, or no points, determined in accordance with subsection (2) |

**Commented [A28]:** The word 'urgent' is used here, yet in the following table for **Classification type ongoing or short-term for service group assistive technology**, the terminology used is 'immediate'. Is this an error or intentional? It is confusing.

*Points*

(2) For the purposes of column 2 of the table in subsection (1), an individual's points are determined by adding together the points specified in column 2 of each item of the following table in which column 1 specifies circumstances that apply to the individual (if any).

| Circumstances and points for eligibility criteria | | |
|---|---|---|
| **Item** | **Column 1<br>Circumstances** | **Column 2<br>Points** |
| 1 | The individual lives alone | 1 |
| 2 | The individual has a cognitive impairment | 1 |
| 3 | The individual is an Aboriginal or Torres Strait Islander person | 1 |
| 4 | The individual is homeless, or at risk of homelessness | 1 |
| 5 | The individual has a need for urgent access to ongoing funded aged care services through the service group home support | 2 |
| 6 | The individual:<br>(a) has waited more than 6 months from:<br>(i) the day on which the individual applied for access to funded aged care services; or | 1 |

**Commented [A29]:** Add circumstances:

Carer stress
Risk of hospital admission
Abuse and Neglect
High risk of falls
High risk of infection
High risk of malnutrition

**Commented [A30]:** Recommend define what is meant by the need for urgent access.

| Circumstances and points for eligibility criteria | | |
|---|---|---|
| **Item** | **Column 1**<br>**Circumstances** | **Column 2**<br>**Points** |
| | (ii) if the individual applied for the reassessment of the individual's need for funded aged care services—the day on which the individual applied for the reassessment; and<br>(b) resides in an area with a 2019 MM category known as MM 5, MM6 or MM 7 | |

## Subdivision B—Service groups assistive technology and home modifications

### 87-6 Priority categories and eligibility criteria—prioritisation assessments conducted before 14 October 2025

(1) For the purposes of subsection 87(1) of the Act, this section prescribes the priority category and eligibility criterion in relation to prioritisation assessments conducted in the period 1 July 2025 to 13 October 2025 for:

(a) the classification types ongoing and short-term for the service group assistive technology; and

(b) the classification type short-term for the service group home modifications.

(2) The priority category for the classification types for the service groups is immediate.

**Commented [A31]:** See our earlier comment re: the word immediate versus urgent.

(3) The eligibility criterion for the priority category is that an approved needs assessor considers the classification type short-term for the service group home support should be approved for the individual.

### 87-7 Priority categories and eligibility criteria—prioritisation assessments conducted on or after 14 October 2025

*Classification type ongoing or short-term for service group assistive technology*

(1) For the purposes of subsection 87(1) of the Act:

(a) column 1 of the following table prescribes the priority categories for the classification types ongoing and short-term for the service group assistive technology in relation to prioritisation assessments conducted on or after 14 October 2025; and

(b) column 2 of the following table prescribes eligibility criteria for each of those priority categories.

| Classification type ongoing or short-term for service group assistive technology | | |
|---|---|---|
| **Item** | **Column 1**<br>**Priority categories** | **Column 2**<br>**Eligibility criteria** |
| 1 | Immediate | An approved needs assessor considers the classification type short-term for the service group home support should be approved for the individual |

**Commented [A32]:** See our earlier comment re: the word immediate versus urgent.

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| Classification type ongoing or short-term for service group assistive technology | | |
|---|---|---|
| **Item** | **Column 1**<br>**Priority categories** | **Column 2**<br>**Eligibility criteria** |
| 2 | High | Two or more of the following circumstances apply to the individual:<br>(a) the individual lives alone;<br>(b) the individual has a mobility impairment;<br>(c) the individual is an Aboriginal or Torres Strait Islander person;<br>(d) the individual's current place of residence poses a moderate or severe risk to the individual's health or safety;<br>(e) both of the following apply:<br>(i) the individual has waited more than 6 months from the day on which the individual made the application to which the priority assessment relates;<br>(ii) the individual resides in an area with a 2019 MM category known as MM 5, MM 6 or MM 7<br>Note: The application referred to in subparagraph (e)(i) could be an application for access to funded aged services under section 56 of the Act or an application for an aged care needs reassessment under section 64 of the Act. |
| 3 | Medium | One circumstance referred to in column 2 of item 2 applies to the individual |
| 4 | Standard | None of the circumstances referred to in column 2 of item 2 apply to the individual |

*Classification type short-term for service group home modifications*

(2) For the purposes of subsection 87(1) of the Act:
(a) column 1 of the following table prescribes the priority categories for the classification type short-term for the service group home modifications; and
(b) column 2 of the following table prescribes eligibility criteria for each of those priority categories.

| Classification type short-term for service group home modifications | | |
|---|---|---|
| **Item** | **Column 1**<br>**Priority categories** | **Column 2**<br>**Eligibility criteria** |
| 1 | Immediate | An approved needs assessor considers the classification type short-term for the service group home support should be approved for the individual |
| 2 | High | Two or more of the following circumstances apply to the individual:<br>(a) the individual lives alone;<br>(b) the individual has a mobility impairment;<br>(c) the individual is an Aboriginal or Torres Strait Islander person;<br>(d) the individual's current place of residence poses a moderate or severe risk to the individual's health or safety;<br>(e) both of the following apply: |

**Commented [A33]:** Add to eligibility criteria:
Carer Stress
Experiencing or at risk of abuse and neglect
At high risk of fall (and define) - this is different from circumstance d, as the person may fall in community

**Commented [A34]:** Add to eligibility criteria:
Carer Stress
Experiencing or at risk of abuse and neglect
At high risk of fall (and define)

**Commented [A35]:** See our earlier comment re: the word immediate versus urgent.

| **Classification type short-term for service group home modifications** | | |
|---|---|---|
| **Item** | **Column 1**<br>**Priority categories** | **Column 2**<br>**Eligibility criteria** |
| | | (i) the individual has waited more than 6 months from the day on which the individual made the application to which the priority assessment relates;<br>(ii) the individual resides in an area with a 2019 MM category known as MM 5, MM 6 or MM 7<br>Note: The application referred to in subparagraph (e)(i) could be an application for access to funded aged services under section 56 of the Act or an application for an aged care needs reassessment under section 64 of the Act. |
| 3 | Medium | One circumstance referred to in column 2 of item 2 applies to the individual |
| 4 | Standard | None of the circumstances referred to in column 2 of item 2 apply to the individual |

## Division 3—Circumstances for urgency ratings—service group residential care

### 87-10 Classification type ongoing

(1) For the purposes of subsection 87(2) of the Act, this section prescribes the circumstances in which an urgency rating of low, medium or high will apply to an individual in relation to the classification type ongoing for the service group residential care.

*High*

(2) An urgency rating of high will apply to the individual if the individual has a need for immediate access to ongoing funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk.

*Medium*

(3) An urgency rating of medium will apply to the individual if:
   (a) the circumstances mentioned in subsection (2) do not apply to the individual; and
   (b) taking into account the individual's circumstances and preferences, the individual is expected to seek access to ongoing funded aged care services delivered in an approved residential care home within the next 6 months.

*Low*

(4) An urgency rating of low will apply to the individual if:
   (a) the circumstances mentioned in subsection (2) do not apply to the individual; and
   (b) the circumstances mentioned in paragraph (3)(b) do not apply to the individual.

### 87-15 Classification type short-term

(1) For the purposes of subsection 87(2) of the Act, this section prescribes the circumstances in which an urgency rating of high will apply to an individual in relation to the classification type short-term for the service group residential care.

(2) An urgency rating of high will apply to the individual if the individual has a need for immediate access to short-term funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk.

[There are no circumstances in which an urgency rating of medium or low will apply to an individual in relation to the classification type short-term for the service group residential care.]

# Part 5—Place allocation

## Division 1—Allocation of places to individuals

### Subdivision A—Acceptance period

#### 92-5 Acceptance period

For the purposes of subsection 92(5) of the Act, the period for an acceptance by an individual of a place for a service group is as follows:

(a) for a place for the classification type ongoing for the service group home support:
  (i) 56 days; or
  (ii) if, within the period referred to in subparagraph (i) of this paragraph, the individual notifies the System Governor that the individual needs an extension to that period—84 days;

(b) for a place for the classification type short-term for the service group home support:
  (i) 168 days; or
  (ii) if, within the period referred to in subparagraph (i) of this paragraph, the individual notifies the System Governor that the individual needs an extension to that period—196 days;

(c) for a place for the service group assistive technology or home modifications:
  (i) 421 days; or
  (ii) if, within the period referred to in subparagraph (i) of this paragraph, the individual notifies the System Governor that the individual needs an extension to that period—449 days;

(d) for a place for the service group residential care—6 years.

**Commented [A36]:** What happens if an individual takes longer than the specified timeframe to accept a place?

### Subdivision B—Method for allocation

#### 93-5 Purpose of this Subdivision

For the purposes of subsection 93(2) of the Act, this Subdivision prescribes methods that the System Governor must follow in deciding the order of allocation under subsection 93(1) of the Act for:

(a) the classification type ongoing for the service group home support; and
(b) the classification types ongoing and short-term for the service group assistive technology; and
(c) the classification type short-term for the service group home modifications.

#### 93-10 Classification type ongoing for the service group home support—method for deciding order of allocation

The method for deciding the order of allocation of a place to an individual for the classification type ongoing for the service group home support is as follows.

Step 1. Using the method in section 93-12, identify if a place is assigned to a priority category for the classification type for the service group.

Step 2. If a place is assigned to a priority category, identify the individuals (if any) who have that priority category for the classification type for the service group.

Step 3. Of those individuals, allocate the place to the individual who has the longest current wait time.

### 93-12 Classification type ongoing for the service group home support—method for assigning places to priority categories

The method for assigning a place to a priority category for the classification type ongoing for the service group home support on a day is as follows.

Step 1. For each priority category for the classification type for the service group, identify the number of waiting individuals for whom the current wait time is equal to or greater than the target priority category wait time for that priority category on the day.

Step 2. Add up the numbers identified for each priority category under step 1.

Step 3. Divide the number worked out under step 2 by the number of places that are available to be allocated to individuals for that service group on the day (as worked out in accordance with the method determined under subsection 91(1) of the Act).

Step 4. For each priority category:

(a) multiply the number identified under step 1 by the result of step 3 and round down to the nearest whole number; and

(b) if the result under paragraph (a) is a number greater than zero, that number of places are assigned to that priority category on the day; and

(c) if the result under paragraph (a) is zero, no places are assigned to that priority category on the day.

### 93-13 Classification type ongoing for the service group home support—method for working out wait time factor

The method for working out the ***wait time factor*** is as follows.

Step 1. Reduce the target classification type wait time most recently determined by the System Governor under section 93-14 by the priority category waiting proportion for the priority category urgent.

| | |
|---|---|
| Step 2. | For each remaining priority category, multiply the priority category waiting proportion by the queue rate. |
| Step 3. | Add up the results of step 2 for each priority category. |
| Step 4. | Divide the result of step 1 by the result of step 3. |

### 93-14 Classification type ongoing for the service group home support—method for System Governor determination of target classification type wait time

The System Governor must, from time to time, determine the ***target classification type wait time*** (in months) for the classification type ongoing for the service group home support by considering:

(a) on the first occasion the System Governor does so—the average of the old Act wait times; or

(b) on any subsequent occasion:

(i) the average of the current wait times for individuals who have been assigned priority categories for the classification type for the service group; and

(ii) what change needs to be made to the previous target classification type wait time to ensure that, on and after 1 July 2027, the average mentioned in subparagraph (i) is not more than 3 months.

**Commented [A37]:** Recommend: determine wait time in weeks - target wait time in weeks will better enable an individual to make interim plans to meet their needs.

**Commented [A38]:** Recommend: reducing the average to 2 months. 2 months combined with assessment wait times is likely to exceed 3 months wait.

### 93-15 Classification types ongoing and short-term for the service group assistive technology—method for deciding order of allocation

The method for deciding the order of allocation of a place to an individual for the classification type ongoing or short-term for the service group assistive technology is as follows.

| | |
|---|---|
| Step 1. | Identify the waiting individuals (if any) who have the priority category immediate for the classification type for the service group. |
| Step 2. | Of those individuals, allocate the place to the individual who has the longest current wait time. |
| Step 3. | If no individuals are identified under step 1, identify the waiting individuals (if any) who have the priority category high for the classification type for the service group. |
| Step 4. | Of those individuals, allocate the place to the individual who has the longest current wait time. |
| Step 5. | If no individuals are identified under step 3, identify the waiting individuals (if any) who have the priority category medium for the classification type for the service group. |

| | |
|---|---|
| Step 6. | Of those individuals, allocate the place to the individual who has the longest current wait time. |
| Step 7. | If no individuals are identified under step 5, identify the waiting individuals who have the priority category standard for the classification type for the service group. |
| Step 8. | Of those individuals, allocate the place to the individual who has the longest current wait time. |

**93-20 Classification type short-term for the service group home modifications—method for deciding order of allocation**

The method for deciding the order of allocation of a place to an individual for the classification type short-term for the service group home modifications is as follows.

| | |
|---|---|
| Step 1. | Identify the waiting individuals (if any) who have the priority category immediate for the classification type for the service group. |
| Step 2. | Of those individuals, allocate the place to the individual who has the longest current wait time. |
| Step 3. | If no individuals are identified under step 1, identify the waiting individuals (if any) who have the priority category high for the classification type for the service group. |
| Step 4. | Of those individuals, allocate the place to the individual who has the longest current wait time. |
| Step 5. | If no individuals are identified under step 3, identify the waiting individuals (if any) who have the priority category medium for the classification type for the service group. |
| Step 6. | Of those individuals, allocate the place to the individual who has the longest current wait time. |
| Step 7. | If no individuals are identified under step 5, identify the waiting individuals who have the priority category standard for the classification type for the service group. |
| Step 8. | Of those individuals, allocate the place to the individual who has the longest current wait time. |

# Chapter 3—Provider registration

## Part 1—Introduction

### 104-1 Simplified outline of this Chapter

[To be drafted.]

# Part 2—Provider registration and residential care home approval process

## Division 1—Applications for registration and registration decisions

### Subdivision A—Application fees, information for applications and decision making periods

#### 104-5 Application for registration—application fee

For the purposes of paragraph 104(2)(b) of the Act, the application fee is $[to be drafted].

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act: see section [to be drafted] of this instrument.

#### 104-15 Application for registration—other information

For the purposes of paragraph 104(3)(i) of the Act, the other information that must be specified in an application by an entity for registration is, for each provider registration category that the entity is applying to be registered in under which funded aged care services are delivered in a home or community setting—each local government area in which the entity intends to deliver funded aged care services.

Note: For provider registration categories, see subsection 11(3) of the Act and section 29 of this instrument.

**Commented [A39]:** Is this level of detail necessary as could be an onerous task for providers delivering services nationally or in many areas of Australia?

#### 105-5 Application for registration—period for making decision

For the purposes of subsection 105(2) of the Act, the period within which the Commissioner must make a decision on an application by an entity for registration is 90 days from the later of the following:

(a) the day the Commissioner receives the application;

(b) if an audit finding referred to in subparagraph 109(2)(d)(i) of the Act is required in relation to one or more provider registration categories specified in the application—the day the Commissioner gives a copy of the final audit report to the entity under section 110-38 of this instrument.

Note: For provider registration categories prescribed for the purposes of paragraph 109(2)(d) of the Act, see section 109-5 of this instrument. For circumstances prescribed for the purposes of subparagraph 109(2)(d)(ii) of the Act, see section 109-10 of this instrument.

#### 107-5 Application for renewal of registration—application fee

For the purposes of paragraph 107(2)(b) of the Act, the application fee is $[to be drafted].

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act: see section [to be drafted] of this instrument.

### 108-5 Application for renewal of registration—period for making decision

For the purposes of subsection 108(2) of the Act, the period within which the Commissioner must make a decision on an application by a registered provider for renewal of registration is 90 days from the later of the following:

(a) the day the Commissioner receives the application for renewal;

(b) if an audit finding referred to in subparagraph 109(2)(d)(i) of the Act is required in relation to one or more provider registration categories specified in the application—the day the Commissioner gives a copy of the final audit report to the registered provider under section 110-38 of this instrument.

Note: For provider registration categories prescribed for the purposes of paragraph 109(2)(d) of the Act, see section 109-5 of this instrument. For circumstances prescribed for the purposes of subparagraph 109(2)(d)(ii) of the Act, see section 109-10 of this instrument.

## Subdivision B—Provider registration category specific requirements

### 109-5 Provider registration categories for which audit findings or prescribed circumstances are required

For the purposes of paragraph 109(2)(d) of the Act, the following provider registration categories are prescribed:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

### 109-10 Circumstances in which audit findings are not required—health service standards assessments

(1) For the purposes of subparagraph 109(2)(d)(ii) of the Act, this section prescribes circumstances for an application by an entity for registration or renewal of registration.

*Provider registration category residential care*

(2) For an application for registration or renewal of registration in the provider registration category residential care, the circumstances are that:

(a) during the 3 years immediately preceding the date of the entity's application, a health service standards assessment was conducted; and

(b) the assessment assessed the entity's ability to comply with the Australian Health Service Safety and Quality Accreditation Scheme requirements for:

(i) the National Safety and Quality Health Service Standards; and

(ii) the Integrated Aged Care Module;

that are equivalent to the Aged Care Quality Standards that apply to the provider registration category residential care, in relation to each residential care home in which the entity delivers or is proposing to deliver funded aged care services; and

(c) the assessment found that the entity is able to comply with those Standards and that Module.

*Provider registration categories personal and care support in the home or community and nursing or transition care*

(3) For the provider registration categories personal and care support in the home or community, and nursing and transition care, the circumstances are that:

(a) during the 3 years immediately preceding the date of the application, a health service standards assessment was conducted; and

(b) the assessment assessed the entity's ability to comply with the Australian Health Service Safety and Quality Accreditation Scheme requirements for:

(i) the National Safety and Quality Health Service Standards; and

(ii) (if relevant) the Integrated Aged Care Module;

that are equivalent to the Aged Care Quality Standards that apply to the provider registration category personal and care support in the home or community, or nursing and transition care (as applicable), in relation to each residential care home from which the entity delivers or is proposing to deliver funded aged care services; and

(c) the assessment found that the entity is able to comply with those Standards and (if relevant) that Module.

**Commented [A40]:** Should this instead refer to home or community or nursing or transition care?

*Meaning of health service standards assessment*

(4) A ***health service standards assessment*** means an assessment conducted:

(a) in accordance with Australian Health Service Safety and Quality Accreditation Scheme formulated and coordinated by the Australian Commission on Quality and Safety in Health Care; and

(b) by an accrediting agency approved by the Australian Commission on Quality and Safety in Health Care to assess health service organisations against the National Safety and Quality Health Service Standards.

### 109-15 Circumstances if audit finds nonconformance

For the purposes of subparagraph 109(2)(d)(ii) of the Act, circumstances for an application by an entity for registration or renewal of registration are that:

(a) an audit referred to in subparagraph 109(2)(d)(i) of the Act has found that the entity has not conformed with one or more of the Aged Care Quality Standards that apply to a provider registration category specified in the application; and

(b) the nonconformance:

(i) has been addressed; or

(ii) can be addressed through an update to a continuous improvement plan that outlines how the nonconformance will be addressed within a specified period; or

(iii) can be addressed by the imposition of a condition under section 143 of the Act.

## 109-25 Other requirements—delivery of funded aged care services in certain circumstances

(1) For the purposes of paragraph 109(2)(e) of the Act, this section prescribes other requirements for an application by an entity for registration, renewal of registration or variation of registration in a provider registration category other than residential care.

*Delivery to certain individuals through the service group home support*

(2) If the entity delivers, or intends to deliver, funded aged care services to an individual:

(a) who has an access approval in effect for the classification type ongoing for the service group home support; or

(b) who has the classification level SAH end-of-life pathway in effect for the classification type short-term for the service group home support;

another requirement is that the entity:

(c) also delivers, or intends to deliver, the service type care management to the individual; and

(d) has applied for, and satisfies the requirements for, registration in the provider registration category personal and care support in the home or community.

*Delivery of services in service type restorative care management*

(3) If the entity delivers, or intends to deliver, funded aged care services in the service type restorative care management, another requirement is that the entity delivers, or intends to deliver, funded aged care services in the service type allied health and therapy.

*Section does not apply to specialist aged care programs*

(4) This section does not apply if the entity delivers, or intends to deliver, funded aged services only under a specialist aged care program.

## Division 2—Audit requirements

### Subdivision A—Purpose of this Division

#### 110-5 Purpose of this Division

For the purposes of subsection 110(1) of the Act, this Division prescribes requirements relating to conducting an audit of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category.

### Subdivision B—How audits must be conducted—general

#### 110-13 Audit must be conducted by quality auditor

(1) An audit of an entity's ability to conform with the Aged Care Quality Standards for a provider registration category must be conducted by a quality auditor assigned by the Commissioner to conduct the audit.

Note: The process for approval as a quality auditor is set out in [Subdivision J—to be drafted] of this Division.

(2) The quality auditor must gather evidence relevant to the scope of the audit being conducted and may be assisted by other quality auditors with the technical knowledge or skill required to collect and interpret information relevant to the scope of the audit.

**Commented [A41]:** If the main auditor does not have the technical knowledge or skill required they should be required to get input from others.

(3) Before the audit is undertaken, the Commissioner must give a notice to the entity that includes the following information:

(a) a general description of the audit process;

(b) that an audit is proposed to be conducted in accordance with the audit process;

(c) the purpose of the audit, and the decision or decisions it will inform;

(d) the scope of the audit, including the applicable Aged Care Quality Standards;

(e) the period during which the audit is proposed to occur;

[(f) the applicable fees for the proposed audit;]

(g) advice on how individuals (if any) should be notified about opportunities to contribute to the audit;

(h) a copy of the audit methodology;

(i) any other information the Commissioner considers relevant.

### Subdivision C—How audits must be conducted—home assessments of approved residential care homes

#### 110-26 Home assessments—approved residential care homes

(1) This section applies if an audit of a registered provider's ability to conform with the Aged Care Quality Standards relates to an application for renewal of the registered provider's registration in the provider registration category residential care.

*Home assessments of approved residential care homes*

(2) The Commissioner must ensure that one or more quality auditors conduct a home assessment of each of the approved residential care homes included in the registered provider's registration.

*Scope of home assessment*

(3) A home assessment of an approved residential care home must assess whether the registered provider delivering funded aged care services in the approved residential care home conforms with the applicable Aged Care Quality Standards.

(4) A home assessment of an approved residential care home must, to the extent possible, consider the following matters as part of the home assessment:
- (a) the experience of individuals to whom funded aged care services are delivered in the approved residential care home;
- (b) documents and records relevant to the home assessment;
- (c) feedback from the following:
  - (i) aged care workers of the registered provider;
  - (ii) responsible persons of the registered provider;
  - (iii) the governing body of the registered provider;
  - (iv) third parties with relevant knowledge or experience;
- (d) observations at the approved residential care home;
- (e) care outcomes relating to the approved residential care home.

*Attendance at approved residential care homes*

(5) A home assessment of an approved residential care home must include:
- (a) attendance by a quality auditor at the approved residential care home;
- (b) such other means of assessment as are appropriate.

*Notice of home assessment*

(6) Before a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must give written notice to the registered provider:
- (a) specifying each approved residential care home included in the registered provider's registration, and stating that a home assessment of each approved residential care home is to be conducted; and
- (b) requiring the registered provider to notify each individual to whom funded aged care services are delivered in each approved residential care home:
  - (i) that the home assessment is going to be conducted; and
  - (ii) that the quality auditor or auditors conducting the home assessment will attend the approved residential care home as part of the home assessment, and the day or days on which this will occur; and
  - (iii) that the quality auditor or auditors attending the approved residential care home will seek the individual's consent before engaging with the individual, or entering a part of the approved residential care home

**Commented [A42]:** Recommend a requirement for a certain percentage of individuals to be interviewed otherwise the response may be unrepresentative.

**Commented [A43]:** Extremely broad and requires clarification. What kinds of things could this include?

**Commented [A44]:** Noting that some providers will have a large number of homes under the one ABN, it will be critical that audits of each of their homes are adequately spaced to give providers enough time to prepare for each audit and to ensure they are able to dedicate the required resources.

**Commented [A45]:** There should be guidance about what is considered acceptable notification to each individual. E.g. is notification in a regular newsletter acceptable?

**Commented [A46]:** What if the person does not have capacity to give informed consent, would the auditors seek consent from their authorised representative or supporter?

that comprises the individual's personal space (for example, the individual's room).

*Rule if consent not obtained from individuals*

(7) If an individual to whom funded aged care services are delivered at an approved residential care home does not give consent as mentioned in subparagraph (6)(b)(iii), the quality auditor or auditors conducting the home assessment will not enter any part of the approved residential care home that comprises the individual's personal space.

Note: This means that if none of the individuals accessing funded aged care services in the approved residential care homes included in a registered provider's registration give consent, the quality auditor or auditors conducting the home assessments will not enter any parts of the approved residential care homes that comprises the personal space of an individual.

### 110-28 Preliminary assessment report of home assessment

(1) If a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must prepare a preliminary assessment report setting out the findings of the home assessment.

(2) The preliminary assessment report must assign a grade for conformance with the Aged Care Quality Standards for the registered provider's delivery of funded aged care services in the approved residential care home as outlined in the audit methodology.

(3) The Commissioner must:
   (a) give a copy of the preliminary assessment report to the registered provider within 14 days from the attendance by a quality auditor at the approved residential care home for the home assessment; and
   (b) give the registered provider the opportunity to respond in writing to the report within 14 days from the day the Commissioner gave the preliminary assessment report to the registered provider.

### 110-30 Final assessment report of home assessment

(1) If a home assessment of an approved residential care home included in the registration of a registered provider is conducted, the Commissioner must prepare a final assessment report setting out the findings of the home assessment.

(2) The final assessment report must assign a grade for conformance with the Aged Care Quality Standards for the registered provider's delivery of funded aged care services in the approved residential care home as outlined in the audit methodology.

(3) In preparing the final assessment report, the Commissioner must consider any response received from the registered provider as mentioned in paragraph 110-28(3)(b).

**Commented [A47]:** Recommend that the final assessment report is a rating of conformance as at the date of that report, taking into account submissions rectifying non-conformance.

(4) The Commissioner must give a copy of the final assessment report to the registered provider within 28 days from:
   (a) if the registered provider responded in writing to the preliminary report within the period mentioned in paragraph 110-28(3)(b)—the day the Commissioner received the response; or
   (b) if the registered provider did not respond in writing to the preliminary report within the period mentioned in paragraph 110-28(3)(b)—the last day of that period.

(5) The registered provider must, within 14 days from receiving the final assessment report, notify the following of the findings of the home assessment (including the grade):
   (a) each responsible person and aged care worker of the registered provider who deliver funded aged care services in the approved residential care home;
   (b) individuals to whom funded aged care services are delivered in the approved residential care home.

**Commented [A48]:** There should be guidance about what is considered acceptable notification to these individuals.

## Subdivision D—How audits must be conducted—site assessments for home or community setting

### 110-32 Site assessments—home or community setting

(1) This section applies if:
   (a) an audit of a registered provider's ability to conform with the Aged Care Quality Standards relates to an application for renewal of the registered provider's registration; and
   (b) the scope of the audit includes funded aged care services delivered by the registered provider in a home or community setting.

*Notice of site assessment*

(2) If the scope of the audit includes a site assessment, the Commissioner must give written notice to the registered provider:
   (a) stating that a site assessment is to be conducted; and
   (b) stating whether or not one or more quality auditors propose to attend individuals' residences or the premises of a community setting in conducting the site assessment; and
   (c) if a quality auditor proposes to attend the residence of one of more individuals—requiring the registered provider to notify the individuals:
      (i) that the site assessment is going to be conducted; and
      (ii) that a quality auditor conducting the home assessment will attend individuals' residences as part of the assessment, and the day or days on which this will occur; and
      (iii) that if a quality auditor proposes to attend the residence of a particular individual, the quality auditor will seek consent to enter the residence from the individual and any other person at their residence; and

**Commented [A49]:** There should be guidance about what is considered acceptable notification to these individuals.

**Commented [A50]:** The Commissioner should be required to provide auditing guidance information that the registered provider can provide to individuals.

(d) if a quality auditor proposes to attend the premises of a community setting—stating that the quality auditor will seek consent from the owner or occupier to enter the premises.

(3) If:

(a) an individual to whom funded aged care services are delivered at their residence does not give consent as mentioned in subparagraph (2)(c)(iii), a site assessment must not include their residence; and

(b) if no such individuals give consent, a site assessment must not be included in the scope of the audit.

(4) If it is not reasonably practicable to obtain consent from the owner or occupier of the premises where funded aged care services are delivered in a community setting, a site assessment must not include those premises.

## Subdivision E—How audits must be conducted—final audit report

### 110-38 Final audit reports

(1) If an audit of an entity's ability to conform with the Aged Care Quality Standards is conducted, the Commissioner must prepare a final audit report.

(2) The final audit report must include the following:

(a) the period to which the audit relates;

(b) the scope of the audit;

(c) the audit outcomes;

(d) an assessment of the entity's conformance, or ability to conform, with the Aged Care Quality Standards;

(e) if the final audit report identifies nonconformance with the Aged Care Quality Standards—whether the entity has the ability to conform and the things the entity must do, or has done, to conform;

(f) the outcomes of the following (if any):

(i) each home assessment of an approved residential care home conducted in accordance with section 110-26(2) for the purposes of the audit;

(ii) each site assessment of residences or other premises conducted in accordance with section 110-32 for the purposes of the audit.

(3) The Commissioner must:

(a) give a copy of the final audit report to the entity within 28 days of the completion of the audit; and

(b) give the entity the opportunity to respond in writing to the final audit report within 14 days from the day the final audit report was given to the entity, or such longer period as the Commissioner agrees with the entity.

(4) An entity that is a registered provider must, within 28 days from receiving the final audit report, notify the following of the outcomes of the audit:

(a) responsible persons and aged care workers of the registered provider;

**Commented [A51]:** There should be guidance about what is considered acceptable notification to these individuals.

(b) if the audit relates to an approved residential care home—any individuals to whom funded aged care services are delivered in the approved residential care home.

## Subdivision F—Type and scope of audits and other matters

### 110-40 Type and scope of audits for provider registration categories

*Provider registration categories*

(1) This section prescribes the types and scope of audits that can be conducted for the following provider registration categories:
(a) personal and care support in the home or community;
(b) nursing and transition care;
(c) residential care.

*Types of audit*

(2) The types of audit that may be conducted in respect of the provider registration categories referred to in subsection (1) are as follows:
(a) registration of an entity;
(b) renewal of an entity's registration;
(c) variation of an entity's registration.

*Scope of audit*

(3) The scope of an audit is to include (as applicable):
(a) whether the audit relates to registration of an entity, or the renewal or variation of an entity's registration; and
(b) the applicable Aged Care Quality Standards in respect of:
(i) the provider registration category or categories for which the audit is being conducted; and
(ii) service types to which the audit relates; and
(c) whether or not the audit will include any home assessments or site assessments.

Note: For the provider registration category residential care, a home assessment of all approved residential care homes must be conducted for renewal of registration (see subsection 110-26(2)). For the provider registration categories personal and care support in the home or community, and nursing and transition care, a site assessment on renewal of registration may be conducted (see subsection 110-32(2)).

(4) The Commissioner must consider the following when determining the scope of the audit:
(a) matters or risks that are identified as requiring specific examination;
(b) in the case of renewal or variation of an entity's registration:
(i) the time that has elapsed since the most recent audit of the entity was conducted; and
(ii) the scope of any previous audits of the entity; and
(iii) the outcomes of previous audits of the entity; and

(iv) the history of compliance with the Act of the entity;

(c) any guidelines relating to audit matters made for the purposes of subsection 348(2) of the Act.

## Subdivision G—Fees payable for an audit

### 110-50 Fees payable by an entity for an audit

The fees payable by an entity for an audit are $[to be drafted].

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act: see section [to be drafted] of this instrument.

**Commented [A52]:** Recommend include when these fees are due and payable.

## Subdivision H—Audit timeframes

### 110-53 Audit timeframes for provider registration categories

(1) Subsections (2) and (3) of this section prescribe the timeframes within which an audit must be conducted for the following provider registration categories:

(a) personal and care support in the home or community;

(b) nursing and transition care;

(c) residential care.

(2) An audit in relation to an initial application for registration must be conducted during the period beginning on the date of the application and ending when the Commissioner makes a decision on the application.

(3) An audit in relation to a renewal of registration must be conducted during the period beginning on the date of the invitation to renew under subsection 106(1) of the Act and ending when the Commissioner makes a decision on the application.

**Commented [A53]:** Recommend a time period is set in which the Commissioner must complete an audit.

(4) The Commissioner must not make a decision to register an entity, or renew a registration, until the final audit report is completed.

## Subdivision J—Requirements for persons conducting audits—registration as a quality auditor [to be drafted]

## Division 3—Applications for approval of residential care homes

### 111-5 Application fee

For the purposes of paragraph 111(2)(b) of the Act, the application fee is $[to be drafted].

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act: see section [to be drafted] of this instrument.

### 111-10 Information for residential care homes

For the purposes of subparagraph 111(3)(b)(ii) of the Act, the other information for each residential care home specified in an application is as follows:

(a) the name of the residential care home;
(b) the street address of the residential care home;
(c) the name of the responsible person in charge of the residential care home;
(d) the certificate of occupancy or equivalent certificate (however described) for the residential care home;
(e) documentary evidence demonstrating that the building or buildings that comprise the residential care home are permanent and will not present a risk to the delivery of quality and safe residential care including, but not limited to:
  (i) floor plans and bed layout; and
  (ii) fixtures, furnishings and design; and
  (iii) an explanation of the design of the residential care home.

### 112-5 Period for making decision

For the purposes of subsection 112(2) of the Act, the period within which the Commissioner must make a decision on an application for approval of a residential care home in relation to an entity is:

(a) if the entity has made an application for registration under subsection 104(1) of the Act—the period that applies to that application under section 105-5 of this instrument; or
(b) if the entity is a registered provider—90 days from the day the Commissioner receives the application for approval of the residential care home.

### 113-5 Approval of residential care homes

For the purposes of subparagraph 113(b)(ii) of the Act, other requirements of which the Commissioner must be satisfied before approving a residential care home in relation to an entity are as follows:

(a) that either:
  (i) the entity owns the premises at which the residential care home is located; or

(ii) if the entity does not own the premises at which the residential care home is located—the owner of the premises agrees to the entity using the premises as a residential care home;

(b) that the building or buildings that comprise the residential care home are permanent; and

(c) that the building or buildings that comprise the residential care home and its total number of beds will not present a risk to the delivery of quality and safe residential care.

## Division 4—Notice of decisions and other provisions

### 114-5 Other matters for notices of decisions to register or renew

For the purposes of paragraph 114(3)(f) of the Act, other matters that must be included in a notice of a decision given to an entity are the details of each residential care home (if any) that is approved in relation to the entity.

### 117-5 Deemed registration—classes of entity

For the purposes of subsection 117(1) of the Act, the following classes of entity are prescribed:

(a) hospitals (whether operated by government entities or non-government entities);

(b) entities that are not registered providers, but that:

(i) deliver services similar to funded aged care services that are delivered in an approved residential care home; or

(ii) deliver services similar to funded aged care services that are delivered in a home or community setting or in a similar sector;

(c) registered providers that are not registered in all of the provider registration categories.

### 117-10 Deemed registration—other matters for determinations of deemed registration

For the purposes of paragraph 117(2)(h) of the Act, other matters that must be specified in a determination that an entity is taken to be a registered provider are as follows:

(a) the ABN of the entity;

(b) each responsible person of the entity;

(c) the business location of the entity.

# Part 3—Variations, suspensions and revocations of registration

## Division 1—Variations, suspensions and revocations

### 124-5 Application fee

For the purposes of paragraph 124(2)(b) of the Act, the application fee is $[to be drafted].

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act: see section [to be drafted] of this instrument.

### 133-5 Classes of persons who must not be appointed as eligible advisers

For the purposes of paragraph 133(4)(a) of the Act, classes of persons who must not be appointed by a registered provider as an eligible adviser are as follows:

(a) persons who are not independent of the registered provider;

(b) current or former employees of the registered provider;

(c) current or former responsible persons of the registered provider;

(d) close relations of persons mentioned in paragraph (b) or (c) of this section.

**Commented [A54]:** This could be problematic for larger providers who may struggle to find an eligible adviser they have never employed (even in a low level role). There should be a time limit, e.g. if they have not worked for the provider for more than five years, there should be discretion for them to be appointed if they are otherwise independent.

### 133-10 Matters to be taken into account in specifying period within which eligible adviser must be appointed

(1) For the purposes of paragraph 133(4)(b) of the Act, this section prescribes matters that the Commissioner must take into account in specifying a period in a notice given under subsection 133(2) of the Act for the purposes of paragraph 133(3)(a) of the Act (requiring a registered provider to appoint an eligible adviser).

(2) The matters are as follows:

(a) the location where funded aged care services are delivered by the registered provider;

(b) the nature of any contravention, or proposed contravention, of the Act by the registered provider that the Commissioner is satisfied has occurred, is occurring or may occur;

(c) whether, as a result of any such contravention or proposed contravention of the Act by the registered provider, there is an immediate and severe risk to the safety, health and well-being of individuals to whom the registered provider is delivering funded aged care services;

(d) the availability of persons who have appropriate qualifications, skills or experience to assist the registered provider to comply with the conditions and obligations that apply to the registered provider under Part 4 of Chapter 3 of the Act in relation to the matters specified in subparagraphs 133(3)(a)(i) and (ii) of the Act (which relate to funded aged care services and governance and business operations);

(e) any other relevant matters.

## Division 2—Variations, suspensions and revocations of approvals of residential care homes

### 136-5 Variation of approval on Commissioner's own initiative—bed availability

For the purposes of paragraph 136(2)(a) of the Act, the period for which the Commissioner must be satisfied that the number of beds available in a residential care home is likely to be reduced is a period of at least 2 years.

### 137-5 Variation of approval on application by registered provider—application fee

For the purposes of paragraph 137(2)(b) of the Act, the application fee is $[to be drafted].

Note: Exemptions, waivers and refunds are dealt with in rules made for the purposes of section 597 of the Act: see section [to be drafted] of this instrument.

### 137-10 Variation of approval on application by registered provider—bed availability

For the purposes of paragraph 137(3)(a) of the Act, the period for which the Commissioner must be satisfied that the number of beds available in a residential care home is likely to be reduced is a period of at least 2 years.

## Division 3—Provider Register

### 141-10 Other matters that must be included in the Provider Register—registered providers

For the purposes of paragraph 141(3)(p) of the Act, other matters that the Provider Register must include in relation to the registration of a registered provider are as follows:

(a) the name of each parent or holding company forming part of the registered provider's business structure;

(b) the ACN of the registered provider's business entity (if relevant);

(c) whether the registered provider is known as an Aboriginal Community Controlled Organisation or Aboriginal Community Controlled Health Organisation;

(d) the name of each associated provider that delivers funded aged care on behalf of the registered provider in any of the following provider registration categories:

(i) personal and care support in the home or community;

(ii) nursing and transition care;

(iii) residential care;

(e) if the registered provider's registration has been suspended:

(i) the date of suspension; and

(ii) the period of suspension, including the expiry date; and

(iii) whether the suspension was at the request of the Commissioner or at the request of the registered provider;

(f) if the registered provider delivers funded aged care services in one or more approved residential care homes:

(i) the name of the responsible person of the registered provider who is in charge of each approved residential care home; and

(ii) the total number of beds at each approved residential care home, updated in accordance with any variations to the registered provider's registration and any notification under subsection 167(1) of the Act;

(g) if a compliance notice has been given to the registered provider under section 481 of the Act:

(i) the date of the notice; and

(ii) whether the notice was given by the Commissioner or the System Governor; and

(iii) the details of the non-compliance or possible non-compliance with the Act; and

(iv) whether the notice was given under paragraph 481(a)(i) of the Act (non-compliance) or paragraph 481(a)(ii) of the Act (possible non-compliance); and

(v) the action the provider must take or refrain from taking in response to the notice; and

(vi) whether the notice was varied or revoked;

**Commented [A55]:** It is unclear how wide this requirement would extend. For example, would it extend to each subcontractor of a residential care home such plumbers or electricians? It is also not going to be workable in the SAH space - every time a new contractor comes on board as an associated provider the register will need to be updated including for example for a subcontract for one service such as a home modification.

Recommend this subsection is deleted until further consideration, including consultation, is given to a workable requirement.

(h) if a banning order against the registered provider is in force under section 497 of the Act:
  (i) the date of the banning order; and
  (ii) a linking electronic reference to the detail of the banning order in the banning orders register.

### 141-15 Other matters that may be included in the Provider Register—former registered providers

For the purposes of paragraph 141(4)(e) of the Act, other matters that the Provider Register may include in relation to an entity that was a registered provider are as follows:

(a) if the entity's registration lapsed—the date the registration lapsed;
(b) if the entity's registration was revoked:
  (i) whether the registration was revoked at the request of the provider, or on the Commissioner's initiative; and
  (ii) the date of the revocation.

### 141-20 Other matters that must be included in the Provider Register—responsible persons and aged care workers against whom banning orders are in force

For the purposes of paragraph 141(5)(d) of the Act, other matters that must be included in the Provider Register in relation to a responsible person, or an aged care worker, of a registered provider against whom a banning order is in force under section 498 are as follows:

(a) the date of the banning order;
(b) a linking electronic reference to the detail of the banning order in the banning orders register.

### 141-22 Other matters that may be included in the Provider Register—responsible persons and aged care workers against whom banning orders were in force

For the purposes of paragraph 141(6)(d) of the Act, other matters that may be included in the Provider Register in relation to a responsible person, or an aged care worker, of a registered provider against whom a banning order was in force under section 498 are as follows:

(a) the date of the banning order;
(b) a linking electronic reference to the detail of the banning order in the banning orders register.

### 141-25 Corrections of the Provider Register

(1) For the purposes of paragraph 141(8)(a) of the Act:
  (a) a person may request orally or in writing that the Commissioner make a correction to information relating to that person that is included in the Provider Register; and

(b) if the Commissioner considers that information included in the Provider Register is inaccurate, incomplete, out-of-date, irrelevant or misleading, the Commissioner must correct the information (whether or not a person has made a request under paragraph (a) of this subsection).

(2) Despite subsection (1), the Commissioner must not make a correction to the Provider Register under this section if there is another process under the Act through which information included on the Provider Register can be updated or changed.

Note: For example, a change that can be made through a variation or change in circumstances notification is not a correction of the Provider Register.

**Commented [A56]:** There should be a timeframe stipulated for the Commissioner to correct the information within. We recommend 14 days.

### 141-30 Publication of the Provider Register

(1) For the purposes of paragraph 141(8)(b) of the Act, this section makes provision for and in relation to the publication of the Provider Register.

(2) In deciding whether to publish the Provider Register in whole or in part, or to publish specified information entered on the Provider Register on the Commission's website the Commissioner must have regard to:

(a) whether the Commissioner considers that publication would be contrary to the public interest; and

(b) whether the Commissioner considers that publication would be contrary to the interests of an individual accessing funded aged care services.

(3) The Commissioner must not publish the Provider Register in whole or in part before the end of the 6 month period beginning on the day on which the Act commences.

# Chapter 4—Conditions on provider registration

## Part 4—Delivery of funded aged care services

### Division 3—Delivery of funded aged care services

### Subdivision A—Kinds of provider to which the condition applies

#### 148-5 Kinds of providers to which the condition applies

For the purposes of section 148 of the Act, every kind of registered provider is prescribed.

### Subdivision B—Requirements for delivering funded aged care services

#### 148-10 Purpose of this Subdivision

For the purposes of paragraph 148(a) of the Act, this Subdivision prescribes requirements for delivery of funded aged care services.

#### 148-15 All registered providers—preventing damage to an individual's property

A registered provider must take reasonable steps to prevent damage being caused to an individual's property by the provider, or an aged care worker of the provider, in delivering funded aged care services to the individual.

#### 148-20 Providers registered in home and community services or personal and care support in the home and community—requirements for meals

(1) This section applies to a registered provider that:
  (a) is registered in any of the following provider registration categories:
    (i) home and community services;
    (ii) personal and care support in the home and community; and
  (b) delivers any of the following funded aged care services to an individual on a day through the service group home support under one of the registration categories mentioned in paragraph (a):
    (i) a service in the service type meals;
    (ii) the service community and centre-based respite in the service type home or community general respite;
    (iii) a service in the service type community cottage respite.

(2) The provider must ensure any meals or refreshments delivered to an individual through the funded aged care services mentioned in subsection (1) are nutritious and appetising, having regard to the individual's abilities and preferences.

(3) The provider must ensure that any meals and refreshments available to be delivered to an individual through the funded aged care services mentioned in

**Commented [A57]:** These requirements should commence no earlier than 1 July 2026 to allow sufficient implementation time for providers.

**Commented [A58]:** It needs to be made clear whether "refreshments" means drinks and/or the provision of food other than meals. Recommend terminology is used which is consistent with the strengthened Aged Care Quality Standards which uses 'meals, drinks and snacks'.

**Commented [A59]:** How is this assessed? "Nutritious" and "appetising" are subjective and a meal like dessert may not be considered nutritious. Recommend adding an objective criteria.

**Commented [A60]:** It needs to be made clear whether "refreshments" means drinks and/or the provision of food other than meals. Recommend terminology is used which is consistent with the strengthened Aged Care Quality Standards which uses 'meals, drinks and snacks'.

subsection (1) have been assessed by an accredited practising dietitian in accordance with subsection (4).

(4) The provider must, at least annually, have an accredited practising dietitian assess the meals and refreshments delivered by the provider through the funded aged care services mentioned in subsection (1) to ensure that any meals and refreshments:

(a) are appetising; and

(b) are appropriate for the needs of individuals accessing funded aged care services, including individuals with specialised dietary needs; and

(c) reflect contemporary and evidence-based practice.

Note Examples of specialised dietary needs include medical needs, or religious or cultural preferences.

(5) The provider must implement a quality assurance framework to continuously improve the meals and refreshments delivered to individuals through the funded aged care services mentioned in subsection (1) by taking into account:

(a) the satisfaction of individuals with the meals and refreshments they are provided; and

(b) the assessments undertaken by the accredited practising dietitian in accordance with subsection (4).

**Commented [A61]:** Funding needs to be made available to providers for this new requirement.

**Commented [A62]:** Consistent with the earlier requirement, this paragraph should refer to nutrition. Recommend changing (4b) to: 'meet the nutrition needs of individuals accessing funded aged care services, including individuals with specialised dietary needs'.

**Commented [A63]:** It will be important for the Commission to be very clear about their expectations for any quality assurance frameworks, so that providers can be sure to meet audit expectations.

**Commented [A64]:** "Continuously improve" is an unreasonable expectation as there may be no need, on occasions, for improvement. Recommend replace with 'review'.

**Commented [A65]:** It needs to be made clear whether "refreshments" means drinks and/or the provision of food other than meals. Recommend terminology is used which is consistent with the strengthened Aged Care Quality Standards which uses 'meals, drinks and snacks'.

**Commented [A66]:** Recommend change to: (b) assessments undertaken and recommendations made by the accredited practising dietitian in accordance with subsection (4).

### 148-25 Providers delivering services under provider registration category home and community services, assistive technology and home modifications or advisory and support services—requirements for service delivery equipment

(1) This section applies to a registered provider that:

(a) is registered in any of the following provider registration categories:

(i) home and community services;

(ii) assistive technology and home modifications;

(iii) advisory and support services; and

(b) is delivering funded aged care services to an individual on a day under any of the registration categories listed in paragraph (a); and

(c) uses equipment in delivering the service; or

(d) delivery of the service involves the sourcing, supply and provision of equipment to the individual.

(2) The provider must ensure that the equipment is safe and meets the needs of the individual at the time the service is delivered to the individual.

### 148-30 Providers delivering services under provider registration category home and community services, assistive technology and home modifications or advisory and support services—requirements for personal protective equipment, infection prevention and control

(1) This section applies to a registered provider that is registered in any of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;
(c) advisory and support services.

(2) When delivering funded aged care services to an individual on a day under any of the registration categories listed in subsection (1), the provider must ensure that:
(a) personal protective equipment is available to the individual, the aged care workers of the provider delivering the services and any other persons who need it; and
(b) the persons mentioned in paragraph (a) are supported to correctly use the equipment.

**Commented [A67]:** Are aged care providers funded to provide PPE to "any other persons who need it" and to support them in using it? What if there are people in attendance at the home the provider wasn't expecting? Is the provider supposed to carry multiple spare sets?

(3) The provider must:
(a) have an appropriate infection prevention and control system for delivery of funded aged care services; and
(b) ensure that aged care workers of the provider use hygienic practices and take appropriate infection prevention and control precautions when delivering funded aged care services.

### 148-35 Providers delivering services under the TCP—services that must be delivered

(1) This section applies to a registered provider that is delivering funded aged care services to an individual under the TCP.

(2) The services delivered to the individual by the provider must include the service transition care management in the service type assistance with transition care.

### 148-40 Providers delivering short-term funded aged care services through the service group home support—services that must be delivered

(1) This section applies to a registered provider that is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for a classification level restorative care pathway [1 or restorative care pathway 2] through the service group home support.

(2) The services delivered to the individual by the provider must comprise a multidisciplinary package of early intervention care that is designed to optimise the functioning and independence of the individual, and reverse or slow the individual's functional decline, to help delay the individual's need to access ongoing funded aged care services.

(3) Without limiting subsection (2), the services delivered to the individual must include the following:
(a) the service home support restorative care management in the service type restorative care management;
(b) a variety of services (where appropriate) from the service type allied health and therapy;
(c) services from the service type nursing care (where appropriate).

(4) The provider must ensure an aged care worker of the provider who is an allied health professional or a registered nurse (a ***restorative care partner***) delivers the service mentioned in paragraph (3)(a) to the individual.

### 148-45 Providers delivering certain funded aged care services through the service group home support—requirements for the service home support care management

(1) This section applies to a registered provider that:
   (a) is delivering ongoing funded aged care services to an individual (other than under a specialist aged care program) through the service group home support; or
   (b) is delivering short-term funded aged care services to an individual (other than under a specialist aged care program) for the classification level end-of-life through the service group home support.

(2) The provider must deliver the service home support care management in the service type care management to the individual at least once in each month where the provider also delivers other services to the individual.

## Subdivision C—Requirements for service agreements

### 148-60 Purpose of this Subdivision

For the purposes of paragraph 148(c) of the Act, this Subdivision prescribes requirements for service agreements.

### 148-65 Requirements for service agreements—general

*Entry into service agreement*

(1) A registered provider must enter into a service agreement with an individual:
   (a) before the individual's start day; or
   (b) if the individual is accessing funded aged care services in any of the circumstances specified in subsection 71(4) of the Act, within 28 days after the day an access approval is given for the individual.

(2) Despite subsection (1) of this section, a registered provider does not have to enter into a service agreement with an individual if an access approval is given for the individual in the circumstances set out in subsection 65(4) of the Act.

(3) A registered provider must ensure the following:
   (a) the individual is involved in the development and negotiation of the service agreement;
   (b) if requested by the individual, a supporter, family member, carer or advocate of the individual, or any other person significant to the individual, is present during the development and negotiation of the service agreement;
   (c) the service agreement is expressed in plain language and is readily understandable by the individual;

**Commented [A68]:** Change to 'on or before'

**Commented [A69]:** Recommend change to "the individual is involved in the preparation of the service agreement to the extent they are able to and proportionate to the individual's service complexity and wishes".

We have recommended the deletion of the words "development and" as it is unclear how an individual can be involved in the development of a service agreement and it's required content, and what this means where providers use template agreements. It is also likely to create excessive administrative burden for providers and individuals.

We also think that indicating that the service agreement in its entirety can be negotiated is misleading. The provider should only be required to ensure that individuals are involved in the "preparation" of the service agreement "to the extent they are able to".

In addition, the provider should be allowed to negotiate with any person authorised under State and Territory guardianship/POA regimes to enter into agreements on behalf of the individual.

It is also unclear how this requirement is meant to be undertaken for services such as transport for CHSP without time provision for a sit down meeting with the individual or care management. Hence our recommendation to add "proportionate to the individual's service complexity and wishes". E.g. a person with intermittent transport support to medical appointments may have limited negotiation/preparation needs.

**Commented [A70]:** This needs qualification to account for where an individual cannot understand the agreement due to cognitive impairment or where an individual chooses not to make the effort to understand.

(d) the individual is helped to understand the terms of the service agreement.

*Cooling-off period*

(4) A service agreement must provide that, if the circumstances prescribed in subsection (5) of this section occur:
  (a) the service agreement has no effect; and
  (b) the registered provider must refund any amount paid by the individual under the service agreement.

(5) The circumstances are:
  (a) the individual notifies (whether verbally or in writing) the registered provider that they wish to withdraw from the service agreement; and
  (b) the notification is given:
    (i) within 14 days after the date of entry into the service agreement; and
    (ii) before the individual's start day.

*Variation of service agreement*

(6) A service agreement must provide that the agreement may be varied:
  (a) by the registered provider if:
    (i) the variation is necessary to implement the *A New Tax System (Goods and Services Tax) Act 1999*; and
    (ii) the provider has given reasonable notice in writing about the variation to the individual; and
    (iii) the variation is not inconsistent with the *A New Tax System (Goods and Services Tax) Act 1999* or the Act; or
  (b) by mutual consent of the individual and the registered provider if:
    (i) there has been adequate consultation about the variation between the individual and the provider; and
    (ii) the provider has obtained written consent from the individual to make the variation; and
    (iii) the variation is not inconsistent with the *A New Tax System (Goods and Services Tax) Act 1999* or the Act.

*Review of service agreement*

(7) A service agreement between a registered provider and an individual accessing ongoing funded aged care services must provide that the provider will review the service agreement:
  (a) at least once every 12 months; and
  (b) upon request from the individual.

(8) Without limiting the nature of the review, the provider must:
  (a) give the individual an opportunity to participate in the review; and
  (b) consider whether any updates need to be made to the service agreement; and
  (c) if necessary, vary the service agreement in accordance with subsection (6) of this section.

**Commented [A71]:** Recommend clarifying what is expected of providers in order to have fulfilled this obligation (e.g. answering a resident's questions, providing an interpreter to explain things to a CALD resident, encouraging a resident to seek their own legal advice).

**Commented [A72]:** Given providers cannot charge for services prior to the individual's start date, why have such a provision? It serves no value and is unnecessarily confusing.

**Commented [A73]:** Add that a home care agreement can be varied annually by the provider for indexation without getting the individual's consent.

**Commented [A74]:** Why is it necessary to refer to the GST Act? Obviously changes to any law may impact the agreement. Is it necessary to expressly refer to this Act?

**Commented [A75]:** Recommend delete these subsections as being potentially very onerous, unreasonable and unnecessary.

In normal settings, parties would only "review" a contract: at a time when it is up for renewal and both parties have a chance to walk away or at the mutual agreement of both parties.

Noting the security of tenure provisions, that would not be possible for the provider to exit the contract yet they are still required to "review" the contract without any right to walk away.

The idea of a contract is to set out the bargain between the parties and give both parties certainty. The idea that a contract should be subject to ongoing negotiation is inconsistent with this.

The obligation to "review" the contract is also vague. What obligation is there on the provider to actually change the terms if they don't wish to? What if the consumer repeatedly asks for a price reduction, will the provider be in breach if they say no? If they repeatedly say no, that might constitute a breach of the requirement to "review" the agreement.

Also, it is onerous to require a provider to renegotiate their contract every time they are requested to. Consumers will inevitably seek to exercise this right in the event of a dispute and the provider may incur significant legal costs in responding to these requests.

There is also no need for such a requirement. Individuals (unlike providers) have the right to exit at any time, for any reason and have the right to go other providers. Providers have an incentive to negotiate if it's reasonable but should not be forced to.

### 148-70 Requirements for service agreements—contents

*All registered providers*

(1) A service agreement must not contain any provision that would have the effect of the individual being treated less favourably in relation to any matter than the individual would otherwise be treated, under any law of the Commonwealth, in relation to that matter.

(2) A service agreement entered into between a registered provider and an individual must contain the following:

(a) a statement setting out the parties to the agreement, including the following:

(i) the name of the individual;

(ii) the contact details of the individual;

(iii) the name of the provider;

(iv) the contact details of the provider;

(b) the contact details of the supporters of the individual (if any);

(c) a copy of the individual's access approval;

(d) the approved residential care home (if any) in or from which the provider will deliver funded aged care services to the individual;

(e) the service delivery branch (if any) through which the provider will deliver funded aged care services to the individual;

(f) the date when the service agreement commences;

(g) the start day for the individual;

(h) if the individual is accessing short-term or hospital transition funded aged care services:

(i) when the provider will cease delivering short-term or hospital transition funded aged care services to the individual; and

(ii) the date when the service agreement ends;

(i) if the individual is accessing ongoing funded aged care services, the date the service agreement is to be reviewed in accordance with subsection 148-65(7);

(j) how the individual will be involved in decisions relating to how, when and by whom funded aged care services are delivered to the individual.

(3) Despite subsection (2), a service agreement entered into between a registered provider and an individual does not have to contain the matters specified in paragraph (2)(j) if the provider is delivering funded aged care services to the individual under the TCP.

*Certain registered providers delivering services through the service groups home support, assistive technology or home modifications*

(4) A service agreement entered into between a registered provider (to whom subsection (7) or (8) applies) and an individual must also contain the following:

(a) the funded aged care services the provider will deliver to the individual, including the following:

(i) the description of each service specified in the aged care service list;

**Commented [A76]:** Given the CHSP Manual 2025-2027 is not yet available (effective 6 May 2025), with clear guidance for CHSP providers on the new requirements for service agreements, it will be impossible for providers with existing clients to have new service agreements in place by 1 July that meet these requirements. Transition arrangements (up to 12 months from 1 July 2025), that allow CHSP providers with existing clients to meet any new requirements for service agreements, is absolutely vital.

**Commented [A77]:** It is not clear why this official document needs to be included in service agreements and therefore add to providers' administration costs.

**Commented [A78]:** Recommend paragraph (j) is deleted and instead refer to the statement of rights. As this paragraph is currently drafted, it is unclear what information would be considered acceptable in an agreement.

(ii) the service type that each service is in;
(iii) the service group through which each service type will be delivered;
(iv) the provider registration category under which the services will be delivered;
(v) if the provider intends for an associated provider to deliver any services to the individual, which services will be delivered by the associated provider;

(b) the prices the provider will charge the individual for each of the funded aged care services the provider will deliver to the individual;

(c) if the individual is to be charged a price for delivery of a funded aged care service that is higher than the price published on the provider's website or the department's website—the reason for the higher price;

(d) the process the provider will follow in setting the prices for delivery of funded aged care services to the individual which are not included in the service agreement under paragraphs (b) and (c);

(e) that the prices mentioned in paragraphs (b) to (d) may be subject to regular price increases to account for indexation and the details of such increases, including:
(i) the date the prices will increase; and
(ii) the method for working out the increase; and
(iii) the reason for the matters specified at subparagraphs (i) and (ii);

(f) that the provider may only cease delivery of funded aged care services to the individual in the circumstances specified in subsection 149-35(2);

(g) if either of the circumstances in paragraphs 149-35(2)(e) or (f) arise, any other requirements for notifying the provider;

(h) how and when the service agreement may be terminated.

*Registered providers delivering services under the CHSP*

(5) A service agreement entered into between a registered provider (to whom subsection (8) applies) and an individual must also contain the following:
(a) an explanation of the effect of any conditions included on an approval of a service type or a funded aged care service for the individual;
(b) a statement that the individual agrees to pay any applicable fees referred to in Division 3 of Part 3 of Chapter 4 of the Act.

*Certain registered providers delivering services through the service groups home support, assistive technology or home modifications (other than under a specialist aged care program)*

(6) A service agreement entered into between a registered provider (to whom subsection (7) of this section applies) and an individual must also contain a statement that the individual agrees to pay any applicable fees or contributions referred to in Division 1 of Part 3 of Chapter 4 of the Act.

(7) This subsection applies to a registered provider that is delivering funded aged care services to an individual through the service groups home support, assistive technology or home modifications (other than under a specialist aged care program).

**Commented [A79]:** Subparagraph (v) should be deleted as too prescriptive and should be covered by the involvement of the individual in service planning. The registered provider remains responsible for the services provided regardless of whether it is an associated provider delivering the service so this provision is not needed. Also for some providers it can be a mix of employees and contractors delivering the same services.

**Commented [A80]:** Recommend adding "as at the date of the Agreement" to make clear that it is subject to price rises as set out in the agreement

**Commented [A81]:** Remove: it is administratively excessive for the reason for the higher price to be recorded in the Service Agreement if both parties have agreed to the price.

**Commented [A82]:** Simplify provision: any regular price increases, frequency, method of working out increase.

This level of detail is unnecessary and words such as 'may' are not clear on process.

**Commented [A83]:** This is a new requirement and needs to be reviewed - may be difficult administratively where people can switch providers based on availability of services and funding for a service. Lots of one-off or non-recurrent services as well such as transport and meals and some allied health services etc. Will be a burden for individuals needing to enter into multiple service agreements.

**Commented [A84]:** Add to guidance material - Clarity required on the conditions to include in the Agreement

**Commented [A85]:** What are the consequences if existing CHSP clients do not agree to enter into a new service agreement?

(8) This subsection applies to a registered provider that is delivering funded aged care services to an individual under the CHSP.

*Registered providers delivering services through the service group residential care*

(9) A service agreement entered into between a registered provider (to whom subsection (11) or (12) of this section applies) and an individual must also contain which fees or contributions (if any), referred to in Division 2 or Division 3 of Part 3 of Chapter 4 of the Act, the provider will charge the individual.

**Commented [A86]:** What if the provider doesn't yet know because they don't have the Services Australia assessment?

*Registered providers delivering ongoing funded aged care services through the service group residential care*

(10) A service agreement entered into between a registered provider (to whom subsection (11) of this section applies) and an individual must also contain the following:

(a) that the provider may only ask the individual to leave the approved residential care home in the circumstances specified in subsection 149-60(1);

(b) the assistance the provider will provide to the individual to obtain suitable alternative accommodation with an alternative registered provider if the individual is asked to leave the approved residential care home;

**Commented [A87]:** Need to allow for the fact that the alternative accommodation may be another approved residential care home of the same registered provider.

(c) how and when the service agreement may be terminated.

(11) This subsection applies to a registered provider that is delivering ongoing funded aged care services to an individual through the service group residential care.

(12) This subsection applies to a registered provider that:

(a) is delivering short-term funded aged care services to an individual through the service group residential care; or

(b) is delivering funded aged care services to an individual through the service group residential care under the TCP.

## Subdivision D—Requirements for care and services plans

### 148-75 Purpose of this Subdivision

For the purposes of paragraph 148(e) of the Act, this Subdivision prescribes requirements for care and services plans.

### 148-80 Requirements for care and services plans—general

*When a care and services plan must be developed*

(1) A registered provider must develop a care and services plan for an individual:

**Commented [A88]:** Change to 'care plan' as the Aged Care Assessor develops the 'services plan'.

(a) before or on the individual's start day; or

(b) if the individual is accessing funded aged care services in any of the circumstances specified in subsection 71(4) of the Act, within 28 days after the day an access approval is given for the individual.

(2) Despite subsection (1) of this section, a registered provider does not have to develop a care and services plan for an individual if an access approval is given for the individual in the circumstances set out in subsection 65(4) of the Act.

*How a care and services plan is developed*

(3) A registered provider to whom subsection (6) of this section applies must actively engage with:
(a) the individual;
(b) supporters of the individual (if any); and
(c) any other persons involved in the care of the individual;
in developing and reviewing the individual's care and services plan through ongoing communication.

*Care and services plan to be in line with the individual's needs*

(4) A registered provider to whom subsection (6) applies must ensure an individual's care and services plan:
(a) describes the current care needs, goals and preferences of the individual; and
(b) includes strategies for risk management and preventative care; and
(c) where an individual is accessing ongoing funded aged care services, is reviewed at least once every 12 months.

*Care and services plan to be accessible to individual*

(5) A registered provider must provide a copy of an individual's care and services plan to the individual at the following times:
(a) once the plan is developed;
(b) any time the plan is updated;
(c) upon request from the individual.

(6) This subsection applies to a registered provider that is delivering funded aged care services to an individual under any of the following registration categories:
(a) home and community services;
(b) assistive technology and home modifications;
(c) advisory and support services.

Note 1: See subsections 15-20(1) to (3) of this instrument for the Aged Care Quality Standards relating to care and services plans which apply to providers registered in provider registration categories personal and care support in the home and community, nursing and transition care, and residential care.

Note 2: For funded aged care services relating to care and services plans, see item 1 of the table in section 33 of this instrument and items 1 and 4 in the table in section 60 of this instrument.

### 148-81 Requirements for care and services plans—restorative care partner to be responsible for care and services plans in certain circumstances

(1) This section applies to a registered provider that is delivering short-term funded aged care services to an individual (other than under a specialist aged care

**Commented [A89]:** This section should not be in the rules. It should be in guidance material and incorporated into the quality standard requirements.

**Commented [A90]:** Change to 'actively attempt engagement'

**Commented [A91]:** Or their authorised representative (ie at State law)?

**Commented [A92]:** What if the supporter isn't legally authorised to make decisions and the representative does not wish the supporter to be involved?

**Commented [A93]:** This should only be if the consumer or their authorised representative has given consent or if no consent, if they are formally appointed. Many people are involved in care who actually don't have decision making powers.

**Commented [A94]:** Guidance is needed from the Department as to what meets ongoing communication for this subsection.

**Commented [A95]:** Clarify that the strategies for the "risks" being managed are those relevant to care - not other issues.

**Commented [A96]:** Previously providers only needed to make it accessible. Some consumers won't want this and if providers don't give it they would be in breach. This should read that they must offer a copy.

program) for a classification level restorative care pathway [1 or restorative care pathway 2] through the service group home support.

(2) The provider must ensure the restorative care partner who will deliver the service mentioned in paragraph 148-40(3)(a) to the individual develops a care and services plan for the individual in accordance with any applicable requirements set out in this Subdivision.

**Commented [A97]:** Clarity is needed as it is unclear what the applicable requirements are that are set out in this Subdivision.

### 148-85 Requirements for care and services plans—contents for all individuals (other than individuals accessing services through the service group residential care)

*Application of this section*

(1) This section applies to a registered provider that is delivering funded aged care services to an individual under any of the following registration categories:
- (a) home and community services;
- (b) assistive technology and home modifications;
- (c) advisory and support services;
- (d) personal and care support in the home or community;
- (e) nursing and transition care.

*Contents*

(2) A care and services plan for an individual must include the following:
- (a) the funded aged care services that the provider will deliver to the individual, including:
  - (i) the frequency of the services; and
  - (ii) the volume or duration of the services;
- (b) when the care and services plan will be reviewed;
- (c) if the individual is accessing ongoing funded aged care services, the date the individual's service agreement is to be reviewed in accordance with subsection 148-65(7).

**Commented [A98]:** Service plan is provided by the MAC assessor

**Commented [A99]:** Is the care plan considered a part of the service agreement? If so, only one date should be required.

# Part 7—Information and access

## Division 1—Personal information and record keeping

### Subdivision O—Information provided to an individual

#### 154-3300 Requirement to keep and retain information provided to an individual

(1) A registered provider must keep records demonstrating their compliance with their obligations and conditions of registration under Chapter 3.

(2) A registered provider must keep a record made under this section for 7 years starting on the day the record is made.

#### 154-3500 Requirement to correct personal information

(1) This section applies to a registered provider that is not any of the following:
  (a) an APP entity within the meaning of the Privacy Act 1988;
  (b) a State or Territory; or
  (c) a body established for a public purpose by or under a law of the State or Territory (other than a local government authority).

(2) For the purposes of paragraph 154(2)(a) of the Act, it is a requirement that when a registered provider keeps and retains records, the registered provider must comply with Australian Privacy Principle 13 as set out in Schedule 1 of the *Privacy Act 1988*, as if it were an organisation for the purposes of the *Privacy Act 1988*.

Note: A registered provider that is an APP entity remains subject to the *Privacy Act 1988*, including APP 13.

### Subdivision P—Claims for subsidy

#### 154-3400 Application of this Subdivision

(1) This Subdivision applies to a registered provider registered in any registration category.

(2) Despite subsection (1), this Subdivision does not apply to a registered provider only delivering funded aged care services under one of the following specialist aged care programs:
  (a) CHSP;
  (b) MPSP;
  (c) NATSIFACP.

#### 154-3410 Requirement to keep and retain records which enable claims for payment of subsidy to be verified

(1) A kind of record that a registered provider must keep and retain under paragraph 154(a) of the Act is any record that enables claims for payments of subsidy to be properly verified.

(2) Without limiting subsection (1), a kind of record that enables claims for payments of subsidy to be properly verified includes the following:
  (a) the service agreement between the registered provider and the individual to whom the provider is delivering funded aged care services;
  (b) the medical records, progress notes and other clinical records of the individual to whom the provider is delivering funded aged care services;
  (c) invoices for the delivery of funded aged care services to an individual;
  (d) attendance records for an aged care worker of the provider.

(3) It is a requirement that a registered provider keep a record prescribed under subsection (1) for 7 years starting on the day the record is made.

**Commented [A100]:** Does this only mean medical records that the provider would normally have, which may be none, rather than all medical records of the individual?

**Commented [A101]:** Consider clarifying "or for any longer period prescribed by any other law". Under State health records laws, the period is 7 years **post discharge** of the patient (ie individual).

## Subdivision QA—Compliance

### 154-3415 Requirement to keep and retain records relating to compliance

(1) A kind of record that a registered provider must keep and retain under section 154 of the Act is any record that enables proper assessments to be made of whether a provider has complied, or is complying, with its obligations under Chapter 3 of the Act.

(2) It is a requirement that a registered provider keep a record prescribed under subsection (1) for 7 years starting on the day the record is made.

**Commented [A102]:** Clarify, would this extend to CCTV? Providers routinely delete CCTV, e.g. after 60 days. Requiring them to retain all CCTV for 7 years could significantly increase their data storage requirements. It would be better to confine this to the records providers are required to create and maintain **under the Aged Care Act** rather than any and all records they *happen* to retain.

## Subdivision Q—Multi-Purpose Service Program

### 154-1205 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under paragraph 247(1)(a) of the Act.

### 154-1210 Requirements for records

(1) For the purposes of paragraph 154(a) of the Act, each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:
  (a) records of the income received to deliver funded aged care services at each approved residential care home, including:
    (i) records of State or Territory government funding received by the registered provider in accordance with a written agreement entered into under 247(1)(a) of the Act; and
    (ii) records of other Commonwealth funding (outside of any subsidy paid to the registered provider under section 249 of the Act for funded aged care services delivered under paragraph 247(1)(a) of the Act; and
    (iii) records of any individual fees or contributions under Part 3 of Chapter 4 of the Act that have been paid by individuals accessing funded aged care services under the MPSP; and
    (iv) investments and donations;

(b) records of the funds spent by the registered provider to deliver funded aged care services at each approved residential care home for the financial year;
(c) records of the types of health and aged care services delivered for the financial year;
(d) records of the number of individuals who have accessed funded aged care services, or are waiting to access services, for the financial year, including:
(i) whether the individual had an access approval when they commenced accessing services; and
(ii) the services the individuals accessed, including the service groups through which services were accessed; and
(iii) the individual's classification type; and
(iv) when the individual commenced and ceased services; and
(v) the reason the individual ceased services;
(e) records of the demographic information about each individual who have accessed funded aged care services, or are waiting to access services for the financial year, including:
(i) the name of the individual; and
(ii) the gender of the individual; and
(iii) the date of birth of the individual; and
(iv) whether the individual is Aboriginal or Torres Strait Islander; and
(v) whether the individual has dementia or dementia symptoms;
(f) records of a summary of the activities undertaken to prevent disease outbreaks.

**Commented [A103]:** It is unclear why the gender of the individual is required to be kept and the individual may not tell the provider.

**Commented [A104]:** It is unclear why a record of whether an individual is Aboriginal or Torres Strait Islander is required to be kept and the individual may not tell the provider.

(2) For the purposes of paragraph 154(a) of the Act, the requirements prescribed are:
(a) that a registered provider must keep a record prescribed in subsection (1) for 7 years starting on the day the record is made or received; and
(b) a record must be kept and retained in written or electronic form.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

## Subdivision R—Transition Care Program

### 154-1215 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under paragraph 247(1)(b) of the Act.

### 154-1220 Requirements for records

(1) For the purposes of paragraph 154(a) of the Act, each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:
(a) records of claims for payment of subsidy under sections 250, 254 and 260 of the Act;
(b) records of the amount of funding the System Governor has provided to the registered provider for the financial year;

(c) records of any individual fees and contributions under Part 3 of the Chapter 4 that have been paid by individuals to the registered provider for the financial year;

(d) records of expenditure by the registered provider for the financial year;

(e) records of any System Governor approved unspent funds from previous financial years.

(2) For the purposes of paragraph 154(a) of the Act, the requirements prescribed are:

(a) that a registered provider must keep a record prescribed in subsection (1) for 7 years starting on the day the record is made or received; and

(b) a record must be kept and retained in written or electronic form.

Note: A registered provider may be required to comply with other Commonwealth, State or Territory laws in relation to the retention of records.

**Commented [A105]:** Delete 'the' as not needed.

## Division 2—Provision of information to individuals

### 155-1 Purpose of this Division

For the purposes of section 155 of the Act, this Division prescribes the requirements for the following:

(a) the records and information that a registered provider must provide and explain to individuals accessing, or seeking to access funded aged care services;

(b) the records and information (including personal information) held by the registered provider about the individual to whom the registered provider delivers funded aged care services that a registered provider must allow and facilitate access by an individual.

### 155-5 Kind of information to be provided and explained

For the purposes of subsection 155(1) of the Act, this Division prescribes requirements for the provision and explanation of the following kinds of information:

(a) Statement of Rights;

(b) information to assist individuals to choose funded aged care services that best meet their needs;

(c) clear and understandable invoices;

(d) information about a registered provider's management and use of refundable deposits;

(e) information for prospective individuals;

(f) monthly statements;

(g) individualised budget;

(h) general information for individuals accessing any funded aged care services;

(i) general information for individuals accessing funded aged care services in a home or community setting;

(j) general information for individuals accessing funded aged care services in an approved residential care home;

(k) information about the financial position of a registered provider in a provider registration category other than residential care;

(l) pricing information.

### 155-15 Information to be provided and explained—Statement of Rights

(1) For the purposes of subsection 155(1) of the Act, a registered provider must provide an individual accessing or seeking to access funded aged care services the following:

(a) information about the individual's rights under the Statement of Rights set out in section 23 of the Act, in relation to the funded aged care services the individual accesses;

(b) a copy of the Statement of rights set out in section 23 of the Act.

**Commented [A106]:** What would this entail that is not covered by paragraph 155-15(1)(b)?

Note: The registered provider must retain records relating to the Statement of Rights given under paragraph (1)(b) of this instrument (see section 154-3300).

(2) A registered provider must assist the individual to understand the information and the Statement of Rights given under subsection (1).

(3) A registered provider must comply with subsections (1) and (2) before, or when, the registered provider commences delivery of funded aged care services to that individual.

**Commented [A107]:** What if the individual doesn't have the cognitive ability to do so?

### 155-20 Information to be provided—information to assist individuals to choose funded aged care services that best meet their needs

(1) This section applies to a registered provider registered in any of the following provider registration categories:
- (a) home and community services;
- (b) assistive technology and home modifications;
- (c) advisory and support services;
- (d) personal and care support in the home or community;
- (e) nursing and transition care.

(2) A registered provider must provide such information as is reasonably necessary to assist an individual to choose the funded aged care services that best meet the individual's goals and assessed needs and preferences within the limits of the resources available.

**Commented [A108]:** This is extremely broad including using an undefined term such as reasonably necessary. What information is expected to be provided under this subsection? For example if the individual is receiving CHSP services but needs would be best met by a SaH classification, is information on assessment and service wait time required?

### 155-25 Information to be provided—clear and understandable invoices

For the purposes of subsection 155(1) of the Act, a registered provider must provide an individual with invoices that are clear and in a format that is understandable.

### 155-30 Information to be provided—information about a registered provider's management and use of refundable deposits

(1) This section applies to a registered provider if the registered provider:
- (a) is registered in the provider registration category residential care; and
- (b) receives or has received payment of any of the following from an individual, wholly or partly as a lump sum:
  - (i) a refundable deposit;
  - (ii) an accommodation bond.

*Notification by registered provider*

(2) Within 7 days after an accommodation agreement is entered into between a registered provider and an individual, the registered provider must notify the individual, in writing, that the registered provider will give the individual, within 7 days of a request by the individual, the following information and documents:

**Commented [A109]:** Can this information also be provided at the time the accommodation agreement is entered into?

(a) a summary of the permitted uses for which refundable deposits and accommodation bonds have been used by the registered provider during the previous financial year;

(b) if, during the 2 years prior to the request, the registered provider has given the System Governor an aged care financial report for the registered provider that included a permitted uses reconciliation—a copy of the permitted uses reconciliation included in the most recent such report;

(c) information about whether the registered provider has, during the previous financial year, complied with:

(i) section 310 of the Act; and

(ii) the Financial and Prudential Standards;

(d) information about:

(i) the number (if any) of refundable deposit balances or accommodation bond balances that, in the previous financial year, were not refunded in accordance with section 311 of the Act; and

(ii) the number (if any) of entry contribution balances that, in the previous financial year, were not refunded in accordance with a formal agreement;

(e) if the registered provider is required to implement and maintain a written investment management strategy under the Financial and Prudential Standards—the registered provider's investment objectives as recorded in the registered provider's investment management strategy;

(f) a copy of the audit opinion referred to in paragraph 166-380(f) for the previous financial year;

(g) a copy of either:

(i) the most recent statement of the audited accounts in relation to the registered provider; or

(ii) if the registered provider is operated as part of a broader organisation—the most recent statement of the audited accounts of the organisation's aged care component;

(h) a copy of the refundable deposit record that relates to the individual, as at the time of the request.

(3) A registered provider that is not required to prepare annual financial reports under Part 2M.3 of Chapter 2M of the *Corporations Act 2001* is not required to comply with paragraph (2)(g) of this section.

*Disclosure on request*

(4) If an individual requests the registered provider of an approved residential care home in which the individual is accessing funded aged care services to give the individual the information and documents referred to in subsection (2), the registered provider must give the individual the information and documents requested within 7 days after receiving the request.

(5) Subsection (4) applies in relation to an individual who is accessing funded aged care services in an approved residential care home:

(a) whether or not the individual entered into an accommodation agreement with the registered provider of the approved residential care home; and

(b) whether or not the individual has paid a refundable deposit; an accommodation bond or an entry contribution to that registered provider.

(6) If:

(a) as a result of a request by an individual, a registered provider is required under subsection (4) to give the individual the summary referred to in paragraph (2)(a); and

(b) the registered provider has given the System Governor an aged care financial report for the registered provider for the previous financial year, and that report included a permitted uses reconciliation;

then the registered provider may satisfy the requirement to give the individual the summary by giving the individual a copy of that permitted uses reconciliation.

*Disclosure after end of financial year for registered provider*

(7) Within 4 months after the end of each financial year for a registered provider, the registered provider must give each individual who has paid a refundable deposit, an accommodation bond or an entry contribution to the registered provider for entry to the approved residential care home operated by the registered provider:

(a) a copy of the refundable deposit record that relates to the individual as at the end of the financial year; and

(b) a written statement that the registered provider will provide, within 7 days of a request by the individual, the information and documents referred to in subsection (2).

### 155-35 Information to be provided—to prospective individuals

(1) This section applies to a registered provider if the registered provider:

(a) is registered in the provider registration category residential care; and

(b) receives or has received payment of any of the following from an individual, wholly or partly as a lump sum:

(i) a refundable deposit;

(ii) an accommodation bond.

(2) Within 7 days of a request from a prospective individual or a prospective individual's authorised person or supporter, a registered provider must give the prospective individual or the prospective individual's authorised person or supporter the information and documents referred to in paragraphs 155-30(2)(a) to (g).

### 155-36 Information to be provided—statement of audited accounts

(1) If section 155-30 of this instrument does not apply to the registered provider that is registered in the provider registration category residential care, the provider must, if asked by an individual to whom the provider is delivering funded aged care services, give the individual, within 7 days of the request, a copy of either:

(a) the most recent statement of the audited accounts in relation to the registered provider; or

(b) if the registered provider is operated as part of a broader organisation—the most recent statement of the audited accounts of the organisation's aged care component; or

(c) the most recent audited general purpose financial report prepared under Subdivision E of Division 1 of Part 2 of Chapter 5 of this instrument.

(2) Despite subsection (1) of this section, a registered provider is not required to comply with this requirement if the registered provider:

(a) is not required to prepare annual financial reports under Part 2M.3 of the Chapter 2M of the *Corporations Act 2001*; and

(b) is not required to prepare a general purpose financial report under section 166-345 of this instrument.

### 155-40 Information to be provided—monthly statement

(1) This section applies to a registered provider registered in any of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;

(e) nursing and transition care.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services delivered under any specialist aged care program.

(3) A registered provider that has delivered funded aged care services to an individual through a service delivery branch in a calendar month must give the individual a written statement relating to the services delivered in that calendar month no later than the last day of the following month.

*Monthly statement for an individual accessing care in the service group home support*

(4) The monthly statement must contain the following:

(a) the amount of person-centred subsidy for the individual for the quarter in their ongoing home support account and/or the amount of person-centred for the individual for the episode in their short-term home support account, less the amount credited as provider-based subsidy;

(b) the amount of person-centred subsidy that was available for the individual in their ongoing and/or short-term home support account at the beginning of the calendar month;

(c) the amount of person-centred subsidy for the individual remaining in their ongoing and/or short term home support account at the end of the calendar month;

(d) the name and amount of the primary-centred supplements (if any) for the individual in their ongoing home support account for the quarter and/or the name and amount of the primary-centred supplements (if any) for the individual in their short-term home support account for the episode;

**Commented [A110]:** This is a significant increase on current requirements. Recommend these requirements don't start until 1 July 2026 at the earliest. Also recommend instead of monthly, the requirement be at least quarterly. Also recommend that statements for short-term programs are not required until the end of the program.

**Commented [A111]:** There appears to be a word missing here.

(e) rollover credits received in respect of the quarter;

(g) an itemised list of:

(i) each episode of services or items delivered to the individual during the calendar month; and

(ii) any adjustments, variations or refunds from previous calendar months, including the service name and delivery date if relating to a service;

(h) for each service or item delivered under the classification type ongoing and the classification type short-term:

(i) the name of the service or item as described in the service list under section 26 of this instrument; and

(ii) the price and/or cost that the registered provider charged the individual in respect of the calendar month; and

(iii) the date on which the service or item was delivered in respect of the calendar month; and

(iv) the contribution rate for the individual in respect of each service or item delivered in the calendar month; and

(v) the total amount of contribution paid by the individual for the calendar month; and

(vi) the amount of subsidy claimed by the registered provider in respect of each service or item delivered in the calendar month; and

(vii) the number of units or hours delivered in respect of the calendar month; and

(viii) the name of the supplier for any third-party services or items.

(5) Paragraphs (4)(g) and (h) of this section do not apply for services or items delivered under the service type care management to an individual.

*Monthly statement for an individual accessing care in the service groups assistive technology and/or home modifications*

(6) The monthly statement must contain the following:

(a) the amount of person-centred subsidy for the individual for the allocation period;

(b) the amount of person-centred subsidy that was available for the individual in their assistive technology and/or home modifications account at the beginning of the calendar month;

(c) the amount of person-centred subsidy for the individual remaining in their assistive technology and/or home modifications account at the end of the calendar month;

(d) the amount of person-centred subsidy for the individual remaining in their assistive technology and/or home modifications account after taking into account any committed funds;

(e) any expired person-centred subsidy in respect of the calendar month;

(f) expiration dates for person-centred subsidy in the following calendar month;

(g) the name and amount of primary person-centred supplements (if any) for the individual for the allocation period;

**Commented [A112]:** This is contrary to the rule about not being able to charge fees for services delivered in previous quarters against the next quarter's Budget. It is ok if it is different months within a quarter but the problem arises where the correction is between quarters.

**Commented [A113]:** On the statement template, lawnmowing has a unit of "per visit" whereas on the indicative price list, home maintenance and repairs has a hourly unit. Does this mean the unit may be left to providers? Should 'or invoice' be added to this subparagraph?

**Commented [A114]:** Recommend delete this paragraph as it is going to be difficult for providers to do and could be a while before systems cater for this. It will be a burden for smaller providers who do not have systems that cater for this - they may have to make manual work-arounds. This adds significant administration costs, and these details could more easily be outlined in the care plan if the client wishes.

(h) any additional approved amounts for assistive technology person-centred subsidy in respect of the calendar month:

(i) an itemised list of:

(i) assistive technology and/or home modification items of services, including administration and/or coordination, delivered to the individual during the calendar month; and

(ii) any adjustments, variations or refunds from previous calendar months;

(j) for each item or service delivered:

(i) the name of the item or service as described in the service list under section 26 of this instrument or the AT-HM List; and

(ii) the price that the registered provider charged the individual for the item or service in respect of the calendar month; and

(iii) the date on which the item or service was delivered in respect of the calendar month; and

(iv) the amount of contribution (if any) paid by the individual in respect of each item or service delivered in the calendar month; and

(v) the total amount of contribution paid by the individual for the calendar month; and

(vi) the amount of subsidy claimed by the registered provider in respect of each service or item delivered in the calendar month; and

(vii) the rate and number of item units or service hours delivered in respect of the calendar month; and

(viii) the name of the supplier for any third-party services or items;

(k) any commitments to assistive technology and/or home modifications made during the calendar month, including those items, modifications or related services which are agreed to with the individual, but which have not yet been delivered within the calendar month;

(l) for each item or service committed to but not yet delivered:

(i) the name and price for each item or service agreed to; and

(ii) the amount of contribution in respect of each item or service that remains to be paid; and

(iii) the total amount of committed funds, including a breakdown of the total amount of subsidy to be claimed and the total amount of contribution to be paid;

(m) any assistive technology and/or home modification items charged through the assistive technology or home modifications account or through unspent Commonwealth portion.

*Unspent funds*

(6A) If an individual has a home care account; or the Commonwealth holds an unspent Commonwealth portion for the individual; or the registered provider holds an unspent Commonwealth portion or an unspent individual portion for the individual, the monthly statement must contain the following:

(a) the individual's unspent home care amount (if any) in respect of the quarter;

**Commented [A115]:** Should this say paid or payable by the individual?

**Commented [A116]:** These are new requirements and are a different way of accounting for things compared to ongoing service account. This is accruing costs based on orders placed - systems will need to be in place to meet. Could be quite complex particularly if the total cost is an estimate.

(b) the Commonwealth portion of the individual's unspent home care amount (if any) held by the Commonwealth in respect of the quarter;
(c) the Commonwealth portion of the individual's unspent home care amount (if any) held by the registered provider in respect of the quarter;
(d) the individual portion of the individual's unspent fee amount (if any) held by the registered provider in respect of the quarter.

*Monthly statement for a period in which no services are delivered*

(7) If no service or item was delivered by registered provider to the individual during the calendar month, a statement must still be provided no later than the end of the following calendar month.

*When statement must be given*

(8) A registered provider must give the statement to the individual no later than the last day of the following calendar month.

**Commented [A117]:** What is expected if there is a delay by Services Australia which impacts the provider's ability to provide an accurate statement in this timeframe?

*Informing the individual of, and helping the individual to understand, statement*

(9) A registered provider must inform the individual of and help the individual to understand the monthly statement.

### 155-45 Information to be given—final monthly statement

(1) This section applies to a registered provider registered in any of the following provider registration categories:
(a) home and community services;
(b) assistive technology and home modifications;
(c) advisory and support services;
(d) personal and care support in the home or community;
(e) nursing and transition care.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services provide under any specialist aged care program.

(3) If a registered provider ceases to deliver funded aged care services to the individual, the registered provider must give the individual or their supporter, after the final claim is made for the existing individual, a final monthly statement.

(4) The final monthly statement must be prepared in accordance with subsection 155-40(4) or (5).

(6) A registered provider must give the final monthly statement to the individual or their supporter no later than the last day of the calendar month after the last claim is made.

### 155-50 Information to be provided—individualised budget

(1) This section applies to a registered provider registered in any of the following provider registration categories:
  (a) home and community services;
  (b) assistive technology and home modifications;
  (c) advisory and support services;
  (d) personal and care support in the home or community;
  (e) nursing and transition care.

(2) The requirements of this section do not apply in respect of the delivery of funded aged care services provide under any specialist aged care program.

(3) A registered provider that delivers funded aged care services to an individual for a classification type for the service groups home support, assistive technology or home modifications through a service delivery branch of the registered provider must give an individual a written individualised budget.

(4) The individualised budget for an individual must:
  (a) be prepared in partnership with the individual; and
  (b) be prepared having regard to the individual's goals and assessed needs, preferences, the resources available and the services selected by the individual; and
  (c) set out an itemised budget for the funded aged care services to be delivered to the individual, as set out in the individual's care plan including:
    (i) if means testing has been completed and Services Australia has advised a contribution rate for the individual—the contribution rate for each item or service for the individual; and
    (ii) if means testing has not been completed and Services Australia has not advised a contribution rate for the individual—the default contribution rate for each item or service; and
    (iii) where the contribution amount to be paid for each item or service in subparagraph (i) or (ii) of this paragraph can be specified on a per unit basis—specify the contribution amount to be paid for each item or service on a per unit basis; and
  (d) for the service group assistive technology, the itemised budget must also specify the following:
    (i) the description and cost for assistive technology products and equipment;
    (ii) the description and cost for assistive technology product and equipment repair or maintenance;
    (iii) the prescription cost (if applicable) for assistive technology;
    (iv) the description and cost of wraparound services for assistive technology;
    (v) administrative costs charged by the registered provider for assistive technology; and
  (e) for the service group home modifications, the itemised budget must also specify the following:

**Commented [A118]:** Amend to: approved services selected

**Commented [A119]:** Where is "default contribution rate" defined?

(i) the description and cost of home modification supplies and services;
(ii) the prescription cost (if applicable) for home modifications;
(iii) the description and cost of wraparound services for home modifications;
(iv) coordination costs charged by the registered provider for home modifications; and

(f) set out the amount of subsidy payable to the registered provider to the individual in respect of the period agreed between the individual and the registered provider.

**Commented [A120]:** Clarity needed as it is unclear what 'set out the amount of subsidy payable to the registered provider to the individual…' means.

(5) A registered provider must give the individualised budget to the individual as soon as practicable after the registered provider has all the necessary information to complete it.

(6) A registered provider must review and, if necessary, revise the individualised budget for the individual if:
(a) a change to the funded aged care services to be delivered to the individual through the service group home support, assistive technology and/or home modifications is proposed; or
(b) the costs of delivering the funded aged care services change; or
(c) the contribution rate for the individual changes; or
(d) the individual requests the registered provider to do so.

(7) If a registered provider reviews and revises the individualised budget for an individual under subsection (6), the registered provider must give the individual a copy of the revised individualised budget:
(a) as soon as practicable after the registered provider has all the necessary information to complete it; or
(b) if the individualised budget is reviewed and revised in response to a request from the individual, within 14 days of the request being made.

(8) The individual must be informed of, and helped to understand, the individualised budget for the individual.

### 155-55 Information to be provided—general information for individuals accessing any funded aged care services

(1) For the purposes of subsection 155(1) of the Act, a registered provider must give an individual accessing or seeking to access funded aged care services the following:
(a) a copy of the document mentioned in paragraph 165-20(1)(f) of this instrument, relating to giving complaints and feedback;
(b) an explanation of the effect of section 168 of the Act (which deals with protection of personal information);
(c) a copy of the Aged Care Code of Conduct.

(2) A registered provider must assist the individual to understand the information given under subsection (1) of this section.

(3) A registered provider must comply with subsections (1) and (2) before, or when, the registered provider commences delivery of funded aged care services to that individual.

### 155-60 Information to be provided—general information for individuals accessing funded aged care services in a home or community setting

(1) This section applies to a registered provider registered in any of the following provider registration categories:
   (a) home and community services;
   (b) assistive technology and home modifications;
   (c) advisory and support services;
   (d) personal and care support in the home or community;
   (e) nursing and transition care.

(2) For the purposes of subsection 155(1) of the Act, a registered provider must give an individual accessing or seeking to access funded aged care services in a home or community setting the following:
   (a) an explanation of the effect of Division 1 of Part 5 of Chapter 4 of the Act and Division 1 of Part 2 of Chapter 10 of this instrument (which deals with means testing in a home or community setting);
   (b) information about the circumstances in which the provider may cease delivery of funded aged care services to the individual as specified in subsection 149-35(2) of this instrument, including an explanation of the effect of section 149-40 (which deals with notice requirements applicable to the provider);
   (c) an explanation of the effect of subsection 148-80(1) of this instrument (which deals with the development of a care and services plan for the individual);
   (d) information that the provider will give the individual a monthly statement in accordance with sections 155-40 and 155-45 of this instrument.

(3) A registered provider must assist the individual to understand the information given under subsection (2) of this section.

(4) A registered provider must comply with subsections (2) and (3) before, or when, the registered provider commences delivery of funded aged care services to that individual.

(5) Despite subsection (2) of this section, the requirements of paragraphs (2)(a) and (2)(d) of this section do not apply in respect of the delivery of funded aged care services delivered under any specialist aged care program.

### 155-65 Information to be provided—general information for individuals accessing funded aged care services in an approved residential care home

(1) This section applies to a registered provider registered in the provider registration category residential care.

(2) For the purposes of subsection 155(1) of the Act, a registered provider must give an individual accessing or seeking to access funded aged care services in an approved residential care home the following:
   (a) information about the circumstances in which the individual may be asked to leave the approved residential care home as specified in subsection 149-60(1) of this instrument, including an explanation of the effect of section 149-65 (which deals with notice requirements applicable to the provider);
   (b) information about any policies or protocols of the approved residential care home that are relevant to the individual.

(3) A registered provider must assist the individual to understand the information given under subsection (2) of this section.

(4) A registered provider must comply with subsections (2) and (3) before, or when, the registered provider commences delivery of funded aged care services to that individual.

### 155-70 Information to be provided—information about the financial position of a registered provider registered in a provider registration category other than residential care

(1) This section applies to a registered provider registered in any of the following provider registration categories:
   (a) home and community services;
   (b) assistive technology and home modifications;
   (c) advisory and support services;
   (d) personal and care support in the home or community;
   (e) nursing and transition care.

(2) For the purposes of subsection 155(1) of the Act, before or when a registered provider commences delivery of funded aged care services to an individual, the registered provider must notify the individual, in writing, that the registered provider will give the individual, within 7 days of a request by the individual, the following information and documents:
   (a) a clear and simple presentation of the financial position of the registered provider;
   (b) a copy of the most recent statement of the audited accounts of the service delivery branch or, if the service delivery branch is operated as part of a broader organisation, the most recent statement of the audited accounts of the organisation's aged care component (that includes the service delivery branch).

(3) If an individual requests the registered provider to give the individual the information and documents referred to in subsection (2), the registered provider must give the individual the information and documents requested within 7 days after receiving the request.

**Commented [A121]:** This should not be an urgent matter and additional time should be allowed. Recommend change to 14 days.

**Commented [A122]:** Clarity is needed on what is meant by a clear and simple presentation.

**Commented [A123]:** This should not be an urgent matter and additional time should be allowed. Recommend change to 14 days.

(4) A registered provider that is not required to prepare annual financial reports under Part 2M.3 of Chapter 2M of the *Corporations Act 2001* is not required to comply with paragraph (2)(b) of this section.

### 155-80 Information to be provided -pricing information (by way of publication)

(1) This section applies to a registered provider registered in any of the following provider registration categories:
- (a) home and community services;
- (b) assistive technology and home modifications;
- (c) advisory and support services;
- (d) personal and care support in the home or community;
- (e) nursing and transition care.

*Service group home support*

(2) A registered provider delivering funded aged care services in the service group home support must publish on the registered provider's website the most common price that the registered provider charges individuals for each service in the following service types:
- (a) allied health and therapy;
- (b) care management;
- (c) domestic assistance;
- (d) home maintenance and repairs;
- (e) home or community general respite;
- (f) meals;
- (g) nursing care;
- (h) personal care;
- (i) restorative care management;
- (j) social support and community engagement;
- (k) therapeutic service for independent living;
- (l) transport.

**Commented [A124]:** What are the transitional arrangements to enable providers to implement this requirement?

(3) The pricing information published for the purposes of subsection (2) of this section must:
- (a) align to the unit type specified in the service list for the applicable service; and
- (b) specify the most common price for delivery of the service during standard business hours; and
- (c) specify the most common price for delivery of the service on weekdays outside standard business hours; and
- (d) specify the most common price for delivery of the service on Saturdays; and
- (e) specify the most common price for delivery of the service on Sundays; and
- (f) specify the most common price for delivery of the service on public holidays.

(4) In this section:

***most common price*** means the price for a service that the registered provider has most frequently charged during the previous 2 calendar months, calculated at the end of the following:

(a) August;
(b) October;
(c) December;
(d) February;
(e) April;
(f) June.

(5) A registered provider must update the pricing information on the registered provider's website for a service where the most common price for the service changes, within 30 days of the end of the calculation period mentioned in subsection (4) of this section.

(6) A registered provider is not required to publish a price for a service under subsection (2) of this section if:

(a) the base efficient price for the service is listed as "not applicable" in the aged care service list; or
(b) the registered provider is not currently delivering the service and has not delivered the service in the last 12 months.

(7) The requirements of this section do not apply to a registered provider in respect of the delivery of funded aged care services under a specialist aged care program.

*Service group assistive technology*

(8) A registered provider registered in the provider registration category assistive technology and home modifications delivering funded aged care services in the service group assistive technology must publish on the registered provider's website:

(a) whether the registered provider charges a provider administration fee for the provision of funded aged care services in the service group assistive technology; and
(b) if the registered provider charges a provider administration fee, the amount of the provider administration fee as a percentage of the price for the provision of services.

(9) A registered provider must update the pricing information on its website where the information published under subsection (8) of this section changes, within 30 days of the change.

*Service group home modifications*

(10) A registered provider registered in the provider registration category assistive technology and home modifications delivering funded aged care services in the service group home modifications must publish on the registered provider's website:

**Commented [A125]:** Using historical prices to publish a price is problematic and potentially misleading (particularly given providers will have to periodically increase fees to cover increased costs). Also two monthly reporting is overly onerous.

Providers should be able to publish the most common price they intend to charge in the next six months.

Separately there could be a provision requiring providers to report to the Department every six months, the most common price charged in the previous six months.

**Commented [A126]:** Amend to maximum of 6 monthly

**Commented [A127]:** State whether this is referring to 'wrap around services'.

**Commented [A128]:** Consider allowing price instead of percentage -Under HCP requirements, the sector was required to remove any reference to percentages as this was found to be more complicated for individuals.

(a) whether the registered provider charges a provider coordination fee for the provision of funded aged care services in the service group home modifications; and

(b) if the registered provider charges a provider coordination fee, the amount of the provider coordination fee as a percentage of the price for the provision of services.

**Commented [A129]:** It is unclear what information is required to be made available as the coordination fee may vary depending on the service.

(11) A registered provider must update the pricing information on its website where the information published under subsection (10) of this section changes, within 30 days of the change.

### 155-85 Requirements for allowing and facilitating access to information held about an individual

(1) For the purposes of subsection 155(2) of the Act, a registered provider that is not any of the following is prescribed:

(a) an APP entity within the meaning of the *Privacy Act 1988*;

(b) a State or Territory;

(c) body established for a public purpose by or under a law of the State or Territory (other than a local government authority).

(2) For the purposes of paragraph 155(2)(b) of the Act, it is a requirement when a registered provider is allowing and facilitating access by an individual to whom the registered provider delivers funded aged care services to records and information (including personal information) held by the registered provider about the individual, that the registered provider must comply with Australian Privacy Principle 12 as set out in Schedule 1 of the *Privacy Act 1988*, as if it were an organisation' for the purposes of the *Privacy Act 1988*.

Note: A registered provider that is an APP entity remains subject to the *Privacy Act 1988*, including APP 12.

# Chapter 5—Registered provider, responsible person and aged care worker obligations

## Part 2—Obligations relating to reporting, notifications and information

### Division 1—Provider obligation—reporting to particular persons

#### Subdivision HA—CHSP

#### 166-628 Child safety compliance statement

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (3) (***child safety compliance statement***) to the System Governor each year.

(2) The child safety compliance statement for the registered provider must be given to the System Governor by 31 March each year.

(3) The child safety compliance statement must include the following information:
- (a) a declaration that the registered provider has delivered grant activities consistent with the Child Safety supplementary term in the registered provider's grant agreement;
- (b) the activity name;
- (c) the activity ID;
- (d) the statement type in relation to the incidental contract term in the grant agreement;
- (e) the reporting start date;
- (f) the reporting end date.

(4) If the registered provider has not complied with the Child Safety supplementary term in the registered provider's grant agreement, the registered provider must provide a description of the non-compliance and set out the reasons for the non-compliance in the child safety compliance statement.

(5) The child safety compliance statement must be in a form approved by the System Governor.

**Commented [A130]:** Recommend delete this new requirement until further consultation is undertaken on the need for the requirement and the most cost efficient way to implement.

#### Subdivision L—Registered nurses

#### 166-800 Application of this Subdivision

(1) Subject to subsection (2), this Subdivision applies to a registered provider registered in the provider registration category residential care.

(2) The requirements of this Subdivision do not apply to a registered provider only delivering funded aged care services under a specialist aged care program.

### 166-805 Reporting requirements relating to registered nurses

(1) For the purposes of paragraph 166(1)(a) of the Act, a registered provider must give the System Governor a report about the obligation in subsection 175(1) of the Act in relation to each approved residential care home of the provider within 7 days after the end of each calendar month, or within a longer period specified by the System Governor by notice in writing given to the provider.

(2) A registered provider is not required to provide a report under subsection (1) of this section in relation to an approved residential care home for a calendar month if, during that calendar month, the registered provider did not deliver funded aged care services to at least one individual in the home.

(3) To avoid doubt, it is a requirement that a registered provider provide a report under subsection (1) of this section in relation to an approved residential care home regardless of whether the registered provider has been granted an exemption under paragraph 175(2)(a) of the Act from the obligation in subsection 175(1) of the Act in relation to that home.

(4) The report must:
- (a) be in a form approved, in writing, by the System Governor; and
- (b) specify in relation to each approved residential care home, whether a registered nurse was on site and on duty at all times for each day during the calendar month on which at least one individual received funded aged care services in the home; and
- (c) if a registered nurse was not on site and on duty at all times on any such day—specify the following information:
  - (i) each period of 30 minutes or more that a registered nurse was not on site and on duty at the home;
  - (ii) for each such period, the reasons why a registered nurse was not on site or on duty (or both) during that period;
  - (iii) for each such period, the alternative arrangements that were made for the period to ensure the clinical needs of the individuals in the home were met, or a statement that no alternative arrangements were made.

## Subdivision O—Multi-Purpose Service Program

### 166-720 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under paragraph 247(1)(a) of the Act.

### 166-725 Annual activity report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (4) (***annual activity report***) to the System Governor each financial year.

(2) The annual activity report for a financial year for the provider must be given to the System Governor:

**Commented [A131]:** Recommend amending to state 7 calendar days (if this is what it is intended to mean).

(a) by 31 July each year; or
(b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual activity report must be in a form approved by the System Governor.

(4) The information that must be included in the annual activity report for the financial year is as follows:
(a) the number of individuals who have accessed funded aged care services in, or from, the approved residential care home;
(b) the number of individuals who commenced accessing funded aged care services through the alternative entry pathway under subsection 71(2) of the Act;
(c) the number of individuals waiting to access such funded aged care services;
(d) any fees or contributions charged to individuals who accessed funded aged care services delivered in, or from, an approved residential care home;
(e) the type of health services delivered;
(f) the service types of aged care services delivered;
(g) the activities undertaken by the residential care home to prevent and manage disease outbreaks.

(5) A registered provider must provide the information prescribed in subsection (4) in respect of each residential care home operated by the registered provider.

### 166-730 Annual statement of financial compliance and income expenditure

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsection (4) (***annual statement of financial compliance and income and expenditure***) to the System Governor each financial year.

(2) The annual statement of financial compliance and income and expenditure must be given to the System Governor:
(a) by 31 October each year; or
(b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual statement of financial compliance and income and expenditure must be in a form approved by the System Governor.

(4) The information that must be included in the annual statement of financial compliance and income and expenditure for the financial year is as follows:
(a) income received from the following sources:
(i) State, Territory or Commonwealth government funding paid to the registered provider in accordance with an agreement entered into under paragraph 247(1)(a) of the Act;
(ii) other Commonwealth funding (outside of any subsidy paid to the registered provider under section 249 of the Act for funded aged care services delivered under paragraph 247(1)(a) of the Act);

(iii) any individual fees or contributions under Part 3 of Chapter 4 of the Act;
(iv) investments and donations;

(b) the amount of expenditure on each of the following:
(i) salaries or wages;
(ii) any labour costs in addition to salaries in wages such as superannuation benefits, leave loadings, payroll tax, workers compensation and other liability insurance, cost of subsidised services to employees and training costs;
(iii) non-salary related other expenditure;
(iv) capital expenditure;
(v) disease outbreak management activities.

### 166-735 Service demographics report

Commented [A132]: Why is this required?

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a registered provider to whom this Subdivision applies must give a report on matters provided for in subsections (4) and (5) (***service demographics report***) to the System Governor each financial year.

(2) The service demographics report must be given to the System Governor:
(a) by 31 July each year; or
(b) at such other time as agreed between the System Governor and the registered provider.

(3) The service demographics report must be in a form approved by the System Governor.

(4) The service demographics report must include a list of individuals who accessed funded aged care services delivered by the registered provider in accordance with an agreement made under paragraph 247(1)(a).

(5) A report prepared for the purposes of subsection (1) of this section must also include the following information:
(a) the service group through which the funded aged care service was delivered for each individual;
(b) the classification type for each individual;
(c) demographic information, including:
(i) the individual's date of birth; and
(ii) the individual's gender; and
(iii) whether the individual is Aboriginal or Torres Strait Islander; and
(iv) whether the individual has dementia or dementia symptoms;
(d) whether the individual has an access approval;
(e) the date on which the individual commenced accessing funded aged care services;
(f) the date on which the individual ceased accessing funded aged care services;
(g) the reason for ceasing any funded aged care services.

Commented [A133]: This should clarify that a provider only has to share information if known by the provider. Sometimes individuals may not share their gender or whether they are an Aboriginal or Torres Strait Islander person.

Commented [A134]: If cessation was by the client, this may not be known.

(6) A registered provider must give the System Governor a service demographics report for each approved residential care home operated by the registered provider.

## Subdivision P—Transition Care Program

### 166-740 Application of Subdivision to certain registered providers

This Subdivision applies to a registered provider delivering funded aged care services under paragraph 247(1)(b) of the Act.

### 166-745 Annual accountability report

(1) For the purposes of paragraph 166(1)(a) of the Act, this section prescribes that a provider to whom this Subdivision applies must give a report on matters provided for in subsection (4) (***annual accountability report***) to the System Governor each financial year.

(2) The annual accountability report for a financial year for the provider must be given to the System Governor:
  (a) annually; or
  (b) at such other time as agreed between the System Governor and the registered provider.

(3) The annual accountability must be in a form approved by the System Governor.

(4) The annual accountability report for the financial year must include the following information for the provider:
  (a) any subsidy received under section 249 of the Act;
  (b) any income derived from any individual fees and contributions under Part 3 or Chapter 4 of the Act;
  (c) State or Territory direct funding;
  (d) State or Territory in-kind contributions;
  (e) other income including;
    (i) donations; and
    (ii) interest; and
    (iii) expenditure recoveries and reimbursements; and
    (iv) client fees; and
    (v) any other income not specified in subparagraph (i) and (ii) of this paragraph or paragraph (a) to (d) of this subsection;
  (f) total income;
  (g) salary expenditure;
  (h) non-salary expenditure including:
    (i) office costs; and
    (ii) operating costs; and
    (iii) service agreements; and
    (iv) consumables and equipment for client use; and
    (v) travel; and

(vi) capital costs;

(i) other expenditure including:

(i) asset related expenses including depreciation; and

(ii) any other expenditure not specified in subparagraph (i) of this paragraph or paragraph (g) and (h) of this subsection;

(j) total expenditure;

(k) TCP activity for the financial year including;

(i) total clients; and

(ii) total care days; and

(iii) total residential care days; and

(iv) total home-based care days;

(l) surplus analysis and itemisation of surplus by income source including;

(i) Commonwealth government; and

(ii) State government; and

(iii) Territory government; and

(iv) client contributions; and

(v) any income specified in paragraph (e) of this subsection;

(m) the Commonwealth surplus expressed as a number of care days;

(n) any explanatory notes or commentary on the following;

(i) income;

(ii) expenditure;

(iii) activity for the financial year;

(iv) surplus analysis;

(v) additional activity;

(o) feedback, complaints and improvements including;

(i) the most common kinds of positive feedback; and

(ii) the most common kinds of complaints; and

(iii) improvements made by the provider;

(p) information in respect of:

(i) whether the Fair Work Commission wage increase component of the Commonwealth subsidy has been passed on to any eligible workers; and

(ii) whether the outbreak management supplement has been used for equipment and activities for the management of outbreaks;

(q) certification that the information provided in the report is true and correct.

## Subdivision Q—Pricing information

### 166-1500 Application of this Subdivision

(1) Subject to subsection (2), this Subdivision applies to a registered provider registered in one or more of the following provider registration categories:

(a) home and community services;

(b) assistive technology and home modifications;

(c) advisory and support services;

(d) personal and care support in the home or community;
(e) nursing and transition care.

(2) The requirements of this Subdivision do not apply in respect of the delivery of funded aged care services delivered under any specialist aged care program.

### 166-1505 Pricing information

(1) For the purposes of paragraph 166(1)(a) of the Act, a registered provider must:
(a) give a report about the information specified in subsection (3) to the System Governor for each reporting period; and
(b) do so within 30 days of the end of the relevant reporting period; and
(c) do so in the approved form.

*Reporting period*

(2) For the purposes of this section, a ***reporting period*** is a period of 2 months commencing on 1 January, 1 March, 1 May, 1 July, 1 September or 1 November of a year.

*Information to be included*

(3) The information that must be included in a report given in accordance with subsection (1) is the most frequently charged price for the relevant reporting period that the provider charges individuals for each service in the following service types:
(a) allied health and therapy;
(b) care management;
(c) domestic assistance;
(d) home maintenance and repairs;
(e) home or community general respite;
(f) meals;
(g) nursing care;
(h) personal care;
(i) restorative care management;
(j) social support and community engagement;
(k) therapeutic service for independent living;
(l) transport.

(4) A registered provider is not required to report on a price for a service in accordance with subsection (1) if:
(a) the base efficient price for the service is listed as “not applicable” in the aged care service list; or
(b) the registered provider is not currently delivering the service and has not delivered the service in the last 12 months; or
(c) the service is delivered under a specialist aged care program.

**Commented [A135]:** This is further increasing the administrative burden on providers.

**Commented [A136]:** Change to 6 monthly - every 2 months is excessive and pricing variations will skew the amounts, particularly for smaller providers delivering individually directly sourced services, which could be misleading.

**Commented [A137]:** The cost of this service could be skewed each month by some changes in length of journeys.

# Part 3—Provider obligation—notifying of change in circumstances

## Division 1—Obligation to notify

### 167-5 Purpose of this Part

This Part is made for the purposes of section 167 of the Act and prescribes:

(a) changes of a kind in relation to which prescribed kinds of registered providers must give notice to the Commissioner under that section; and

(b) circumstances in relation to which a notice must also be given to the System Governor under that section; and

(c) information that must be included in a notice given to the Commissioner or the System Governor under that section.

### 167-10 Notifying the Commissioner—kinds of registered providers and changes

The following table prescribes the kinds of registered providers and kinds of changes that those providers must give notice to the Commissioner under subsection 167(1) of the Act.

**Kinds of registered providers and changes**

| Item | Column 1<br>Kind of registered providers | Column 2<br>Kinds of changes |
|---|---|---|
| 1 | every kind of registered provider | a change referred to in section 167-20 relating to the provider's suitability to be a registered provider |
| 2 | every kind of registered provider | a change referred to in section 167-25 relating to the suitability of a responsible person of the provider |
| 3 | every kind of registered provider | a change referred to in section 167-30 of responsible persons of the provider |
| 4 | every kind of registered provider | a significant change referred to in section 167-35 relating to the organisation arrangements of the provider |
| 5 | a registered provider to whom section 157 of the Act applies | a significant change referred to in section 167-40 relating to the governance arrangements of the provider |
| 6 | every kind of registered provider | a change referred to in section 167-45 relating to the scale of operations of the provider |
| 7 | a registered provider registered in the following provider registration categories:<br>(a) home and community services;<br>(b) assistive technology and home modifications; | a change referred to in section 167-50 relating to intended service types |

Section 167-15

**Kinds of registered providers and changes**

| Item | Column 1<br>Kind of registered providers | Column 2<br>Kinds of changes |
|---|---|---|
| | (c) advisory and support services;<br>(d) personal care and care support in the home or community;<br>(e) nursing and transition care | |
| 8 | a registered provider registered in the following provider registration categories:<br>(a) personal care and care support in the home or community;<br>(b) nursing and transition care;<br>(c) residential care | a change referred to in section 167-55 relating to associated providers |
| 9 | every kind of registered provider, except government entities | a change referred to in section 167-60 relating to financial and prudential matters, except a change prescribed in item 10 of this table |
| 10 | a registered provider that:<br>(a) is registered in the provider registration category residential care; and<br>(b) is not a government entity or a local government authority | a change referred to in section 167-65 relating to liquidity |
| 11 | a registered provider registered in the provider registration category residential care | a change referred to in section 167-70 relating to approved residential care homes |

### 167-15 Notifying the System Governor—circumstances

For the purposes of subsection 167(2) of the Act, the circumstances in which a notice must also be given to the System Governor under that subsection are the circumstances in which a notice must be given to the Commissioner under subsection 167(1) of the Act relating to the following:

(a) the circumstances prescribed by item 4, of the table in section 167-10, to the extent that the circumstances relate to entering into administration;

(b) the circumstances prescribed by item 9 of the table in section 167-10 (relating to financial and prudential matters);

(c) the circumstances prescribed by item 10 of the table in section 167-10 (relating to liquidity);

(d) the circumstances prescribed by item 11 of the table in section 167-10 (relating to approved residential care homes).

## Division 2—Changes in circumstances

### 167-20 Suitability of a registered provider

(1) The change prescribed in item 1 of the table in section 167-10 is any change in circumstances for a registered provider that materially affects, or may materially affect, the provider's suitability to be a registered provider, taking into account the matters referred to in paragraph 109(1)(b) of the Act (which deals with suitability of registered providers).

Note: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the date on which a responsible person for the provider first became aware of the change of circumstances that materially affects the provider's suitability to be a registered provider; and

(b) how the provider became aware of the change of circumstances; and

(c) details about the change of circumstances.

### 167-25 Suitability of a responsible person of a registered provider

(1) The change prescribed in item 2 of the table in section 167-10 is any change in circumstances relating to a responsible person of a registered provider that materially affects, or could materially affect, the responsible person's suitability to be a responsible person of the provider, having regard to the matters referred to in subsection 13(1) of the Act (which deals with suitability matters in relation to an individual).

Note: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the name of the responsible person; and

(b) the date the provider first became aware of the change in circumstances; and

(c) how the provider became aware of the change in circumstances; and

(d) details of the change of circumstances; and

(e) whether, after considering those matters, the provider is reasonably satisfied that the responsible person continues to be suitable to be a responsible person of the provider; and

(f) what, if any, action the provider has taken, or proposes to take, in relation to the responsible person.

### 167-30 Change of responsible persons of a registered provider

(1) The change prescribed in item 3 of the table in section 167-10 is any change of responsible persons of a registered provider, including:

(a) an individual becoming a responsible person of the provider; and

(b) an individual ceasing to be a responsible person of the provider.

Note: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) for a change relating to an individual becoming a responsible person of the provider:

(i) the name and contact details of the individual; and

(ii) a description of the individual's responsibilities in their capacity as a responsible person of the provider; and

(iii) a statement to the effect that the provider has had regard to the suitability matters in relation to the individual, as referred to in subsection 13(1) of the Act, and that the provider is satisfied that the individual is suitable to be involved in the delivery of funded aged care services; and

(b) for a change relating to an individual ceasing to be a responsible person of the provider:

(i) the name of the individual ceasing to be a responsible person; and

(ii) the reason that the individual has ceased to be a responsible person of the provider; and

(iii) the name and contact details of another individual (if any) who is carrying out, or will carry out, the responsibilities of the individual ceasing to be a responsible person.

### 167-35 Organisation arrangements of a registered provider

(1) The change prescribed in item 4 of the table in section 167-10 is any significant change of the following kind to the organisation of a registered provider:

(a) if the provider is not a government entity—any change to the provider's legal and business structure, including any of the following:

(i) a restructure of the organisation of the provider;

(ii) a sale, acquisition, or merger relating to the provider;

(b) for any registered provider (including a government entity)—the entering into of an agreement by the provider with another entity in which the other entity agrees to deliver services that support the management or governance function of the provider;

(c) for any registered provider (including a government entity)—any change to an agreement (including the cessation of a such an agreement) by the provider with another entity in which the other entity agrees to deliver services that support the management or governance of the provider;

(d) if the provider is not a government entity—any of the following events:

(i) the provider enters into administration;

(ii) the provider appoints a restructuring practitioner (within the meaning of the *Corporations Act 2001*);

(iii) an insolvency event (within the meaning of the *Aged Care (Accommodation Payment Security) Act 2006*) occurs in relation to the provider.

Note 1: See section 167-10, which relates to notifying the Commissioner.

**Commented [A138]:** What does this mean and what purpose is it intended to serve? Organisations are constantly changing their internal structures.

**Commented [A139]:** What are some examples of this? Would it include matters such as accounting support, use of a payroll bureau, external HR services?

Note 2: See section 167-15, which relates to notifying the System Governor of matters relating to entering administration.

(2) To avoid doubt, the circumstances referred to in paragraph (1)(b) relating to the provider entering into an agreement do not include the entering into of an agreement for the delivery of funded aged care services.

**Commented [A140]:** With an individual?

(3) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) for a change to the provider's legal or business structure—details about the change to the provider's legal or business structure; and

(b) for an event referred to in paragraph (1)(b) or (c) (which relate to agreements):

(i) a detailed statement about the services that the other entity is to provide to the registered provider; and

**Commented [A141]:** Recommend removing the word 'detailed' to lessen administrative burden.

(ii) the nature and duration of the agreement; and

(iii) if the notification is about the cessation of the agreement—the reason and date of cessation; and

(c) for an event set out in paragraph (1)(d) of this section (which relates to administration, restructuring and insolvency):

(i) the date on which the event occurred; and

(ii) the type of administration (where applicable); and

(iii) the name of the administrator or restructuring practitioner (where applicable).

### 167-40 Governance arrangements of a registered provider

(1) The change prescribed in item 5 of the table in section 167-10 is any change to the governance of a registered provider that would result in the registered provider no longer complying with subsection 157(2) of the Act.

Note 1: See sections 157-5 and 157-10, which prescribe the kinds of registered providers to whom section 157 of the Act applies.

Note 2: See section 167-10, which relates to notifying the Commissioner.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) a statement that the provider no longer complies with a condition of registration set out in paragraph 157(2)(a) or (b) of the Act (whichever is relevant to the provider); and

(b) the names of incoming and outgoing members in relation to the non-compliance; and

(c) information on steps being taken to return to compliance, including whether an application under subsection 159(1) of the Act (which relates to determinations that certain conditions relating to the governing body of a registered provider do not apply) has been submitted, or will be submitted.

Section 167-45

### 167-45 Change relating to the scale of operations of a provider

(1) The change prescribed in item 6 of the table in section 167-10 is any of the following changes:

(a) for a registered provider other than a registered provider registered in the provider registration category residential care—a change to the local government area in which the provider delivers a funded aged care service;

(b) for a registered provider (including a registered provider registered in the provider registration category residential care)—a significant increase or decrease in the number of aged care workers of the provider that materially affects the provider's ability to deliver funded aged care services.

Note: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) details of the change; and

(b) the aged care funded services that will be, or are likely to be, affected by the change; and

(c) any other anticipated effects of the change; and

(d) the reason for the change; and

(e) any actions that the provider has taken or will take to manage the effect on services, or other anticipated effects.

### 167-50 Changes relating to intended service types

(1) The change prescribed in item 7 of the table in section 167-10 is any change relating to a registered provider's intended service types.

Note 1: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

Note 2: See Division 4 of Part 4 of Chapter 4 of this instrument for provisions relating to starting and ceasing the provision of funded aged care services to a *particular* individual and continuity of those services.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the relevant service type; and

(b) the date on which the provider expects the change to take effect.

### 167-55 Changes relating to arrangements with associated providers

(1) The change prescribed in item 8 of the table in section 167-10 is any of the following changes:

(a) the commencement of a new arrangement between the registered provider and an associated provider for the delivery of funded aged care services by the associated provider on behalf of the registered provider;

(b) the variation or extension of an existing such arrangement between the registered provider and an associated provider;

**Commented [A142]:** This should only need to be reported during statistical reporting. A provider may have one or two individuals in a council area that could leave the program at any time. It will be administratively burdensome to monitor when this changes.

**Commented [A143]:** How is this defined? A reasonable approach to what is a 'significant' increase or decrease will need to be taken to account for fluctuations in workforce.

**Commented [A144]:** These requirements are very burdensome and are going to cause significant administrative burden, particularly for providers under Support at Home. It will be particularly impractical for large providers who have hundreds, if not thousands of contractors - particularly those operating nationally and those with large numbers of self-managed clients who are bringing contractors with them.

It should be limited to where such arrangements materially affect the provider's ability to deliver care, not every subcontracting arrangement.

The requirement to update the Commissioner of any "variation" of an arrangement is also onerous. Does this include a variation in the price? In the terms of the contract relating to confidentiality?

Also, contracts may expire but then continue on a month-by-month basis. If the contract has expired, do providers then need to go back and update the Commissioner each month?

(c) the cessation of an existing such arrangement between the registered provider and an associated provider.

Note: See section 167-10, which relates to notifying the Commissioner.

(2) Subsection (1) does not apply to circumstances where the registered provider has entered into an arrangement with an associated provider for:

(a) the supply of labour under a labour hire arrangement; or

(b) the delivery of services that support the management or governance function of the registered provider.

(3) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) in all circumstances—information about the associated provider, including:

(i) the associated provider's business name; and

(ii) the associated provider's ABN; and

(iii) the associated provider's ACN (if any); and

(iv) the associated provider's business location; and

(b) in circumstances relating to the delivery of funded aged care services in a residential care home—information about the residential care home, including:

(i) the name of the residential care home; and

(ii) the address of the residential care home; and

(c) in circumstances relating to the commencement of a new arrangement:

(i) details of the services to be delivered under the new arrangement; and

(ii) the reasons for the new arrangement; and

(iii) the time period for the new arrangement (including the commencement date and expiry date of the arrangement); and

(d) in circumstances relating to the variation or extension of an arrangement:

(i) details of the variation or extension, including any new commencement dates or expiry dates for the arrangement; and

(ii) the reason for the variation or extension; and

(e) in circumstances relating to the cessation of an arrangement:

(i) the date on which the arrangement ceased or will cease; and

(ii) the reason for the cessation.

### 167-60 Changes relating to financial and prudential matters

(1) The change prescribed in item 9 of the table in section 167-10 is any change to a registered provider's capacity to deliver funded aged care services that the provider is registered to deliver, including:

(a) the inability to pay the entitlements of the provider's aged care workers;

(b) any change that materially affects an existing or anticipated revenue source;

(c) any instance in which the provider is unable to pay the provider's debts as and when those debts become due and payable.

Note: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

**Commented [A145]:** Again, this should be limited to where it has an impact on a provider's ability to deliver care.

**Commented [A146]:** Aligned to our earlier comment, this is going to be very burdensome, particularly for large providers who have many contractors.

**Commented [A147]:** This should be limited to where the provider considers this could materially impact their ability to deliver care.

(2) Subsection (1) does not apply to circumstances set out in section 167-65 (which relates to liquidity).

(3) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:
(a) details about the change; and
(b) the impact that the providers expects that the change to have on the provider's ability to deliver funded aged care services; and
(c) details about any mitigating strategies the provider has attempted, or will attempt, to manage this impact.

**Commented [A148]:** Should be provider (singular) and is unnecessarily wordy. Recommend changing to 'the expected impact of the change on the provider's ability to deliver funded aged care services'

### 167-65 Changes relating to liquidity

(1) The change prescribed in item 10 of the table in section 167-10 is any circumstance in which a registered provider's liquidity falls below, or is at risk of falling below, an amount that is sufficient for the provider to ensure that the provider can continue to:
(a) meet the provider's financial obligations as they fall due; and
(b) refund, in accordance with the Act and this instrument, any deposited amount balances that can be expected to fall due in the following 12 months; and
(c) deliver safe and quality care to individuals.

Note: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:
(a) the provider's current and expected liquidity for the relevant quarter; and
(b) the reason for the reduction, or expected reduction in liquidity; and
(c) the provider's Liquidity Management Strategy; and
(d) the provider's plan to increase liquidity to a level that is sufficient for the purposes set out in subsection (1).

### 167-70 Changes relating to approved residential care homes

(1) The change prescribed in item 11 of the table in section 167-10 is any of the following changes relating to an approved residential care home of a registered provider:
(a) a change that may affect whether the approved residential care home of the provider continues to meet the definition of residential care home in the Act;
(b) a change to a building or the premises that comprise the approved residential care home that presents a risk to the delivery of quality and safe residential care;
(c) a planned construction or renovation activity relating to the approved residential care home that the provider reasonably expects will affect the delivery of funded aged care services at the residential care home;

(d) an unplanned event relating to the approved residential care home that the provider reasonably expects will cause sustained disruption to the delivery of funded aged care services at the residential care home;

(e) for any provider other than a provider referred to in paragraph (f)—a reduction in the availability of the total number of beds covered by the approval of the approved residential care home that the provider expects will continue for a continuous period of at least 3 months;

(f) for a registered provider in the 2019 MM category known as MM 6 or MM 7—a reduction in the availability of the total number of beds covered by the approval of the approved residential care home for any period of time;

(g) a change in circumstances that causes beds that were unavailable as referred to in paragraph (1)(e) or (f) to become available.

Note 1: See section 167-10, which relates to notifying the Commissioner, and section 167-15, which relates to notifying the System Governor.

Note 2: See section 136 of the Act, which relates to varying the approval of a residential care home of a registered provider.

(2) For the purposes of paragraph 167(4)(c) of the Act, the information that must be included in a notice given in relation to a change to which this section applies is:

(a) the name of the approved residential care home; and

(b) the street address of the residential care home; and

(c) a description of the change of circumstances; and

(d) for circumstances referred to in paragraph (1)(e) or (f):

(i) the number of beds in respect of which the registered provider is, or will be, unable to provide residential care; and

(ii) the period during which the registered provider is, or will be, unable to provide residential care for those beds; and

(iii) the reason for the change to the availability of beds.

**Commented [A149]:** Does this include taking beds off-line for refurbishment or renovation?

Section 187-1

# Chapter 6—Obligations of operators of aged care digital platforms

## Part 1—Introduction

### 187-1 Simplified outline of this Chapter

[To be drafted.]

# Part 2—Obligations

### 188-1 Duty of operators of aged care digital platforms

For the purposes of subparagraph 188(1)(b)(vi) of the Act, the information that the operator of an aged care digital platform must check and display in relation to an entity that represents via the platform that the entity can deliver a service in the Commonwealth aged care system is:

(a) for an entity that is an aged care worker of a registered provider—that the entity complies with any applicable worker screening requirements prescribed by rules made under paragraph 152(b) of the Act that apply to the entity; and

(b) for an entity that seeks to deliver services in the Commonwealth aged care system—that the entity holds the credentials or qualifications that are stated on the aged care digital platform; and

(c) general information about the processes undertaken in order to check an entity's credentials or qualifications for the purposes of paragraph (b) of this section.

### 189-1 Notifying Commissioner of operation of aged care digital platforms

*Period within which notice must be given*

(1) For the purposes of paragraph 189(1)(a) of the Act, a notice given by an entity that is both a constitutional corporation and the operator of an aged care digital platform must be given:

(a) not later than 14 days after the first day on which the platform displays a representation by another entity that the other entity can deliver a service in the Commonwealth aged care system; or

(b) if the entity becomes the operator of the aged care digital platform after the end of the period referred to in paragraph (a) of this subsection—not later than 14 days after the entity becomes the operator of the aged care digital platform.

Note: Paragraph (b) is to ensure that the provision covers changes in operators.

*Content of notice*

(2) The notice must include the following information:

(a) the name of the aged care digital platform;

(b) details of the operator, including a key contact person;

(c) if the operator has an ABN—the ABN;

(d) the date on which the operator started to operate the aged care digital platform;

(e) details of the service types that the operator intends to facilitate;

(f) details of any professional relationships between the operator and registered providers in their corporate or business structures or otherwise.

Section 189-5

### 189-5 Managing complaints

*Purpose for which requirements are prescribed*

(1) For the purposes of paragraph 189(1)(b) of the Act, this section prescribes the requirements for managing complaints under a complaints management system implemented by an entity that is both a constitutional corporation and the operator of an aged care digital platform, being complaints about entities that represent that they can deliver, or have delivered, funded aged care services via the platform.

Note: Under subsection 189(3) of the Act, the requirements prescribed by this section may only be for the purpose of ensuring that systems implemented by operators of aged care digital platforms support compliance by registered providers with certain obligations.

*General requirements relating to management of receipt etc. of complaints*

(2) In managing complaints, the operator of the aged care digital platform must:
- (a) ensure that complaints are received and recorded, and responses are facilitated, in accordance with specified procedures; and
- (b) collect data relating to complaints for the purposes of meeting any applicable reporting requirements; and
- (c) protect the security and confidentiality of information relating to complaints; and
- (d) ensure that complaints:
  - (i) can be made by any person; and
  - (ii) can be made anonymously; and
  - (iii) can be withdrawn; and
- (e) not impose a fee or charge (however described) for receiving a complaint or for dealing with a complaint.

*Specific requirements relating to management of receipt and referral of complaints*

(3) In managing complaints, the operator of the aged care digital platform must:
- (a) acknowledge each complaint in writing within 3 days of receipt; and
- (b) refer each complaint in writing to the registered provider to which the complaint relates no more than 7 days after receipt, if referral is appropriate; and
- (c) ensure that information about the nature of each complaint, and contact details of the person making the complaint (if practicable), is provided to the registered provider to which the complaint relates, to the extent that the information is reasonably necessary to address the complaint; and
- (d) if the operator makes 3 attempts to refer a complaint to a registered provider during the 14-day period beginning on the day of the first attempt, but the registered provider does not acknowledge receipt of the complaint during that period—refer the complaint to the Aged Care Quality and Safety Commission; and
- (e) if a complaint that has been referred to a registered provider or the Aged Care Quality and Safety Commission is withdrawn after the referral—

**Commented [A150]:** What circumstances does this capture? What if the person making the complaint does not give informed consent to refer it within 7 days?

**Commented [A151]:** How is this referred and should the provider be notified of this referral?

notify the registered provider or the Commission, as the case requires, of the withdrawal no more than 2 days after the complaint is withdrawn.

*Other requirements relating to management of complaints*

(4) In managing complaints, the operator of an aged care digital platform must ensure:

(a) that the operator does not refer a complaint, or give information about a complaint, to a registered provider or the Aged Care Quality and Safety Commission without the informed consent of the person making the complaint (or their authorised supporter or advocate); and

(b) that the operator provides support and assistance to a person making a complaint (or making an enquiry that may form a complaint), for example, by facilitating access to translation services; and

(c) that the complaint-handling roles and responsibilities of the operator, registered providers and aged care workers are clear; and

(d) that the operator undertakes reviews as required, and at least annually, to ensure the complaints management system meets the requirements of this section.

**Commented [A152]:** Detail required on what constitutes informed consent.

## 189-10 Managing reportable incidents

*Purpose for which requirements are prescribed*

(1) For the purposes of paragraph 189(1)(c) of the Act, this section prescribes the requirements for managing reportable incidents under an incident management system implemented by an entity that is both a constitutional corporation and the operator of the aged care digital platform, being reportable incidents involving entities that represent that they can deliver funded aged care services via the platform.

Note: Under subsection 189(3) of the Act, the requirements prescribed by this section may only be for the purpose of ensuring that systems implemented by operators of aged care digital platforms support compliance by registered providers with certain obligations.

*General requirements relating to management of reportable incidents*

(2) In managing reportable incidents, the operator of the aged care digital platform must:

(a) ensure that reportable incidents are reported and recorded, and responses to such incidents are facilitated, in accordance with specified procedures; and

(b) collect data relating to reportable incidents for the purposes of meeting reporting requirements; and

(c) protect the security and confidentiality of information relating to reportable incidents; and

(d) promote the prevention of reportable incidents in public explanations of the operator's role and responsibilities; and

(e) ensure that any person may report a reportable incident; and

(f) not impose a fee or charge (however described) for reporting of reportable incidents or supporting registered providers in responding to such incidents.

**Commented [A153]:** Guidance material should provide further information on what is expected here.

Section 189-10

*Specific requirements relating to management of reportable incidents*

(3) In managing reportable incidents, the operator of an aged care digital platform must:

(a) acknowledge each report of a reportable incident in writing; and

(b) refer a report of a reportable incident in writing to the registered provider to which the incident relates no more than 24 hours after receipt of the report; and

(c) if the operator makes 3 attempts to refer a report of a reportable incident to a registered provider during the 3-day period beginning on the day of the first attempt, but the registered provider does not acknowledge receipt of the report during that period—refer the report of the incident to the Aged Care Quality and Safety Commission; and

(d) ensure that templates are specified for reporting, and recording the following information about, reportable incidents:

(i) the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected by the reportable incident;

(ii) to the extent known—the consequences of that harm;

(iii) the time and date when the reportable incident was identified;

(iv) the name and contact details of the person recording the details of the reportable incident;

(v) whether or not the reportable incident was reported to the police;

(vi) to the extent known—the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;

(vii) to the extent known—the names and contact details of the persons directly involved in the reportable incident;

(viii) to the extent known—the names and contact details of any witnesses to the reportable incident.

*Other requirements relating to management of reportable incidents*

(4) In managing reportable incidents, the operator of an aged care digital platform must ensure:

(a) that the operator provides support and assistance to a person wishing to report a reportable incident (or making an enquiry that may relate to reporting such an incident), for example, by facilitating access to translation services; and

(b) that the operator provides advice to entities that represent that they can deliver funded aged care services via the platform on how to report a reportable incident; and

(c) that the incident management roles and responsibilities of the operator, registered providers and aged care workers are clear; and

(d) that the operator undertakes reviews as required, and at least annually, to ensure the incident management system meets the requirements of this section; and

**Commented [A154]:** It should be made clear to providers in guidance material how digital platforms and registered providers' obligations on reportable incidents interact and intersect.

(e) that the operator has regard to the obligations of registered providers in relation to reporting reportable incidents, and gives them information in a manner that facilitates compliance with those obligations; and

(f) that the operator provides training to staff in identifying and taking responsibility for referring reportable incidents including, but not limited to, referring them to registered providers or emergency services if required.

Note: ***Reportable incident*** is defined in section 16 of the Act.

**Commented [A155]:** It should be made clear to providers in guidance material how digital platforms and registered providers' obligations on reportable incidents interact and intersect.

**Commented [A156]:** 'Staff' should be defined in the context of aged care digital platform operators. Also, consider including an obligation for digital platform operators to ensure workers cooperate with the provider and/or regulator in relation to these obligations.

### 189-15 Reporting requirements

(1) For the purposes of paragraph 189(1)(e) of the Act, this section sets out the prescribed requirements in relation to a notice to be given to the Commissioner by an entity that is a constitutional corporation and the operator of an aged care digital platform.

(2) The operator must report the following information for each quarter:

(a) the number and type of complaints received, referred, or otherwise handled during that quarter about the following:

(i) registered providers;

(ii) aged care workers of registered providers;

(b) the number and type of reportable incidents reported, referred to another person or body, or otherwise handled, during that quarter about the following:

(i) registered providers;

(ii) aged care workers of registered providers;

(c) the number and details of the following that were removed from the platform by the operator during that quarter, and the reasons why they were removed:

(i) entities that represented via the platform that the entity could deliver funded aged care services;

(ii) individuals to whom funded aged care services were delivered via the platform;

(d) the aggregate number of the following on the platform during that quarter:

(i) aged care workers of registered providers;

(ii) registered providers;

(iii) other entities seeking to deliver funded aged care services via the platform;

(e) if available, the aggregate number of individuals to whom funded aged care services were delivered via the platform during that quarter.

(3) For the purposes of paragraphs (2)(a) and (b), the report must deal separately with each registered provider, and each aged care worker of a registered provider, about whom a complaint or a report of a reportable incident was received, referred, or otherwise handled during the quarter concerned.

(4) For the purposes of paragraph (2)(c), the report must deal separately with each entity, and each individual, removed from the platform by the operator during the quarter concerned.

Section 189-18

### 189-18 Reporting changes to the Commissioner

For the purposes of paragraph 189(1)(e) of the Act, if:

(a) an entity that is both a constitutional corporation and the operator of an aged care digital platform has given a notice to the Commissioner under paragraph 189(1)(a) of the Act in accordance with subsection 189-1(1) of this instrument; and

(b) there is a change in the information included in the notice;

the entity must report the change to the Commissioner not later than 14 days after the change.

### 189-20 Keeping and retaining records, etc.

(1) For the purposes of paragraph 189(1)(g) of the Act, the records to be kept and retained by an entity that is both a constitutional corporation and the operator of an aged care digital platform are prescribed by this section.

(2) The operator must keep and retain the following records for each complaint made and each report of a reportable incident received:

(a) the complaint made, or the report of the reportable incident, and any information relating to the complaint or report, as the case requires;

(b) how the complaint or report was managed through the operator's systems;

(c) details of when the complaint or report was referred to the following:

(i) the relevant registered provider;

(ii) the Aged Care Quality and Safety Commission (if applicable);

(d) the date of acknowledgement of receipt by the following:

(i) the relevant registered provider;

(ii) the Aged Care Quality and Safety Commission (if applicable).

(3) The operator must keep and retain records of the following entities that represent via the platform that they can deliver a funded aged care service:

(a) aged care workers of registered providers;

(b) registered providers and their associated providers.

(4) The operator must, if appropriate, keep and retain records of:

(a) the funded aged care services delivered to an individual; and

(b) the aged care workers and the registered providers responsible for the delivery of those services.

**Commented [A157]:** What circumstances does this capture?

(5) The operator must, if appropriate, keep and retain records of the following that the operator removed from the platform, and the reasons why:

(a) the names and numbers of aged care workers of registered providers;

(b) registered providers and associated providers of registered providers;

(c) individuals to whom funded aged care services were delivered via the platform.

**Commented [A158]:** What circumstances does this capture?

(6) The operator must, if appropriate, keep and retain records of the details of requests for corrections to information held on the platform, and the operator's responses to those requests.

(7) The operator must ensure that procedures are in place requiring that all records that must be kept and retained by the operator are retained for at least 7 years.

### 189-25 Disclosing information included in records, etc.

(1) For the purposes of paragraph 189(1)(g) of the Act, the information that is to be disclosed by an entity that is both a constitutional corporation and the operator of an aged care digital platform is prescribed by this section.

(2) If the operator has records about an individual to whom funded aged care services are being or have been delivered, the operator must provide that information on request in a timely manner:
   (a) to the individual; and
   (b) with the individual's informed consent—to their supporters or advocates, or to a registered provider.

### 189-30 Correcting records, etc.

(1) For the purposes of paragraph 189(1)(g) of the Act, this section applies to records that are kept and retained, as prescribed by section 189-20 of this instrument, by an entity that is both a constitutional corporation and the operator of an aged care digital platform.

(2) Another entity may request, in writing or orally, that the operator make a correction to information relating to the other entity that is included in the operator's records.

(3) If the operator is satisfied that information included in its records is inaccurate, incomplete, out of date, irrelevant or misleading, the operator must take reasonable steps to correct the information.

# Chapter 9—Funding of aged care services—accommodation payments and accommodation contributions

## Part 2—Accommodation bonds and accommodation charges

### Division 1—Application of this Part

#### 287-10 Application of this Part

(1) For the purposes of subsection 287(2) of the Act, the class of individuals in the pre-2014 accommodation class is prescribed.

(2) For the purposes of subsection 287(3) of the Act, this Part prescribes different requirements of a kind referred to in that subsection for an individual in the pre-2014 accommodation class.

#### 287-11 Application to accommodation bonds

(1) This section applies to an individual in the pre-2014 accommodation class if, immediately before the transition time, an accommodation bond agreement was in effect for the individual with an approved provider that is, because of subitem 5(1) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*, taken to be a registered provider at the transition time.

(2) For the purposes of applying this Part to the individual:
   (a) the accommodation bond agreement continues in effect (and may be dealt with) on and after that time as if it were a pre-2014 bond-related accommodation agreement entered into with the registered provider under Division 2 of this Part; and
   (b) residential care (within the meaning of the old Act) that was provided to the individual by the approved provider through a residential care service (within the meaning of the old Act) in accordance with the agreement before the transition time is taken on and after that time to have been the delivery of ongoing funded aged care services to the individual in the approved residential care home of the registered provider that the System Governor, in accordance with subitem 5(7) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*, deems the service to be or be part of; and
   (c) the individual's day of entry (within the meaning of the old Act) for the residential care service is taken to be the individual's start day for the approved residential care home; and
   (d) an election made by the individual under section 57-17 of the *Aged Care (Transitional Provisions) Act 1997* is taken to have been made in accordance with section 287-70 of this instrument; and
   *(e)* an amount of interest that, before the transition time, was paid or payable to the approved provider in accordance with section 74 of the *Aged Care*

*(Transitional Provisions) Principles 2014* is taken to have been paid, or to be payable, to the registered provider in accordance with section 287-80 of this instrument; and

(f) income:

(i) retained by the approved provider in accordance with subsection 57-18(1) of the *Aged Care (Transitional Provisions) Act 1997* before the transition time; or

(ii) permitted to be retained by the approved provider before that time in accordance with that subsection but that had not been retained as at that time;

is taken to have been retained, or to be permitted to be retained, in accordance with subsection 287-85(1) of this instrument; and

(g) an amount that, before the transition time, was paid or payable to the approved provider in accordance with subsection 57-18(2) or (3) of the *Aged Care (Transitional Provisions) Act 1997* or section 91 or 92 of the *Aged Care (Transitional Provisions) Principles 2014* is taken to have been paid, or to be payable, to the registered provider in accordance with subsections 287-85(2) to (6) of this instrument; and

(h) an amount:

(i) deducted before the transition time from the accommodation bond balance (within the meaning of the old Act) for the individual's accommodation bond in accordance with section 57-19 of the *Aged Care (Transitional Provisions) Act 1997* or section 95 of the *Aged Care (Transitional Provisions) Principles 2014*; or

(ii) permitted to be deducted from that balance before that time in accordance with that section but that had not yet been deducted as at that time;

is taken to have been deducted, or to be permitted to be deducted, from the pre-2014 accommodation balance for the individual's pre-2014 bond-related accommodation payment in accordance with section 287-90 of this instrument; and

(i) an amount:

(i) deducted before the transition time from the accommodation bond balance (within the meaning of the old Act) for the individual's accommodation bond in accordance with section 57-20 of the *Aged Care (Transitional Provisions) Act 1997* or section 97 or 98 of the *Aged Care (Transitional Provisions) Principles 2014*; or

(ii) permitted to be deducted from that balance before that time in accordance with that section but that had not yet been deducted as at that time;

is taken to have been deducted, or to be permitted to be deducted, from the pre-2014 accommodation balance for the individual's pre-2014 bond-related accommodation payment in accordance with sections 287-95 and 287-100 of this instrument; and

(j) a refundable deposit (within the meaning of the old Act):

(i) used by the approved provider in accordance with section 52N-1 of the old Act or section 62, 63 or 64 of the *Fees and Payments Principles 2014 (No. 2)* before the transition time; or

(ii) permitted to be used before that time but that had not yet been used as at that time;

is taken to have been used, or to be permitted to be used, by the registered provider in accordance with section 287-101.

(3) Subsection (2) is not intended to change the time at which any thing referred to in that subsection was done or happened.

[Transitional rules to deem a pre-2014 bond-related accommodation agreement to be an accommodation agreement, a pre-2014 bond-related accommodation payment to be an accommodation payment and a refundable accommodation deposit, a pre-2014 bond-related retention amount to be a retention amount and a pre-2014 accommodation balance to be an accommodation balance are to be drafted].

### 287-12 Application to accommodation charges

(1) This section applies to an individual in the pre-2014 accommodation class if, immediately before the transition time, an accommodation charge agreement was in effect for the individual with an approved provider that is, because of subitem 5(1) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*, taken to be a registered provider at the transition time.

(2) For the purposes of applying this Part to the individual:

(a) the accommodation charge agreement continues in effect (and may be dealt with) on and after that time as if it were a pre-2014 charge-related accommodation agreement entered into with the registered provider under Division 4 of this Part; and

(b) residential care (within the meaning of the old Act) that was provided to the individual by the approved provider through a residential care service (within the meaning of the old Act) in accordance with the agreement before the transition time is taken on and after that time to have been the delivery of ongoing funded aged care services to the individual in the approved residential care home of the registered provider that the System Governor, in accordance with subitem 5(7) of Schedule 2 to the *Aged Care (Consequential and Transitional Provisions) Act 2024*, deems the service to be or be part of; and

(c) the individual's day of entry (within the meaning of the old Act) for the residential care service is taken to be the individual's start day for the approved residential care home; and

(d) an amount of interest that, before the transition time, was paid or payable to the approved provider in accordance with section 57A-12 of the *Aged Care (Transitional Provisions) Act 1997*, as in force immediately before the transition time, is taken to have been paid, or to be payable, to the registered provider in accordance with section 287-155 of this instrument.

(3) Subsection (2) is not intended to change the time at which any thing referred to in that subsection was done or happened.

[Transitional rules to deem a pre-2014 charge-related accommodation agreement to be an accommodation agreement, a pre-2014 charge-related accommodation payment to be an accommodation contribution and a pre-2014 bond-related retention amount to be a retention amount are to be drafted].

## Division 2—Pre-2014 bond-related accommodation agreements

### 287-13 Entry into pre-2014 bond-related accommodation agreement

A registered provider may enter into a pre-2014 bond-related accommodation agreement with an individual in the pre-2014 accommodation class after the transition time in relation to an approved residential care home (the ***new home***) if:

(a) immediately before the transition time, either of the following were in effect for the individual:
  (i) a formal agreement;
  (ii) an accommodation bond agreement; and
(b) the individual ceased (whether before or after the transition time) accessing funded aged care services in another approved residential care home and will start, or has started, accessing funded aged services in the new home.

Note 1: The new home and the former home may be approved in relation to the same registered provider.

Note 2: An individual in the pre-2014 accommodation class may change homes before the transition time and still be a member of that class: see paragraph (b) of the definition of ***pre-2014 accommodation class***.

### 287-15 Information to be given before registered provider enters into a pre-2014 bond-related accommodation agreement with an individual

Before a registered provider enters into a pre-2014 bond-related accommodation agreement with an individual, the provider must:

(a) give the individual a copy of the proposed agreement that meets the requirements set out in section 287-25; and
(b) inform the individual of the following:
  (i) that if the individual has given the provider sufficient information to determine the value of the individual's assets, the provider is required to leave the individual, after paying the pre-2014 bond-related accommodation payment, with assets with a value at least equal to the individual's pre-2014 minimum permissible asset value;
  (ii) the interest rate to be charged on amounts owed under the agreement;
  (iii) the capacity for amounts owed under the agreement and accrued interest to be deducted from the balance of the amount paid under the agreement before it is refunded;
  (iv) the amount to be charged under the agreement;
  (v) the pre-2014 bond-related retention amount charged;
  (vi) the interest rate on the pre-2014 bond-related accommodation payment amount if there is a delay in payment of the lump sum or the amount is paid in whole or in part by periodic payments;
  (vii) the periods when the pre-2014 bond-related retention amount and interest are charged;
  (viii) payment options (that is, by lump sum, periodic payment, or a combination of lump sum and periodic payment);

(ix) refund arrangements;

(x) the prudential arrangements applying to the pre-2014 accommodation balance;

(xi) when a pre-2014 bond-related accommodation payment amount is not required or, if paid, is refundable.

### 287-20 Time within which registered providers must enter into pre-2014 bond-related accommodation agreements

A registered provider must enter into a pre-2014 bond-related accommodation agreement with an individual in relation to an approved residential care home before, or within 21 days after, the individual's start day for the home.

### 287-25 Pre-2014 bond-related accommodation agreements

(1) A pre-2014 bond-related accommodation agreement between a registered provider and an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider must set out the following:

(a) the individual's start day, or proposed start day, for the home;

(b) the pre-2014 bond-related accommodation payment that:

(i) will be payable if the individual starts accessing the services in the home; or

(ii) is payable if the individual has already started to access the services in the home;

(c) how the pre-2014 bond-related accommodation payment is to be paid, and if the payment is to be paid by periodic payment, the conditions relating to the payments (which must comply with the requirements of section 287-70);

(d) when the pre-2014 bond-related accommodation payment is payable;

(e) the amount of each pre-2014 bond-related retention amount that will be deducted from the pre-2014 accommodation balance;

(f) when pre-2014 bond-related retention amounts and other amounts permitted by section 287-90 to be deducted from the pre-2014 accommodation balance will be deducted;

(g) the individual's room that the pre-2014 bond-related accommodation payment entitles the individual to be provided with;

(h) any services that the pre-2014 bond-related accommodation payment entitles the individual to be provided with;

(i) that a fee reduction supplement under section 231 of the Act may apply to the individual and reduce the pre-2014 bond-related accommodation payment, including to nil;

(j) that, if the individual changes the individual's room in the home, this will not change the individual's start day for the home;

(k) the circumstances in which the pre-2014 accommodation balance must be refunded and the way the amount of the refund will be worked out;

(l) the rate of interest, or interest equivalent, payable if the pre-2014 bond-related accommodation payment amount:
  (i) is paid in whole or in part as a lump sum after the due date; or
  (ii) is paid by periodic payment; or
  (iii) is not paid when it is due to be paid;
(m) the way interest, or interest equivalent, charges are calculated;
(n) the total amount of interest, or interest equivalent, charges payable under the agreement:
  (i) if they can be calculated when the agreement is made; and
  (ii) assuming that the individual will make all payments when they are due;
(o) the pre-2014 bond-related retention amounts payable if the provider delivers the services to the individual in the home for 2 months or less;
(p) the frequency at which interest, or interest equivalent, charges will be debited.

*Additional matters in relation to periodic payments*

(2) Subsection (3) applies if the individual elects to pay the pre-2014 bond-related accommodation payment amount by periodic payment, in whole or in part.

(3) In addition to the matters specified in subsection (1), the pre-2014 bond-related accommodation agreement must state:
(a) the amount of the lump sum equivalent; and
(b) the amount and frequency of the periodic payments; and
(c) the components of each periodic payment representing:
  (i) retention; and
  (ii) interest; and
(d) that the individual may, at any time, pay as a lump sum the whole or a part of the lump sum equivalent.

*Additional matters in relation to voluntary moves to an approved residential care home of another registered provider*

(4) The pre-2014 bond-related accommodation agreement must state that, if the individual wishes to move from the approved residential care home of the registered provider (the ***original home***) to an approved residential care home of another registered provider (the ***new home***), the registered provider of the original home may ask the individual for permission to provide the following information to the registered provider of the new home:
(a) whether the individual has agreed to pay a pre-2014 bond-related accommodation payment;
(b) if so, the amount agreed and, if the individual has agreed to pay the amount in whole or in part by periodic payments, the lump sum equivalent;
(c) the period remaining during which, under sections 287-95 and 287-100, pre-2014 bond-related retention amounts may be deducted from the individual's pre-2014 accommodation balance;

(d) amounts that may be deducted from the pre-2014 accommodation balance.

### 287-30 Pre-2014 bond-related accommodation agreements may be incorporated into other agreements

For the purposes of this Division, an individual is taken to have entered into a pre-2014 bond-related accommodation agreement if the individual has entered into an agreement that contains the provisions required by section 287-25.

### 287-35 Pre-2014 bond-related accommodation agreements cannot affect requirements of this Division

The requirements of this Division apply despite any provision of a pre-2014 bond-related accommodation agreement, or any other agreement, to the contrary.

## Division 3—Pre-2014 bond-related accommodation payments

### Subdivision A—Charging of pre-2014 bond-related accommodation payments

#### 287-40 Charging of pre-2014 bond-related accommodation payments

A registered provider must comply with the following in relation to the charging of a pre-2014 bond-related accommodation payment to an individual for the delivery of ongoing funded aged care services to the individual after the transition time through the service group residential care in an approved residential care home (the ***new home***) of the provider:

(a) subject to this section, a pre-2014 bond-related accommodation payment must be charged if:
  (i) the individual ceased accessing the services in another approved residential care home (the ***former home***) before or after the transition time and started accessing the services in the new home; and
  (ii) the individual paid a pre-2014 bond-related accommodation payment or entry contribution to access the services in the former home;

Note 1: The new home and the former home may be approved in relation to the same registered provider.

Note 2: An individual in the pre-2014 accommodation class may change homes before the transition time and still be a member of that class (see paragraph (b) of the definition of ***pre-2014 accommodation class***).

(b) the pre-2014 bond-related accommodation payment must not exceed the maximum amount under section 287-45, and the individual must not be charged more than one pre-2014 bond-related accommodation payment to access the services in the home;

(c) if a fee reduction supplement under section 231 of the Act applies to the individual—the pre-2014 bond-related accommodation payment must be reduced (but not below zero) to reflect any amount of the supplement that is applied towards the payment;

(d) payment of the pre-2014 bond-related accommodation payment can only be required during a period specified in section 287-65;

(e) payment of the pre-2014 bond-related accommodation payment by periodic payments must meet the requirements set out in section 287-70;

(f) the registered provider must not use the pre-2014 bond-related accommodation payment unless the use of the payment is permitted (see section 287-101);

(g) the registered provider is entitled to income derived from investing the pre-2014 accommodation balance (see section 287-85);

(h) amounts must not be deducted from the pre-2014 accommodation balance, except for amounts deducted under section 287-90;

(i) the registered provider must not charge a pre-2014 bond-related accommodation payment if:
  (i) the Commissioner has imposed a condition on the registration of the registered provider under section 143 of the Act; and

(ii) the condition prohibits the provider charging a payment.

## Subdivision B—Pre-2014 bond-related accommodation payments

### 287-45 Maximum amount of pre-2014 bond-related accommodation payments

(1) Subject to subsection (2), the maximum pre-2014 bond-related accommodation payment that may be charged for the delivery of ongoing funded aged care services to an individual through the service group residential care in an approved residential care home of a registered provider is the lowest of the following:

(a) an amount that, when subtracted from an amount equal to the value of the individual's assets at the start of the individual's start day for the home, leaves an amount at least equal to the individual's pre-2014 minimum permissible asset value (see subsection (3));

(b) if paragraph 287-40(a) applies in relation to an individual who paid a pre-2014 bond-related accommodation payment—the pre-2014 accommodation balance that was refunded or is payable to the individual under section 287-102 in respect of the pre-2014 bond-related accommodation payment referred to in subparagraph 287-40(a)(ii);

(c) if paragraph 287-40(a) applies in relation to an individual who paid an entry contribution—the entry contribution balance that was refunded or is payable to the individual in respect of the entry contribution referred to in subparagraph 287-40(a)(ii).

Note: The operation of this section may be modified if, before entering a pre-2014 bond-related accommodation agreement, the individual gives the registered provider a determination under section 329 of the Act of the value of the individual's assets. See subsection (5).

(2) If an individual seeking to access ongoing funded aged care services through the service group residential care in an approved residential care home of a registered provider does not, before entering into a pre-2014 bond-related accommodation agreement, give the provider sufficient information about the individual's assets for the provider to be able to determine the amount referred to in paragraph (1)(a), the maximum amount of the individual's pre-2014 bond-related accommodation payment is the amount referred to in paragraph (1)(b) or (c), as applicable.

(3) An individual's ***pre-2014 minimum permissible asset value*** is the amount obtained by rounding to the nearest $500.00 (rounding $250.00 upwards) an amount equal to 2.25 times the basic age pension amount at the start of the individual's start day for the home.

(4) The value of an individual's assets is to be worked out in accordance with section 330 of the Act.

(5) However, subsections (1), (2) and (3) are modified as described in the following table, and subsection (4) does not apply, if, before entering the pre-2014 bond-related accommodation agreement, the individual gives the registered provider a copy of a determination that:

(a) is a determination under section 329 of the Act of the value of the individual's assets at a time (the ***valuation time***) that is before or at the start of the individual's start day for the home; and

(b) is in force at the start of the start day, if that is after the valuation time.

| **Modifications of subsections (1), (2) and (3)** | | |
|---|---|---|
| **Item** | **Column 1**<br>**If …** | **Column 2**<br>**subsections (1), (2) and (3) have effect as if …** |
| 1 | the valuation time is before the start of the start day for the home | (a) the references in paragraph (1)(a) and subsection (3) to the start of the individual's start day for the home were references to the valuation time; and<br>(b) the value of the individual's assets at the valuation time were the value specified in the determination |
| 2 | the valuation time is at the start of the start day for the home | the value of the individual's assets at the start of the individual's start day for the home were the value specified in the determination |

## Subdivision C—Payment of pre-2014 bond-related accommodation payments

### 287-65 Period for payment of pre-2014 bond-related accommodation payment

An individual must not be required to pay a pre-2014 bond-related accommodation payment before the day that is 6 months after the individual's start day for the approved residential care home to which the payment relates.

Note: However, under sections 287-85 and 287-95, amounts representing income derived and pre-2014 bond-related retention amounts are payable from the day an individual starts accessing ongoing funded aged care services.

### 287-70 Payment of pre-2014 bond-related accommodation payment by periodic payment

(1) An individual may elect to pay a pre-2014 bond-related accommodation payment, in whole or in part, by periodic payment.

(2) If the individual elects to pay the payment by periodic payment, the registered provider for the approved residential care home to which the payment relates and the individual must agree on:

(a) the frequency of payments; and

(b) the amount of a payment, worked out in accordance with subsection (3).

(3) For the purposes of paragraph (2)(b), the formula for working out the amount of a periodic payment is as follows:

$$\frac{(\text{LSE} \times \text{IR}) + \text{RC}}{\text{NPP}}$$

where:

***IR*** is the lower of:

(a) the interest rate stated in the individual's pre-2014 bond-related accommodation agreement; and

(b) the maximum permissible interest rate for the individual's start day for the home.

***LSE*** is the amount of the individual's lump sum equivalent.

***NPP*** is the number of periodic payments payable by the individual in the relevant year.

***RC*** is the amount of the retention component worked out:

(a) if no part of the pre-2014 bond-related accommodation payment is paid as a lump sum—in accordance with subsection (4); or

(b) if part of the pre-2014 bond-related accommodation payment is paid as a lump sum—in accordance with subsections (5) and (6) and, if applicable, (7).

Note: See also section 287-95.

(4) The amount of the retention component must not exceed the maximum pre-2014 bond-related retention amount that may be deducted under section 287-95, during the year beginning on the individual's start day for the home, from the amount that would have been the pre-2014 accommodation balance if the individual had paid the whole of the pre-2014 bond-related accommodation payment as a lump sum.

Note: An amount deducted from an accommodation balance in accordance with section 57-19 of the old Act before the transition time is taken to have been deducted from a pre-2014 accommodation balance in accordance with section 287-90 of this instrument.

(5) If part of the pre-2014 bond-related accommodation payment is paid as a lump sum, the amount of the retention component of the periodic payments is reduced, on a proportionate basis, in accordance with the ratio of the lump sum equivalent to the amount of the pre-2014 bond-related accommodation payment.

(6) However, if the lump sum is sufficient to cover the total of the pre-2014 bond-related retention amounts for the period of 5 years for the whole of the pre-2014 bond-related accommodation payment, including the lump sum equivalent, and the individual elects:

(a) the amount of the retention component is nil; and

(b) the total of the pre-2014 bond-related retention amounts, including the retention component that would otherwise be payable on the lump sum equivalent, may be deducted from the amount paid as a lump sum.

(7) For the purposes of subsection (6):

(a) the period of 5 years begins on the individual's start day for the home; and

(b) the individual's election must be made in writing and given to the registered provider.

### 287-75 Minimum amount of periodic payments

(1) The minimum amount of a periodic payment payable by an individual is the amount representing the periodic payments that would have been payable for 3 calendar months.

(2) If a registered provider ceases to deliver ongoing funded aged care services to an individual through the service group residential care in an approved residential care home of the provider, the provider may charge the individual the full amount of a periodic payment that is payable for the month in which the provider ceases to deliver the services.

### 287-80 Payment if agreed pre-2014 bond-related accommodation payment not paid

(1) This section applies if:
- (a) an individual has agreed to pay a pre-2014 bond-related accommodation payment to a registered provider in whole or in part as a lump sum; and
- (b) the provider ceases to deliver ongoing funded aged care services to the individual through the service group residential care in the approved residential care home to which the payment relates; and
- (c) the provider delivered the services to the individual for more than 2 months; and
- (d) the individual does not pay the pre-2014 bond-related accommodation payment before the provider ceases to deliver the services to the individual.

(2) The individual may be required to pay an amount (the ***interest equivalent amount***) worked out in accordance with subsection (3), in relation to the individual's pre-2014 accommodation balance, to the registered provider.

Note: This subsection has effect subject to section 287-86.

(3) For the purposes of subsection (2), the interest equivalent amount, in relation to the individual's pre-2014 accommodation balance, is the amount worked out in accordance with the following formula:

$$\frac{I \times LS \times D}{365}$$

where:

***D*** is the number of days in the period:
- (a) beginning on the first day of the month in which the lump sum was to be paid; and
- (b) ending on the last day of the month in which the individual ceases to access the services.

***I*** is the lower of:
- (a) the interest rate stated in the individual's pre-2014 bond-related accommodation agreement; and

(b) the maximum permissible interest rate for the individual's start day for the home.

***LS*** is the amount of the pre-2014 bond-related accommodation payment agreed to be paid as a lump sum.

## Subdivision D—Retention, deduction and transfer of pre-2014 accommodation balances

### 287-85 Registered provider may retain income derived

(1) A registered provider may retain income derived from the investment of a pre-2014 accommodation balance in respect of a pre-2014 bond-related accommodation payment paid to the provider for the delivery of ongoing funded aged care services to an individual through the service group residential care in an approved residential care home of the provider.

Note: This subsection has effect subject to section 287-86.

(2) Despite section 287-65, if an individual pays a pre-2014 bond-related accommodation payment to a registered provider in whole or in part as a lump sum after the individual's start day for the home to which the payment relates, the individual may be required to pay to the provider an amount (the ***interest equivalent amount***) worked out in accordance with subsection (3) that is equivalent to the income the provider could be expected to have derived, through investing the pre-2014 accommodation balance, during the period:

(a) beginning on the start day for the home; and

(b) ending on the day on which the pre-2014 bond-related accommodation payment was paid.

Note: This subsection has effect subject to section 287-86.

(3) For the purposes of subsection (2), the interest equivalent amount, in relation to the individual's pre-2014 accommodation balance, is the amount worked out in accordance with the following formula:

$$\frac{IR \times LS \times ND}{365}$$

where:

***IR*** is the lower of:

(a) the interest rate stated in the individual's pre-2014 bond-related accommodation agreement; and

(b) the maximum permissible interest rate for the individual's start day for the home.

***LS*** is the amount of the lump sum.

***ND*** is the number of days in the period:

(a) beginning on the individual's start day for the home; and

(b) ending on the day when the pre-2014 bond-related accommodation payment was paid in whole or in part as a lump sum.

(4) If a registered provider delivers ongoing funded aged care services to an individual through the service group residential care at an approved residential care home of the provider for 2 months or less, the individual may be required to pay to the provider an amount (the ***interest equivalent amount***) worked out in accordance with subsection (5) or (6) representing the income the provider could be expected to have derived, through investing the pre-2014 accommodation balance, during:

(a) the whole of the month in which the provider delivered the services; and

(b) the 2 following months.

Note: This subsection has effect subject to section 287-86.

Example: If a registered provider started delivering ongoing funded aged care services to an individual through the service group residential care at an approved residential care home of the provider on 20 January and the individual left on 3 March, the amount would be the amount the registered provider could have been expected to have derived if the provider delivered the services to the individual for the whole of January, February and March.

(5) If:

(a) the individual pays the pre-2014 bond-related accommodation payment in whole or in part as a lump sum; and

(b) the amount paid as a lump sum is refunded to the individual within 3 months after the individual's start day for the home;

the interest equivalent amount, in relation to the individual's pre-2014 accommodation balance, is the amount worked out in accordance with the following formula:

$$\frac{IR \times LS \times ND}{365}$$

where:

***IR*** is the lower of:

(a) the interest rate stated in the individual's pre-2014 bond-related accommodation agreement to which the payment relates; and

(b) the maximum permissible interest rate for the individual's start day for the home.

***LS*** is the amount of the lump sum.

***ND*** is the number of days in the period:

(a) beginning on the day when the lump sum was refunded; and

(b) ending 3 months after the start day for the home.

(6) If the individual:

(a) has agreed to pay the pre-2014 bond-related accommodation payment in whole or in part as a lump sum; and

(b) does not pay the lump sum before the individual ceases to access ongoing funded aged care services in the home;

the interest equivalent amount, in relation to the individual's pre-2014 accommodation balance, is the amount worked out in accordance with the following formula:

$$\frac{IR \times LS \times ND}{365}$$

where:

***IR*** is the lower of:

(a) the interest rate stated in the individual's pre-2014 bond-related accommodation agreement; and

(b) the maximum permissible interest rate for the individual's start day for the home.

***LS*** is the amount of the lump sum.

***ND*** is the number of days in 3 calendar months from the individual's start day for the home.

(7) An individual cannot be required to pay the interest equivalent amounts worked out under both subsections (3) and (6).

(8) The registered provider may require payment of an amount less than the interest equivalent amount required to be paid under subsection (2) or (4).

### 287-86 Restriction on retention of income derived

Despite subsections 287-80(2) and 287-85(1), (2) and (4), if a fee reduction supplement under section 231 of the Act applies to an individual and is reducing the individual's pre-2014 bond-related accommodation payment, a registered provider must not do either of the following in respect of the period for which the supplement applies to the individual:

(a) retain income derived from the investment of the individual's pre-2014 accommodation balance in accordance with subsection 287-85(1);

(b) require the individual to pay an interest equivalent amount under subsection 287-80(2) or 287-85(2) or (4) in relation to the individual's pre-2014 accommodation balance.

Section 287-90

### 287-90 Amounts to be deducted from pre-2014 accommodation balance

(1) A registered provider to whom a pre-2014 bond-related accommodation payment was paid by an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider may deduct from the pre-2014 accommodation balance:
  (a) a pre-2014 bond-related retention amount in respect of the pre-2014 bond-related accommodation payment (see section 287-95); and
  (b) an amount owed to the registered provider by the individual under a pre-2014 bond-related accommodation agreement or a service agreement; and
  (c) subject to subsection (3), an amount of interest on the amount referred to in paragraph (b) that does not exceed the maximum permissible interest rate for the individual's start day for the home.

(2) The registered provider must not deduct any other amounts from the pre-2014 accommodation balance.

(3) The registered provider may only charge interest for the period:
  (a) beginning on the day that is 1 month after the day on which the amount was payable under the pre-2014 bond-related accommodation agreement or service agreement; and
  (b) ending on the earlier of the following days:
    (i) the day on which the amount was paid;
    (ii) the day the provider ceased delivering the services to the individual at the home of the provider.

### 287-95 Pre-2014 bond-related retention amounts

(1) The maximum pre-2014 bond-related retention amount that may be deducted, from an individual's pre-2014 accommodation balance, during a year (the ***first year***) beginning on the individual's start day for an approved residential care home, or a year (a ***later year***) beginning on the anniversary of the individual's start day for the home, is:
  (a) if the pre-2014 bond-related accommodation payment is not more than the lower threshold amount—10% of the lower threshold amount; or
  (b) if the pre-2014 bond-related accommodation payment is more than the lower threshold amount but not more than the higher threshold amount—10% of the bond-related accommodation payment; or
  (c) if the pre-2014 bond-related accommodation payment is more than the higher threshold amount—10% of the higher threshold amount.

(2) However, despite subsections (3) and (4), the maximum pre-2014 bond-related retention amount for the individual for a later year is the same as the maximum pre-2014 bond-related retention amount for the first year.

(3) In subsection (1):

***lower threshold amount*** is:

(a) for a year beginning in a financial year beginning on or after 1 July 1997 and before 1 July 2025—the amount equal to the amount X worked out for the year in accordance with sections 97 and 98 of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time; or

(b) for a year beginning in a later financial year—the amount specified in column 2 of the table in subsection (4) for the financial year.

***higher threshold amount*** is:

(a) for a year beginning in a financial year beginning on or after 1 July 1997 and before 1 July 2025—an amount equal to the amount Y worked out for the year in accordance with sections 97 and 98 of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time; or

(b) for a year beginning in a later financial year—the amount specified in column 3 of the table in subsection (4) for the financial year.

(4) For the purposes of paragraph (b) of the definitions of ***lower threshold amount*** and ***higher threshold amount*** in subsection (3), the amount for a financial year is specified in the following table:

**Amounts for financial years beginning on or after 1 July 2025**

| Item | Column 1<br>For the financial year beginning on … | Column 2<br>the lower threshold amount is … | Column 3<br>and the higher threshold amount is … |
|---|---|---|---|
| 1 | 1 July 2025 | [Amount to be calculated] | [Amount to be calculated] |

(5) The maximum monthly pre-2014 bond-related retention amount is the amount worked out in accordance with subsection (1) divided by 12.

### 287-100 Restriction on deduction of pre-2014 bond-related retention amounts

(1) If a fee reduction supplement under section 231 of the Act applies to an individual and is reducing the pre-2014 accommodation balance, the registered provider delivering ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider must not deduct any pre-2014 bond-related retention amounts from the individual's pre-2014 accommodation balance during the period for which the supplement applies to the individual.

(2) Subject to subsections (3) and (5), a registered provider may deduct a pre-2014 bond-related retention amount from a pre-2014 accommodation balance for each month, or part of a month, during which the provider is delivering ongoing funded aged care services to the individual in an approved home of the provider in respect of which the pre-2014 bond-related accommodation payment was paid.

(3) Subject to subsection (5), pre-2014 bond-related retention amounts may only be deducted during the period of 5 years beginning on the individual's start day for

the first approved residential care home for which the individual paid a pre-2014 bond-related accommodation payment.

(4) The 5 year period referred to in subsection (3) is extended by one day for each day during any period:
   (a) for which a fee reduction supplement under section 231 of the Act applies to the individual and is reducing the pre-2014 accommodation balance; or
   (b) during which the individual is not accessing ongoing funded aged care services in an approved residential care home.

(5) If, before the pre-2014 bond-related accommodation payment was paid, amounts had already been deducted from a pre-2014 accommodation balance in respect of another pre-2014 bond-related accommodation payment previously paid by the individual for another approved residential care home, the period of 5 years referred to in subsection (3) is reduced by each month in respect of which a pre-2014 bond-related retention amount was so deducted.

Note: The effect of this subsection is that all periods spent accessing ongoing funded aged care services in the service group residential care after a pre-2014 bond-related accommodation payment is first paid will count towards the 5 year maximum under subsection (3) for deducting pre-2014 bond-related retention amounts.

Example: If an individual initially receives 6 weeks of ongoing funded aged care services through the service group residential care in an approved residential care home and then moves to another home, pre-2014 bond-related retention amounts can be deducted for 3 months in respect of the 6 weeks (see subsection (6)), but after that only for up to 4 years and 9 months.

(6) For the purposes of this section, if the registered provider delivers the services to the individual for 2 months or less, the individual is taken, for the purposes of working out the pre-2014 bond-related retention amounts payable, to have received the services during:
   (a) the whole of the month in which the provider started delivering the services to the individual; and
   (b) the 2 following months.

Example: An individual who started receiving ongoing funded aged care services on 20 January and left on 3 March would be taken to have received care for the whole of January, February and March. Therefore, pre-2014 bond-related retention amounts could be deducted for each of these months.

### 287-101 Pre-2014 bond-related accommodation payments to be used only for permitted purposes

(1) A registered provider must not use a pre-2014 bond-related accommodation payment unless the use is permitted by this section.

*Permitted uses*

(2) A registered provider is permitted to use a pre-2014 bond-related accommodation payment for the following:
   (a) for capital expenditure of a kind covered by subsection (3);

(b) to invest in a financial product (within the meaning of Division 3 of Part 7.1 of the *Corporations Act 2001*) covered by subsection (4);

(c) to make a loan in relation to which the following conditions are satisfied:

(i) the loan is not made to an individual;

(ii) the loan is made on a commercial basis;

(iii) there is a written agreement in relation to the loan;

(iv) it is a condition of the agreement that the money loaned will only be used as mentioned in paragraph (a), (b), (d) or (e) of this subsection;

(d) to refund, or to repay debt accrued for the purposes of refunding, pre-2014 accommodation balances;

(e) to repay debt accrued for the purposes of capital expenditure of a kind covered by subsection (3);

(f) to meet reasonable businesses losses that are incurred in the course of delivering funded aged care services within the period of 12 months after the day the registered provider begins to deliver funded aged care services to the individual through the service group residential care;

(g) to invest in a fund, but not a controlling entity of a fund, listed in item 2 of the first Schedule to *Banking exemption No. 1 of 2021* made under the *Banking Act 1959*.

(3) For the purposes of paragraphs (2)(a) and (e), the following kinds of capital expenditure are covered by this subsection:

(a) expenditure to acquire land on which are, or are to be built, the premises needed for delivering funded aged care services through the service group residential care, but only to the extent that the expenditure relates to those premises;

(b) expenditure to acquire, erect, extend or significantly alter premises used or proposed to be used for delivering funded aged care services through the service group residential care, but only to the extent that the expenditure relates to the delivery of those funded aged care services;

(c) expenditure to acquire or install furniture, fittings or equipment for premises used or proposed to be used for delivering funded aged care services through the service group residential care, when those premises are initially erected or following an extension, a significant alteration or a significant refurbishment, but only to the extent that the expenditure relates to the delivery of those funded aged care services;

(d) expenditure that is directly connected to expenditure covered by paragraph (a), (b) or (c).

(4) For the purposes of paragraph (2)(b), the following financial products are covered by this subsection:

(a) any deposit-taking facility made available by an ADI in the course of its banking business (within the meaning of the *Banking Act 1959*), other than an RSA;

(b) a debenture, stock or bond issued, or proposed to be issued, by the Commonwealth, a State or a Territory;

(c) a security;

(d) any of the following in relation to a registered scheme (within the meaning of the *Corporations Act 2001*):
  (i) an interest in the scheme;
  (ii) a legal or equitable right or interest in an interest covered by subparagraph (i);
  (iii) an option to acquire, by way of issue, an interest or right covered by subparagraph (i) or (ii);
(e) an interest in a scheme established for the purpose of investment in the delivery of funded aged care services through the service group residential care in an approved residential care home that:
  (i) is a managed investment scheme within the meaning of the *Corporations Act 2001*; and
  (ii) is not a registered scheme within the meaning of the *Corporations Act 2001*;
(f) a legal or equitable right or interest in an interest covered by paragraph (e);
(g) an option to acquire, by way of issue, an interest or right covered by paragraph (e) or (f).

### 287-102 Refund of pre-2014 accommodation balance

*Circumstances in which pre-2014 accommodation balance must be refunded*

(1) If a pre-2014 bond-related accommodation payment is paid to a registered provider, the provider must refund the pre-2014 accommodation balance if:
  (a) the individual dies; or
  (b) both of the following apply:
    (i) the registered provider ceases to deliver ongoing funded aged care services to the individual through the service group residential care in the approved residential care home to which the payment relates (other than because the individual is on leave);
    (ii) the registered provider has not transferred, or is not required to transfer, the pre-2014 accommodation balance to another registered provider under section 287-103.

*Period within which pre-2014 accommodation balance must be refunded*

(2) If paragraph (1)(a) applies, the pre-2014 accommodation balance must be refunded:
  (a) if the registered provider is shown the probate of the will of the individual or letters of administration of the estate of the individual—within 14 days after the day on which the provider was so shown; or
  (b) if the registered provider is not shown the probate of the will of the individual or letters of administration of the estate of the individual and the registered provider is shown other evidence that satisfies the provider that the pre-2014 accommodation balance is to be refunded to a person—within 14 days after the other evidence is shown to the provider.

(3) If paragraph (1)(b) applies, the pre-2014 accommodation balance must be refunded in accordance with the following table.

**When a pre-2014 accommodation balance must be refunded if paragraph (1)(b) applies**

| Item | Column 1<br>If … | Column 2<br>the pre-2014 accommodation balance must be refunded … |
|---|---|---|
| 1 | both of the following apply:<br>(a) the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care;<br>(b) the individual notified the registered provider of the move more than 14 days before the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i) | on the day on which the registered provider ceased delivering the services mentioned in subparagraph (1)(b)(i) |
| 2 | both of the following apply:<br>(a) the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care;<br>(b) the individual notified the registered provider of the move within 14 days before the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i) | within 14 days after the day on which the notice was given to the provider |
| 3 | both of the following apply:<br>(a) the individual is to move to another approved residential care home to receive ongoing funded aged care services through the service group residential care;<br>(b) the individual did not notify the provider of the move before the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i) | within 14 days after the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i) |
| 4 | items 1, 2 and 3 of this table do not apply | either:<br>(a) within 14 days after the day on which the provider ceased delivering the services mentioned in subparagraph (1)(b)(i); or |

**When a pre-2014 accommodation balance must be refunded if paragraph (1)(b) applies**

| Item | Column 1<br>If … | Column 2<br>the pre-2014 accommodation balance must be refunded … |
|---|---|---|
| | | (b) if the individual has agreed with the registered provider as mentioned in subsection (4) and the individual has notified the registered provider, in writing, that they wish to cease that agreement—within 14 days after the day on which the individual has notified the provider. |

(4) The agreement is an agreement between the individual and the registered provider to delay refunding the pre-2014 accommodation balance on condition that, if the individual requests re-entry to the approved residential care home, the registered provider must allow entry to the individual if:

(a) a room, or part of a room, is vacant in the approved residential care home; and

(b) the individual has an access approval in effect that includes the classification type ongoing for the service group residential care.

[The transitional rules will deal with refunds that were pending at the transition time.]

### 287-103 Transfer of pre-2014 accommodation balance to another registered provider

(1) This section applies if:

(a) a pre-2014 bond-related accommodation payment was paid by an individual to a registered provider (the ***outgoing provider***) for accommodation in an approved residential care home through which the provider delivers ongoing funded aged care services through the service group residential care to the individual; and

(b) the outgoing provider ceases to deliver ongoing funded aged care services through the service group residential care in the residential care home; and

(c) there is continuity of the delivery of those services to the individual through that service group in the same residential care home by another registered provider (the ***incoming provider***).

(2) The pre-2014 accommodation balance must not be transferred to the incoming provider if:

(a) the incoming provider delivers ongoing funded aged care services through the service group residential care only under one or more specialist aged care programs; or

(b) the registered provider does not deliver any ongoing funded aged care services through the service group residential care.

Note: This means the pre-2014 accommodation balance is not required to be transferred under section 287-103 in these circumstances and instead must be refunded in accordance with section 287-102: see subparagraph 287-102(1)(b)(ii).

(3) The outgoing provider must, by written notice, give the following information to the incoming provider in relation to the individual's pre-2014 accommodation balance:
   (a) the transfer day (which must be a day that is more than 14 days after the day the notice is given);
   (b) the pre-2014 accommodation payment and the day it was paid by the individual to the outgoing provider (or another registered provider);
   (c) if the pre-2014 accommodation balance has been previously transferred—the amount of the pre-2014 accommodation balance on the transfer day for each such transfer;
   (d) any amount of interest payable on or before the transfer day under section 287-103A in relation to the refundable deposit balance and the amount of that interest;
   (e) any amounts deducted under section 287-90 on or before the transfer day by the outgoing provider (or another registered provider) and the day the most recent amount was deducted;
   (f) any pre-2014 bond-related retention amounts deducted from a pre-2014 accommodation balance on or before the transfer day that have been taken to be applied in relation to the pre-2014 accommodation balance.

(4) The outgoing provider must give written notice to an individual of the proposed transfer of the individual's pre-2014 bond-related accommodation payment which includes:
   (a) details of the incoming provider; and
   (b) the transfer day referred to in paragraph (3)(a).

(5) A notice under subsection (4) must be given at least 14 days before the transfer day.

(6) The outgoing provider must transfer a pre-2014 accommodation balance on the transfer day for the pre-2014 accommodation balance referred to in paragraph (3)(a).

[The transitional rules will deal with the transfer of balances that were pending at the transition time.]

### 287-103A Payment of interest—refund of pre-2014 accommodation balances

(1) A registered provider must pay an amount of interest relating to a refund of a pre-2014 accommodation balance, worked out in accordance with subsections (2) and (3), to an individual on the day on which the registered provider refunds the pre-2014 accommodation balance to the individual if the registered provider is required under section 287-102 to refund the pre-2014 accommodation balance to the individual.

*Amount of base interest—balance refunded on or before last day of refund period*

(2) If a registered provider refunds a pre-2014 accommodation balance on or before the last day of the refund period, the amount of base interest on the pre-2014

accommodation balance is the amount worked out in accordance with the following formula:

$$\frac{BIR \times AB \times ND}{365}$$

where:

***AB*** is the amount of the pre-2014 accommodation balance.

***BIR*** is the base interest rate, calculated on the first day of the refund period.

***ND*** is the number of days in the period beginning on the day after the day on which the refunding event occurred and ending on the day on which the pre-2014 accommodation balance is refunded.

Note: Subsection (2) does not apply in the situation described in item 1 of the table in subsection 287-102(3) because column 2 of item 1 does not specify a refund period.

*Amount of base interest plus maximum permissible interest—balance refunded after last day of refund period*

(3) If a registered provider refunds a pre-2014 accommodation balance after the last day of the refund period, or after the day referred to in column 2 of item 1 of the table in subsection 287-102(3), the amount of interest on the pre-2014 accommodation balance is the amount worked out in accordance with the following formula:

$$\left(\frac{BIR \times AB \times ND(RP)}{365}\right) + \left(\frac{MPIR \times AB \times ND(PP)}{365}\right)$$

where:

***AB*** is the amount of the pre-2014 accommodation balance.

***BIR*** is the base interest rate, calculated on the first day of the refund period.

***MPIR*** is the maximum permissible interest rate for:

(a) if item 1 of the table in subsection 287-102(3) applies—the day after the day referred to in column 2 of item 1 of that table; or

(b) if item 2, 3 or 4 of the table in subsection 287-102(3) applies—the day after the last day in the refund period.

***ND(PP)*** is the number of days in the period:

(a) beginning on:

(i) if item 1 of the table in subsection 287-102(3) applies—the day after the day in column 2 of item 1 of that table; or

(ii) if item 2, 3 or 4 of the table in subsection 287-102(3) applies—the day after the last day of the refund period; and

(b) ending on the day on which the pre-2014 accommodation balance is refunded.

***ND(RP)*** is equal to:

(a) if item 1 of the table in subsection 287-102(3) applies—zero; or
(b) if item 2, 3 or 4 of the table in subsection 287-102(3) applies—the number of days in the period beginning on the day after the day on which the refunding event occurred and ending on the last day of the refund period.

## Division 4—Pre-2014 charge-related accommodation agreements

### 287-104 Entry into pre-2014 charge-related accommodation agreement

A registered provider may enter into a pre-2014 charge-related accommodation agreement with an individual in the pre-2014 accommodation class after the transition time in relation to an approved residential care home (the ***new home***) if:

(a) immediately before the transition time, an accommodation charge agreement was in effect for the individual; and

(b) the individual ceased (whether before or after the transition time) accessing funded aged care services in another approved residential care home and will start, or has started, accessing funded aged care services in the new home.

Note 1: The new home and the former home may be approved in relation to the same registered provider.

Note 2: An individual in the pre-2014 accommodation class may change homes before the transition time and still be a member of that class: see paragraph (b) of the definition of ***pre-2014 accommodation class***.

### 287-105 Information to be given before registered provider enters into a pre-2014 charge-related accommodation agreement with an individual

Before a registered provider enters into a pre-2014 charge-related accommodation agreement with an individual, the provider must:

(a) give the individual a copy of the proposed pre-2014 charge-related accommodation agreement that meets the requirements set out in section 287-115; and

(b) inform the individual of the following:

(i) that, if the individual has given the provider sufficient information to determine the value of the individual's assets, the provider is required to leave the individual with assets with a value at least equal to the individual's pre-2014 minimum permissible asset value;

(ii) the interest rate to be charged on amounts owed under the pre-2014 charge-related accommodation agreement;

(iii) the pre-2014 charge-related accommodation payment;

(iv) when a pre-2014 charge-related accommodation payment is not required;

(v) when a pre-2014 charge-related accommodation payment must not be charged at more than a specified daily amount because a fee reduction supplement applies to the individual and is reducing the individual's pre-2014 charge-related accommodation payment;

(vi) if a pre-2014 charge-related accommodation payment is paid—when the charge is refundable.

### 287-110 Time within which registered providers must enter into pre-2014 charge-related accommodation agreement

A registered provider must enter into a pre-2014 charge-related accommodation agreement with an individual in relation to an approved residential care home before, or within 21 days after, the individual's start day for the home.

### 287-115 Pre-2014 charge-related accommodation agreements

A pre-2014 charge-related accommodation agreement between a registered provider and an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home of the provider must set out the following:

(a) the individual's start day, or proposed start day, for the home;

(b) the pre-2014 charge-related accommodation payment that:

(i) will accrue for each day (including a day on which the individual is on leave from the home) if the individual starts accessing the services at the home; or

(ii) if the individual has already started to access the services at the home—has accrued and will accrue for each day (including a day on which the individual is on leave from the home);

(c) how the pre-2014 charge-related accommodation payment is to be paid;

(d) when the pre-2014 charge-related accommodation payment is payable;

(e) the individual's room that the pre-2014 charge-related accommodation payment entitles the individual to be provided with;

(f) any services that the pre-2014 charge-related accommodation payment entitles the individual to be provided with;

(g) that a fee reduction supplement under section 231 of the Act may apply to the individual and reduce the pre-2014 charge-related accommodation payment, including to nil;

(h) that if the individual wishes to move from the approved residential care home (the ***original home***) of the provider to another approved residential care home (the ***new home***) of another registered provider, the registered provider of the original home may ask the individual for permission to provide the following information to the registered provider of the new home:

(i) whether the individual has agreed to pay a pre-2014 charge-related accommodation payment;

(ii) if so, the payment agreed;

(iii) the number of days for which the payment accrued under the agreement.

### 287-120 Pre-2014 charge-related accommodation agreements may be incorporated into other agreements

For the purposes of this Division, an individual is taken to have entered into a pre-2014 charge-related accommodation agreement if the individual has entered into an agreement that contains the provisions required by section 287-115.

### 287-125 Pre-2014 charge-related accommodation agreements cannot affect requirements of this Division

The requirements of this Division apply despite any provision of a pre-2014 charge-related accommodation agreement, or any other agreement, to the contrary.

## Division 5—Pre-2014 charge-related accommodation payments

### Subdivision A—Charging of pre-2014 charge-related accommodation payments

#### 287-130 Charging of pre-2014 charge-related accommodation payments

A registered provider must comply with the following in relation to the charging of a pre-2014 charge-related accommodation payment to an individual for the delivery of ongoing funded aged care services to the individual through the service group residential care in an approved residential care home (the ***new home***) of the provider:

(a) subject to this section, a pre-2014 charge-related accommodation payment must be charged if:
  (i) the individual ceased accessing the services in another approved residential care home (the ***former home***) of the provider or another registered provider before or after the transition time and started accessing the services in the new home; and
  (ii) the individual paid a pre-2014 charge-related accommodation payment to access the services in the former home;

(b) the daily amount at which the pre-2014 charge-related accommodation payment accrues must not exceed the maximum provided for by section 287-135, and the individual must not be charged more than one pre-2014 charge-related accommodation payment to access the services in the home;

(c) the pre-2014 charge-related accommodation payment must not accrue after the day on which the registered provider ceases to deliver the services to the individual in the new home;

(d) if a fee reduction supplement under section 231 of the Act applies to the individual—the pre-2014 charge-related accommodation payment must be reduced (but not below zero) to reflect any amount of the supplement that is applied towards the payment;

(e) the registered provider must comply with the requirements of section 287-150 relating to payment of the pre-2014 charge-related accommodation payment;

(f) the individual may be required to pay interest to the registered provider in accordance with section 287-155 if some or all of the pre-2014 charge-related accommodation payment is not paid within the time that section permits;

(g) the registered provider must not charge a pre-2014 charge-related accommodation payment if:
  (i) the Commissioner has imposed a condition on the registration of the registered provider under section 143 of the Act; and
  (ii) the condition prohibits the provider charging a pre-2014 charge-related accommodation payment.

## Subdivision B—Daily accrual amounts of pre-2014 charge-related accommodation payments

### 287-135 Maximum daily accrual amount of pre-2014 charge-related accommodation payment

(1) Subject to subsection (2) and paragraph 287-130(d), the maximum daily amount at which a pre-2014 charge-related accommodation payment accrues is the lowest of the following:

(a) the amount of the daily accrual of the pre-2014 charge-related accommodation payment that was specified in the most recent pre-2014 charge-related accommodation agreement that was in effect for the individual;

(b) the amount (rounded down to the nearest cent) obtained by:

(i) taking the amount that, when subtracted from an amount equal to the value of the individual's assets at the start of the individual's start day for the approved residential care home to which the payment relates, leaves an amount at least equal to the individual's pre-2014 minimum permissible asset value; and

(ii) dividing the result by 2,080;

(c) if sections 117 and 119, or section 118, of the *Aged Care (Transitional Provisions) Principles 2014*, as in force immediately before the transition time, applied to the individual as at that time—the amount worked out in accordance with whichever of those sections was applicable.

Note: The operation of this section may be modified if, before entering into a pre-2014 charge-related accommodation agreement, the individual gives the registered provider a determination under section 329 of the Act of the value of the individual's assets. See subsection (4).

(2) If an individual seeking to access ongoing funded aged care services through the service group residential care at an approved residential care home of a registered provider does not, before entering into a pre-2014 charge-related accommodation agreement, give the provider sufficient information about the individual's assets for the provider to be able to determine the amount referred to in paragraph (1)(b), the maximum amount of the individual's accommodation is the lesser of:

(a) the amount referred to in paragraph (1)(a); and

(b) the amount referred to in paragraph (1)(c).

(3) The value of an individual's assets is to be worked out in accordance with section 330 of the Act.

(4) However, subsections (1) and (2) are modified as described in the table, and subsection (3) does not apply, if, before entering into the pre-2014 charge-related accommodation agreement, the individual gives the registered provider a copy of a determination that:

(a) is a determination under section 329 of the Act of the value of the individual's assets at a time (the ***valuation time***) that is before or at the start of the individual's start day for the home; and

(b) is in force at the start of the start day, if that is after the valuation time.

| **Modifications of subsections (1) and (2)** | | |
|---|---|---|
| **Item** | **Column 1**<br>**If …** | **Column 2**<br>**subsections (1) and (2) have effect as if …** |
| 1 | the valuation time is before the start of the start day for the home | (a) the reference in paragraph (1)(b) to the start of the individual's start day for the home were a reference to the valuation time; and<br>(b) the value of the individual's assets at the valuation time were the value specified in the determination; and<br>(c) subsection 287-45(3) defined ***pre-2014 minimum permissible asset value*** by reference to the basic age pension amount at the valuation time (instead of the start of the start day) |
| 2 | the valuation time is at the start of the start day for the home | the value of the individual's assets at the start of the individual's start day for the home were the value specified in the determination |

## Subdivision C—Payment of pre-2014 charge-related accommodation payments

### 287-150 Pre-2014 charge-related accommodation payment may be payable not more than one month in advance

(1) An individual may be required to pay a pre-2014 charge-related accommodation payment from the day that is one month before the day for which the payment will accrue.

(2) If the pre-2014 charge-related accommodation payment does not in fact accrue, the individual is entitled to a refund of the amount paid.

### 287-155 Registered provider may charge interest

(1) If:

(a) an individual is required, under a pre-2014 charge-related accommodation agreement, to pay an amount of pre-2014 charge-related accommodation payment to a registered provider; and

(b) the individual does not pay the required amount before the day that is one month after the day for which the payment accrues; and

(c) the agreement provides for interest to be charged on the balance outstanding at a specified rate;

the individual may be required to pay interest to the registered provider from the day that is one month after the day for which the payment accrues while the balance remains unpaid.

(2) However, the rate at which the interest is charged must not be more than twice the below threshold rate determined by the Minister under subsection 1082(1) of the Social Security Act.

Section 338-1

# Chapter 11—Governance of the aged care system

## Part 1—Introduction

### 338-1 Simplified outline of this Chapter

[To be drafted.]

# Part 2—Aged Care Quality and Safety Commission

## Division 1—Safeguarding functions of the Commissioner

### 349-5 Actions the Commissioner may take in dealing with reportable incidents

(1) The Commissioner must, upon receiving a notice about a reportable incident given by a registered provider under section 166-520 or 166-525, do the following:
  (a) acknowledge receipt of the notice;
  (b) take steps to consider the notice and the appropriateness of taking action in relation to that notice.

(2) The Commissioner may, upon receiving a notice about a reportable incident given by a registered provider under section 166-520 or 166-525, do one or more of the following:
  (a) refer the incident to whichever of the following the Commissioner considers appropriate:
    (i) the Australian Federal Police;
    (ii) the police force or police service of a State or Territory;
    (iii) a person or body with responsibilities in relation to the incident;
  (b) require or request the provider to undertake specified remedial action in relation to the incident within a specified period, including remedial action to ensure the safety, health and well-being of individuals receiving funded aged care services affected by the incident;
  (c) carry out an inquiry in relation to the incident in accordance with section 349-10;
  (d) take any other action to deal with the reportable incident that the Commissioner considers reasonable in the circumstances.

(3) The Commissioner may, upon receiving 2 or more notices about reportable incidents given by a registered provider under section 166-525, and in circumstances where the Commissioner considers it appropriate to do so, manage 2 or more notices about such reportable incidents through a single action, including one or more of the following:
  (a) refer the incidents to whichever of the following the Commissioner considers appropriate:
    (i) the Australian Federal Police;
    (ii) the police force or police service of a State or Territory;
    (iii) a person or body with responsibilities in relation to the incidents;
  (b) require or request the provider to undertake specified remedial action in relation to the incidents within a specified period, including remedial action to ensure the safety, health and well-being of the individuals receiving funded aged care services affected by the incident;
  (c) carry out an inquiry in relation to the incidents in accordance with section 349-10;
  (d) take any other action to deal with the reportable incidents that the Commissioner considers reasonable in the circumstances.

**Commented [A159]:** An ongoing issue with recording of SIRS reports is that a worker's name can be linked to an alleged incident prior to confirmation of their involvement, which may implicate an innocent party. Some incidents are reported but are unlikely to have occurred. There should be provision for the Commission to efficiently update the SIRS entry to confirm a worker's innocence.

**Commented [A160]:** Add timeframe for acknowledgement

**Commented [A161]:** It may not be necessary for the Commissioner to take further action. If a provider has addressed any issues, the Commissioner should be able to close the incident without further action.

**Commented [A162]:** Investigation by the Commission should be required prior to other actions.

**Commented [A163]:** This gives the Commissioner extremely broad discretion. What are some examples of what could be 'reasonable in the circumstances'?

**Commented [A164]:** Investigation by the Commission should be required prior to other actions.

**Commented [A165]:** This gives the Commissioner extremely broad discretion. What are some examples of what could be 'reasonable in the circumstances'?

### 349-10 Commissioner's inquiries in relation to reportable incidents

(1) The Commissioner may inquire into any of the following:
  (a) a reportable incident for a registered provider;
  (b) a series of reportable incidents that relate to the delivery of funded aged care services delivered by one or more registered providers;
  (c) the compliance of one or more registered providers with:
    (i) Division 1 of Part 10 of Chapter 4; or
    (ii) Subdivision G of Division 1 of Part 2 of Chapter 5.

(2) An inquiry may be carried out under subsection (1) whether or not any of the reportable incidents have been notified to the Commissioner under section 166-520 or 166-525.

(3) An inquiry may be carried out as the Commissioner thinks fit.

(4) Without limiting subsection (3), the Commissioner may:
  (a) consult with other persons, organisations and governments on matters relating to the inquiry; and
  (b) request information or documents that are relevant to the inquiry from any person; and
  (c) provide opportunities for individuals receiving funded aged care services to participate in the inquiry.

(5) The Commissioner may prepare and publish a report setting out the Commissioner's findings in relation to the inquiry.

**Commented [A166]:** This provides the Commissioner with very wide powers. There must be sufficient procedural fairness afforded to providers who are involved in such inquiries. Requests for information and documents etc should be reasonable and within sufficient timeframes.

**Commented [A167]:** It what circumstances would this occur/be considered appropriate?

### 349-15 Taking of other action not prevented by this Division

Nothing in this Division prevents the Commissioner from taking action under the Act in relation to:
  (a) a reportable incident for a registered provider; or
  (b) information or documents given to the Commissioner under:
    (i) this Division; or
    (ii) Division 1 of Part 10 of Chapter 4; or
    (iii) Subdivision G of Division 1 of Part 2 of Chapter 5.

## Division 2—Establishment and functions of the Complaints Commissioner

### 358-5 Complaints functions of the Complaints Commissioner—requirements for giving written reports to the Minister

For the purposes of paragraph 358(m) of the Act, the requirements in accordance with which the Complaints Commissioner must give the Minister written reports, in relation to complaints and feedback received by the Complaints Commissioner, are that:

(a) a report must be for a period (the ***reporting period***) of 6 months beginning on 1 January or 1 July; and

(b) the report for a reporting period must contain the following for the reporting period:

(i) the matters referred to in section 372-5 of this instrument;

(ii) any other matters that the Complaints Commissioner considers relevant; and

(c) the report for a reporting period must be given to the Minister within 3 months after the end of the reporting period.

Section 361-5

## Division 3—Complaints Commissioner—complaints and feedback

### Subdivision A—Preliminary

#### 361-5 Purpose of this Division

This Division is made for the purposes of subsection 361(1) of the Act.

### Subdivision B—How complaints may be made and withdrawn, and how feedback may be given

#### 361-10 How complaints may be made and feedback may be given

*Complaints*

(1) A person (the ***complainant***) may make a complaint to the Complaints Commissioner about:
  (a) the compliance with the Act of a registered provider or a responsible person or aged care worker of a registered provider; or
  (b) a registered provider acting in a way that is incompatible with the Statement of Rights.

*Feedback*

(2) A person may give the Complaints Commissioner feedback about a registered provider or a responsible person or aged care worker of a registered provider.

*Complaints and feedback*

(3) A complaint may be made, and feedback may be given, orally or in writing.

(4) A complaint may be made, and feedback may be given, anonymously.

(5) If:
  (a) a complainant makes a complaint or a person gives feedback; and
  (b) the complainant or person giving the feedback requests that any of the following information be kept confidential:
    (i) the identity of the complainant or person giving the feedback;
    (ii) the identity of a person identified in the complaint or feedback;
    (iii) any other details included in the complaint or feedback;

the Complaints Commissioner must take such steps as are reasonable in the circumstances to keep the information confidential.

Note: See also section 549 of the Act in relation to complaints or feedback that are disclosures that qualify for protection under section 547 of the Act (whistleblower protections), where the individual making the disclosure requests that the individual, or any other individual named in the request, remain anonymous.

**Commented [A168]:** What would feedback entail (as distinct from complaints) in this context? Is it effectively a complaint about something broader than the specified topics in subsection 361-10(1) or is it meant to be to allow people to provide positive feedback as well? If the latter, this would presumably reduce the Complaints Commissioner's resources for dealing with complaints.

### 361-15 How complaints may be withdrawn

If a complainant makes a complaint to the Complaints Commissioner under section 361-10, the complainant may withdraw the complaint, either orally or in writing, at any time.

Note 1: The Complaints Commissioner must deal with complaints (see section 361-40), and must do so by deciding to take no further action in relation to the complaint for a reason referred to in section 361-50 or deciding to undertake a resolution process under this Division in relation to the complaint (see section 361-42).

Note 2: The withdrawal of a complaint is a reason for which the Complaints Commissioner may decide to take no further action in relation to the complaint or decide to end a resolution process in relation to the complaint (see paragraph 361-50(b)).

Note 3: A complainant who withdraws a complaint will not receive certain communications under this Division (see paragraphs 361-25(2)(e), 361-30(2)(d) and 361-35(2)(d)) or be able to apply under Subdivision D for the reconsideration of a decision of the Complaints Commissioner in relation to the complaint.

## Subdivision C—Processes for dealing with complaints and feedback

### 361-20 Requirements for processes

*General*

(1) The Complaints Commissioner's processes for dealing with complaints and feedback must provide appropriate support and assistance (including access to advocates and language services) to:
  (a) complainants and persons giving feedback; and
  (b) individuals accessing funded aged care services to whom complaints or feedback relate.

Note: One of the complaints functions of the Complaints Commissioner is to uphold the rights under the Statement of Rights, and protect and enhance the safety, health, wellbeing and quality of life, of individuals accessing funded aged care services, by maintaining independent, transparent, accountable, accessible, safe and culturally safe processes for making complaints and giving feedback (see paragraph 358(a) of the Act).

**Commented [A169]:** Who is this referring to? Is this suggesting that complaints may be made about other residents (for example)? Or is this in relation to where a person has made a complaint about an issue which affects not only the complainant themselves, but also other residents (for example)?

*Complaints that are also disclosures that qualify for protection under section 547 of the Act (whistleblower protections)*

(2) The Complaints Commissioner's processes for dealing with complaints and feedback must include processes for dealing with complaints and feedback that are also disclosures that qualify for protection under section 547 of the Act (whistleblower protections).

### 361-25 Acknowledging receipt of complaints and feedback

(1) If:
  (a) a complainant makes a complaint to the Complaints Commissioner as mentioned in subsection 361-10(1); or
  (b) a person gives the Complaints Commissioner feedback as mentioned in subsection 361-10(2);

the Complaints Commissioner must, within 3 business days from the day the complaint was made or the feedback was given, give the complainant or the person who gave the feedback an acknowledgement of the receipt of the complaint or feedback.

(2) Subsection (1) does not apply to a complaint or feedback if:

(a) giving the complainant or the person who gave the feedback an acknowledgement of the complaint or feedback would contravene a provision of Chapter 7 of the Act (information management); or

(b) the complaint was made or the feedback was given anonymously; or

(c) the complainant or the person who gave the feedback cannot be contacted because of a request for confidentiality under subsection 361-10(5); or

(d) the complainant or the person who gave the feedback requested not to receive an acknowledgement of receipt of the complaint or feedback; or

(e) for a complaint—the complainant has withdrawn the complaint.

**Commented [A170]:** Should this state 'the complainant has withdrawn the complaint within 3 business days from the day the complaint was made' (as a person who made a complaint but withdrew it after 10 days, for example, should still receive an acknowledgement within the first 3 days)?

### 361-30 Referral of complaints and feedback to other persons or bodies

(1) This section applies if the Complaints Commissioner refers a complaint or feedback to another person or body under paragraph 358(e) of the Act.

Note: One of the complaints functions of the Complaints Commissioner is, for complaints and feedback that is better dealt with by other persons or bodies, to refer the complaints and feedback to those persons or bodies (see paragraph 358(e) of the Act).

*Giving written notice of referral*

(2) The Complaints Commissioner must give written notice of the referral to the complainant or person who gave the feedback, unless:

(a) giving written notice of the referral to the complainant or person who gave the feedback would contravene a provision of Chapter 7 of the Act (information management); or

(b) the complaint was made or the feedback was given anonymously; or

(c) the complainant or person who gave the feedback cannot be contacted because of a request for confidentiality under subsection 361-10(5) of this instrument; or

(d) for a complaint—the complainant has withdrawn the complaint.

*Giving information and documents to other person or body*

(3) Subject to Chapter 7 of the Act (information management) and subsection 361-10(5) of this instrument, the Complaints Commissioner must give the other person or body any information or documents that relate to the complaint or feedback and that are in the Complaints Commissioner's possession or under the Complaints Commissioner's control.

### 361-35 Communications with complainant, entity against which complaint made and other persons

*Communications with complainant*

(1) If a complainant makes a complaint to the Complaints Commissioner as mentioned in subsection 361-10(1), the Complaints Commissioner must:
  (a) communicate regularly with the complainant, as agreed with the complainant, about progress in dealing with the complaint; and
  (b) give the complainant a proposed complaint determination (see section 361-40) and seek the complainant's views on the proposed complaint determination.

(2) Subsection (1) does not apply if:
  (a) communicating regularly with the complainant or giving the complainant a proposed complaint determination would contravene a provision of Chapter 7 of the Act (information management); or
  (b) the complaint was made anonymously; or
  (c) the complainant cannot be contacted because of a request for confidentiality under subsection 361-10(5) of this instrument; or
  (d) the complainant has withdrawn the complaint; or
  (e) the complainant has requested not to receive communications about the complaint.

*Communications with entity against which complaint made*

(3) The Complaints Commissioner must give the entity against which the complaint is made written notice of the complaint as soon as practicable after the complaint was made.

**Commented [A171]:** This should be a specific timeframe e.g. 7 days.

(4) Subsection (3) does not apply if:
  (a) the giving of the notice would contravene a provision of Chapter 7 of the Act (information management); or
  (b) the Complaints Commissioner considers that the giving of the notice will, or is likely to:
    (i) place the safety, health or well-being of the complainant, an individual accessing funded aged care services or any other person at risk; or
    (ii) place the complainant or an individual accessing funded aged care services at risk of intimidation or harassment.

*Communications with other persons*

(5) If the complaint was made on behalf of an individual accessing funded aged care services, the Complaints Commissioner must communicate regularly with the following persons, as agreed with those persons, about progress in dealing with the complaint:
  (a) the individual;
  (b) the individual's supporter (if any);

(c) an independent aged care advocate who is providing support to the individual (if any), if the individual has consented to the Complaints Commissioner communicating with the advocate about the complaint.

(6) Subsection (5) does not apply in relation to a person if:

(a) communicating regularly with the person would contravene a provision of Chapter 7 of the Act (information management); or

(b) the person cannot be contacted because of a request for confidentiality under subsection 361-10(5) of this instrument; or

(c) the complaint has been withdrawn and the Complaints Commissioner has decided to take no further action in relation to the complaint, or to end a resolution process in relation to the complaint; or

(d) the person has requested not to receive communications about the complaint; or

(e) it is not appropriate to communicate with the person.

Note: For paragraph (e):

(a) an example of when it is not appropriate to communicate with an individual accessing funded aged care services about progress in dealing with a complaint is if the individual lacks capacity for the communication; and

(b) an example of when it may not be appropriate to communicate with an individual accessing funded aged care services, or supporters or advocates for such individuals, about progress in dealing with a complaint is if the complaint was made on behalf of a large number of such individuals.

### 361-40 Complaint determinations and seeking feedback

*Complaint determinations*

(1) If a complaint is made to the Complaints Commissioner about:

(a) the compliance with the Act of a registered provider or a responsible person or aged care worker of a registered provider; or

(b) a registered provider acting in a way that is incompatible with the Statement of Rights;

the Complaints Commissioner must, by the end of the period referred to in subsection (2):

(c) deal with and resolve the complaint; and

(d) prepare a written statement (a ***complaint determination***) setting out:

(i) what action (if any) the Complaints Commissioner took to deal with and resolve the complaint; and

(ii) what action (if any) should be taken by another person to deal with and resolve the complaint; and

(iii) information relating to the review or reconsideration of decisions made under the scheme; and

(e) give the complainant a copy of the complaint determination.

(2) For the purposes of subsection (1), the period is:

(a) 90 days from the day the complaint is made, unless paragraph (b) or (c) applies; or

(b) 120 days from the day the complaint is made, if:

**Commented [A172]:** It is important to recognise that no action may be taken. This should be communicated to individuals to manage expectations.

**Commented [A173]:** We support the inclusion of timeframes for when complaints must be resolved by so complaints do not go unresolved for too long, causing inefficiency for providers and the Complaints Commissioner.

(i) the Complaints Commissioner is satisfied that there are circumstances requiring a period of more than 90 days; and
(ii) the Complaints Commissioner has communicated the circumstances to the complainant; and
(iii) paragraph (c) does not apply; or

(c) 120 days from the day the complaint is made plus one or more additional periods of 30 days, for each of which:
(i) the Complaints Commissioner is satisfied that there are exceptional circumstances requiring the additional period and the Complaints Commissioner has communicated the exceptional circumstances to the complainant; or
(ii) the complainant has agreed to the additional period.

(3) The Complaints Commissioner must also give a copy of the complaint determination to:
(a) each person with whom the Complaints Commissioner has been communicating under subsection 361-35(5); and
(b) the entity against which the complaint is made.

*Seeking feedback*

(4) The Complaints Commissioner must also seek feedback from the following about how the complaint was dealt with and resolved:
(a) the complainant, if the Complaints Commissioner has been communicating with the complainant under subsection 361-35(1);
(b) each person with whom the Complaints Commissioner has been communicating under subsection 361-35(5);
(c) the entity against which the complaint is made.

**Commented [A174]:** This should be removed - this should not be a standalone justification for a longer time period, without exceptional circumstances.

**Commented [A175]:** There should be guiding criteria for what 'circumstances' and 'exceptional circumstances' warrant a longer resolution period - it is important this does not become a default option.
Could an example be included in the legislation similar to the Notes under subsection 361-60(7) and subsection 361-65(2)?

**Commented [A176]:** It is important that all parties involved in a complaint have the opportunity to provide feedback. What will the Complaints Commissioner do with this information? It should be used to inform and improve complaints processes and be considered from a balanced perspective.

### 361-42 Dealing with complaints—general

The Complaints Commissioner must deal with a complaint by:
(a) deciding to take no further action in relation to the complaint for a reason referred to in section 361-50; or
(b) deciding to undertake a resolution process under this Division in relation to the complaint.

### 361-45 Dealing with complaints—resolution processes

(1) This section applies if the Complaints Commissioner decides to undertake a resolution process under this Division in relation to the complaint.

*Actions that may be taken*

(2) The Complaints Commissioner may take any one or more of the following actions:
(a) require the entity against which the complaint is made to attempt to resolve the complaint and report back to the Complaints Commissioner within a specified period;

(b) require the entity against which the complaint is made to take other specified action in relation to the complaint within a specified period;

(c) investigate (other than under Part 3 of the Regulatory Powers Act (see Part 3 of Chapter 6 of the Act)) the circumstances giving rise to the complaint, including by:

(i) requiring the entity against which the complaint is made to give the Complaints Commissioner information or documents (or copies of documents); or

(ii) attending an approved residential care home or a home or community setting in which funded aged care services are delivered;

(d) consider information and documents;

(e) subject to Chapter 7 of the Act (information management), discuss the complaint, in person or by other means, with any of the following entities:

(i) the complainant;

(ii) the entity against which the complaint is made;

(iii) any other relevant person;

(f) facilitate a conciliation process, including by requesting any of the entities mentioned in paragraph (e) to participate in the process;

(g) conduct a restorative engagement process, including by requesting the entities mentioned in paragraph (e) to participate in the process.

Note: Other actions that the Complaints Commissioner may take under the Act are the following:

(a) request persons to give the Complaints Commissioner information or documents relevant to the Complaints Commissioner's functions (see section 359 of the Act);

(b) give a registered provider a required action notice in relation to a matter that relates to the registered provider that is raised in a complaint (see section 474 of the Act);

(c) require persons to attend before an authorised Commission officer to answer questions or give information or documents (or copies of documents) relevant to whether a registered provider, or a former registered provider, is complying with the Act in relation to a matter that relates to the Complaints Commissioner's functions (see section 488 of the Act).

*Ending resolution process*

(3) The Complaints Commissioner may decide to end the resolution process for a reason referred to in section 361-50.

### 361-50 Dealing with complaints—reasons for taking no further action or ending resolution processes

For the purposes of paragraph 361-42(a) and subsection 361-45(3), the reasons for which the Complaints Commissioner may decide to take no further action in relation to a complaint, or to end a resolution process in relation to a complaint, are as follows:

(a) the complaint has been resolved because:

(i) the complainant and the entity against which the complaint was made have agreed on an outcome; and

(ii) the entity against which the complaint was made has addressed the complaint to the satisfaction of the Complaints Commissioner;

**Commented [A177]:** The 'specified period' must be reasonable.

**Commented [A178]:** This should be within a reasonable timeframe and adequate notice.

(b) the complaint has been withdrawn;
(c) the Complaints Commissioner refers the complaint to another person or body under paragraph 358(e) of the Act;
(d) the circumstances giving rise to the complaint cannot be determined;
(e) the complainant has been provided with an explanation in relation to the complaint and is satisfied with the explanation;
(f) the complaint is frivolous, vexatious or not raised in good faith;
(g) the complaint is, or has been, the subject of legal proceedings;
(h) the complaint is already being dealt with, or has already been dealt with, under section 361 of the Act or a former complaints scheme;
(i) the complaint is better dealt with, or is already being dealt with, through a different process (for example, through the Commissioner's safeguarding functions or under Chapter 6 of the Act (regulatory mechanisms);
(j) the circumstances giving rise to the complaint occurred more than one year before the complaint was made, and no longer exist;
(k) the complaint is subject to a coronial inquiry;
(l) an individual accessing funded aged care services who is identified in the complaint does not wish the complaint to be considered by the Complaints Commissioner;
(m) having regard to all the circumstances, no further action is required, or the continuation of the resolution process is not required.

**Commented [A179]:** It is vital this provision remains to enable these types of complaints not to proceed.

## Subdivision D—Reconsideration of decisions to take no further action or to end resolution processes

### 361-55 Requesting reconsideration of decisions

(1) If the Complaints Commissioner decides to take no further action in relation to a complaint, or to end a resolution process in relation to a complaint, the following entities may request the Complaints Commissioner to reconsider the decision:
(a) the complainant, unless:
(i) the complainant withdrew the complaint before the decision was made; or
(ii) the reason for the decision was that the complaint is frivolous, vexatious or not raised in good faith;
(b) the entity against which the complaint was made.

(2) The request:
(a) may be made orally or in writing; and
(b) must set out the reasons for the request; and
(c) must be given to the Complaints Commissioner within the following period:
(i) 42 days after the entity making the request receives the complaint determination for the complaint;
(ii) if the Complaints Commissioner determines a longer period for the request than would otherwise apply under subparagraph (i)—that period.

**Commented [A180]:** Recommend changing to 'identify' or 'explain'. 'Set out' implies written communication, but requests can be made orally per subparagraph 261-55(2)(a).

**Commented [A181]:** Recommend changing to 'made'. Aligned with the above comment - 'given to' implies written communication, but requests can be made orally per subparagraph 261-55(2)(a).

**Commented [A182]:** In what circumstances would the Commissioner do so here? There should be a limit to the timeframe for the 'longer period'.

### 361-57 Withdrawing requests for reconsideration of decisions

(1) If an entity requests the reconsideration of a decision, the entity may withdraw the request, either orally or in writing, at any time.

(2) If the entity withdraws the request before a reconsideration decision is made under section 361-60 in relation to the decision, the Complaints Commissioner must end the reconsideration of the decision.

### 361-60 Reconsideration of decisions

(1) This section is subject to section 361-57.

(2) If a request is made under section 361-55 for reconsideration of a decision, the Complaints Commissioner must:
  (a) personally reconsider the decision; or
  (b) cause the decision to be reconsidered by a person:
    (i) to whom the Complaints Commissioner has delegated the Complaints Commissioner's functions and powers under this Division; and
    (ii) who was not involved in making the decision; and
    (iii) who occupies a position that is at least the same level as that occupied by the person who made the decision.

(3) The person who reconsiders the decision is the ***internal decision reviewer***.

*Reconsideration decision*

(4) After reconsidering the decision, the internal decision reviewer must:
  (a) affirm the decision; or
  (b) set the decision aside and:
    (i) if the decision was to take no further action in relation to a complaint—make a new decision under section 361-42 in relation to the complaint; or
    (ii) if the decision was to end a resolution process in relation to a complaint—decide to undertake a new resolution process under this Division in relation to the complaint.

(5) The decision made by the internal decision reviewer is the ***reconsideration decision***.

(6) After the internal decision reviewer makes the reconsideration decision, the internal decision reviewer must, within the period referred to in subsection (7), give the entity who requested the reconsideration written notice of:
  (a) the reconsideration decision; and
  (b) the reasons for the decision.

(7) For the purposes of subsection (6), the period is:
  (a) 60 days from the day the reconsideration request is made, unless paragraph (b) applies; or
  (b) 60 days from the day the reconsideration request is made plus one or more additional periods, for each of which the Complaints Commissioner:

(i) is satisfied that there are reasonable grounds to believe that the additional period is required; and

(ii) has communicated the grounds to the entity who requested the reconsideration.

Note: For subparagraph (b)(i), an example of when a period of more than 60 days may be required is if the complaint is particularly complex.

*Application of sections 588 and 589 of the Act to internal decision reviewers*

(8) If the internal decision reviewer is a delegate of the Complaints Commissioner, section 588 and subsection 589(2) of the Act apply to the internal decision reviewer in the same way that those provisions would apply to the Complaints Commissioner if the Complaints Commissioner were the internal decision reviewer.

### 361-65 Period for completing resolution process following reconsideration decision

(1) This section applies if:

(a) a reconsideration decision under section 361-60 is to make a new decision under section 361-42 in relation to a complaint, and that new decision is to undertake a resolution process under this Division in relation to the complaint; or

(b) a reconsideration decision under section 361-60 is to undertake a new resolution process under this Division in relation to a complaint.

(2) The internal decision reviewer must complete the resolution process within:

(a) 90 days from the day the reconsideration request is made, unless paragraph (b) applies; or

(b) 120 days from the day the reconsideration request is made, if the Complaints Commissioner:

(i) is satisfied that there are reasonable grounds to believe that a period of more than 90 days is required; and

(ii) has communicated the grounds to the entity who requested the reconsideration.

Note: For paragraph (b), the following are examples of when a period of more than 90 days may be required to complete a resolution process:

(a) if the complaint is particularly complex;

(b) if the internal decision reviewer requires extensive further information to assist in completing the process.

**Commented [A183]:** Do these grounds need to relate to the circumstances of the specific complaint (such as being a complex matter per the Note) or can they be more general (e.g. if the Complaints Commissioner has limited resources at the time)? There should be specific criteria as to what constitutes 'reasonable grounds', to ensure this is applied appropriately.

**Commented [A184]:** As above, do these grounds have to relate to the specific matter (such as the examples in the Notes) or can they be more general (e.g. resource constraints)?

Section 372-5

## Division 4—Reporting and planning

### 372-5 Annual report—other matters relating to complaints functions of the Complaints Commissioner

For the purposes of paragraph 372(i) of the Act, the other matters that an annual report mentioned in section 372 of the Act for a reporting period (within the meaning of that section) must include are the following:

(a) the total number of complaints received by the Complaints Commissioner in the reporting period about the following:
  (i) the compliance with the Act of a registered provider or a responsible person or aged care worker of a registered provider;
  (ii) a registered provider acting in a way that is incompatible with the Statement of Rights;

(b) of that total, the numbers of complaints that relate to the following:
  (i) each State or Territory;
  (ii) each provider registration category;
  (iii) each registered provider;
  (iv) each approved residential care home;

(c) of that total, the numbers of complaints:
  (i) that have been dealt with by the Complaints Commissioner; and
  (ii) that are ongoing; and
  (iii) of the numbers mentioned in subparagraphs (i) and (ii), the numbers of each that relate to each State and Territory;

(d) a summary of the topics of complaints;

(e) for each topic—the number of complaints that relate to the following:
  (i) each provider registration category;
  (ii) each registered provider;
  (iii) each approved residential care home;

(f) a summary of the outcomes of complaints;

(g) a summary of the feedback received under subsection 361-40(4);

(h) the average time taken to deal with complaints;

(i) the percentage of complaints in relation to which subsection 361-40(1) (complaint determinations) was complied with within each of the periods mentioned in subsection 361-40(2);

(j) for complaints in relation to which subparagraph 361-40(2)(c)(i) applied—a summary of the exceptional circumstances mentioned in that subparagraph relating to those complaints;

(k) the number of decisions to take no further action reconsidered under Subdivision E of Division 3, and of that number:
  (i) the number for which the reconsideration decision was to affirm the decision; and
  (ii) the number for which the reconsideration decision was to set the decision aside and decide to make a new decision under section 361-42 in relation to the complaint;

**Commented [A185]:** Complaints that proceeded vs those that did not should be clearly distinguished. Otherwise, there is a risk that frivolous and vexatious complaints are captured in this summary without qualification, which could contribute to a perception that such complaints are reasonable and require action from providers. There should also be a statement of the number of complaints that were withdrawn.

(l) the number of decisions to end resolution processes reconsidered under Subdivision E of Division 3 and, of that number:
  (i) the number for which the reconsideration decision was to affirm the decision; and
  (ii) the number for which the reconsideration decision was to set the decision aside and decide to undertake a new resolution process under Division 3;

(m) a summary of activities undertaken by the Complaints Commissioner in performing the complaints functions mentioned in paragraphs 358(f), (g), (h), (i) and (j) of the Act.

# Chapter 13—Information management

## Part 4—Information sharing

### Division 1—Publication by System Governor

### Subdivision A—System Governor must publish information about funded aged care services generally

#### 544-5 Preliminary

(1) This Subdivision is made for the purposes of subsection 544(1) of the Act.

(2) Information published in accordance with this Subdivision must:
  (a) be published on a portal or website maintained by the Department; and
  (b) be published as soon as practicable after the information is given to the System Governor.

Note: See also subsection 544(3) of the Act, which relates to not publishing certain personal information.

#### 544-10 Pricing information

If a registered provider gives a report to the System Governor under section 166 of the Act, in accordance with section 166-1505 of this instrument (relating to prices of services), the System Governor must publish the information in that report.

#### 544-15 Approved residential care home—income and expenditure

(1) The System Governor must publish information about the following matters in relation to an approved residential care home of a registered provider:
  (a) the provider's income in relation to the approved residential care home in a financial year for the provider;
  (b) expenditure by the provider on the following matters in relation to the approved residential care home in the financial year:
    (i) the delivery of funded aged care services, including labour costs;
    (ii) catering;
    (iii) maintenance;
    (iv) cleaning and laundry;
    (v) administration;
  (c) the provider's profit or loss in relation to the approved residential care home in the financial year.

**Commented [A186]:** What about commercially sensitive information? This should not be publicly available.

(2) To avoid doubt, the requirements in subsection (1) do not apply in respect of the delivery of funded aged care services delivered only under the NATSIFACP or the MPSP.

### 544-20 Approved residential care home—other information

(1) The System Governor must publish information about the following matters in relation to an approved residential care home of a registered provider registered in the provider registration category residential care:

(a) information given to the System Governor in accordance with paragraph 166-710(1)(a) (relating to kinds of feedback and complaints);

(b) information given to the System Governor in accordance with paragraph 166-710(1)(b) (relating to improvements made by the provider);

(c) information given to the System Governor in accordance with paragraph 166-710(1)(c) (relating to initiatives to support a diverse and inclusive environment);

(d) subject to subsection (2)—information given to the System Governor in accordance with paragraph 166-710(1)(d) (relating to the representation of different demographic groups in the membership of the governing body);

(e) information given to the System Governor in accordance with [to be drafted] (relating to the total number of individuals accessing funded aged care services in the approved residential care home);

(f) information given to the System Governor in accordance with [to be drafted] (relating to the occupancy rate of total available beds in the approved residential care home);

(g) information given to the System Governor in accordance with [to be drafted] (relating to the number of individuals who commenced accessing funded aged care services in the approved residential care home);

(h) information given to the System Governor in accordance with [to be drafted] (relating to the number of individuals who ceased accessing funded aged care services in the approved residential care home).

(2) The System Governor must not publish information in accordance with paragraph (1)(d) relating to the demographic group of a member of a governing body of a registered provider unless that member has consented to the publishing of that information.

### 544-25 Nursing and transition care

(1) The System Governor must publish information about the following matters in relation to a registered provider registered in the provider registration category nursing and transition care:

(a) information given to the System Governor in accordance with paragraph 166-710(1)(a) (relating to kinds of feedback and complaints);

(b) information given to the System Governor in accordance with paragraph 166-710(1)(b) (relating to improvements made by the provider);

(c) information given to the System Governor in accordance with paragraph 166-710(1)(c) (relating to initiatives to support a diverse and inclusive environment);

(d) subject to subsection (2)—information given to the System Governor in accordance with paragraph 166-710(1)(d) (relating to the representation of different demographic groups in the membership of the governing body);

(e) information given to the System Governor in accordance with [to be drafted] (relating to the total number of individuals to whom the provider delivers funded aged care services under the TCP).

(2) The System Governor must not publish information in accordance with paragraph (1)(d) relating to the demographic group of a member of a governing body of a registered provider unless that member has consented to the publishing of that information.

(3) To avoid doubt, the requirements in subsection (1) do not apply in respect of the delivery of funded aged care services delivered only under the NATSIFACP or the MPSP.

(4) To avoid doubt, the requirements in paragraphs (1)(c) and (d) do not apply in respect of the delivery of funded aged care services delivered only under the TCP.

### 544-30 Approved residential care home—direct care responsibilities

(1) The System Governor must publish information about the following matters in relation to an approved residential care home of a registered provider:

(a) information given to the System Governor in accordance with [to be drafted] (relating to the required combined staff average amount of direct care per individual per day in respect of the approved residential care home for the quarter worked out under subsection 176-20(1));

(b) information given to the System Governor in accordance with [to be drafted] (relating to the required registered nurse average amount of direct care per individual per day in respect of the approved residential care home for the quarter worked out under subsection 176-20(2));

(c) information given to the System Governor in accordance with [to be drafted] (relating to the average amount of direct care delivered in the approved residential care home by direct care staff members of the registered provider per mainstream counted individual per day during the quarter);

(d) information given to the System Governor in accordance with [to be drafted] (relating to the average amount of direct care delivered in the approved residential care home by enrolled nurse staff members of the registered provider per mainstream counted individual per day during the quarter);

(e) information given to the System Governor in accordance with [to be drafted] (relating to the average amount of direct care delivered in the approved residential care home by registered nurse staff members of the registered provider per mainstream counted individual per day during the quarter).

Note: See also Subdivision A of Division 2 of Part 6 of Chapter 5 to this instrument (Delivery of direct care—mainstream providers).

(2) To avoid doubt, the requirements in subsection (1) do not apply in respect of the delivery of funded aged care services delivered only under the NATSIFACP or the MPSP.

## Subdivision B—Information that System Governor may publish about particular funded aged care services

### 545-20 Additional matters that the System Governor may publish

For funded aged care services delivered in a particular residential care home or home or community setting, the matters are the following:

(a) any information included in a report referred to in section 166-805 of this instrument (relating to reporting requirements relating to registered nurses);

(b) if the provider has been granted an exemption from section 175 of the Act (relating to registered nurses) in relation to the residential care home:

(i) the steps the provider has taken to ensure that the clinical care needs of the care recipients residing in the residential care home will be met during the period for which the exemption is in force; and

(ii) confirmation that the System Governor is satisfied that those steps are reasonable;

(c) any information included in a report referred to in section 166-10, 166-15, 166-20 or 166-25 of this instrument (relating to service staff and individuals who have received certain vaccinations);

(d) any information included in any of the following:

(i) an aged care financial report referred to in section 166-310 of this instrument;

(ii) a response to a request for further information given under subsection 166-310(8) of this instrument (relating to an aged care financial report);

(iii) a financial support statement referred to in section 166-315 of this instrument;

(iv) a response to a request for further information given under subsection 166-315(7) of this instrument (relating to a financial support statement);

(v) a care minutes performance statement referred to in section 166-335 of this instrument;

(vi) an audit referred to in subsection 166-335(5) of this instrument of a care minutes performance statement;

(vii) a quarterly financial report referred to in section 166-340 of this instrument;

(viii) a response to a request for further information given under subsection 166-340(11) of this instrument (relating to a quarterly financial report);

(ix) a general purpose financial report referred to in section 166-345 of this instrument;

(x) a response to a request for further information given under subsection 166-345(10) of this instrument (relating to a general purpose financial report);

(xi) an audit referred to in section 166-350 of this instrument of a general purpose financial report;

(xii) an annual prudential compliance statement referred to in section 166-360 of this instrument;

(xiii) an audit referred to in section 166-385 of this instrument of a general purpose financial report;

(xiv) a report referred to in section 166-705 of this instrument (relating to governing body statements);

(xv) a report referred to in section 166-710 of this instrument (relating to provider operations reporting); and

(e) any information included in an annual wellness and reablement report referred to in section 166-615 of this instrument (relating to CHSP reporting);

(f) the grade assigned to a provider in a final assessment report referred to in section 110-30 of this instrument (relating to an entity's conformance with the Aged Care Quality Standards);

(g) any information included in an audit referred to in section 110-38 of this instrument (relating to an entity's conformance with the Aged Care Quality Standards);

(h) any information relating to a compliance notice given under section 481 or 482 of the Act, including:

(i) the date the compliance notice was sent to the provider;

(ii) brief details of the non-compliance or possible non-compliance;

(iii) action that the provider must take, or refrain from taking, to address the non-compliance or possible non-compliance;

(iv) the period within which the provider must take, or refrain from taking, the action to address the non-compliance or possible non-compliance;

(v) whether the System Governor or the Commissioner (as applicable) is satisfied that the provider has complied with the compliance notice;

(vi) whether the compliance notice is varied or revoked;

(i) any information included in an annual activity report referred to in section 166-725 of this instrument (relating to MPSP reporting);

(j) any information included in an annual statement of financial compliance and income expenditure referred to in section 166-730 of this instrument (relating to MPSP reporting);

(k) any information included in a service demographics report referred to in section 166-735 of this instrument (relating to MPSP reporting).

Note: See also subsection 545(2) of the Act, which relates to not publishing certain personal information.

**Commented [A187]:** We are concerned that *possible* non-compliance can be published, as this can lead to reputational damage for providers if it proves unfounded. Recommend removing references to possible non-compliance from these provisions.

## Division 2—Publication by Commissioner

### 546-5 Purpose of this Division

For the purposes of paragraph 546(1)(l) of the Act, this Division prescribes matters, about which the Commissioner may publish information, relating to funded aged care services delivered in a particular residential care home or home or community setting by a particular registered provider.

### 546-10 Matters included in or related to final assessment reports for approved residential care homes

For funded aged care services delivered in a particular residential care home, the matters are matters included in or related to the final assessment report of a home assessment of the home, including, but not limited to, the following:

(a) the report's findings;
(b) information considered in reaching those findings;
(c) the grade assigned for conformance with the Aged Care Quality Standards for the registered provider's delivery of funded aged care services in the approved residential care home.

### 546-15 Matters included in or related to final audit reports

For funded aged care services delivered in a particular residential care home or home or community setting, the matters are matters included in or related to a final audit report of an entity's ability to conform with the Aged Care Quality Standards, including, but not limited to, the following:

(a) the name of the entity to which the final audit report relates;
(b) the date of completion of the final audit report;
(c) a summary of the outcome of the audit including the grade assigned for conformance with the Aged Care Quality Standards (as outlined in the audit methodology);
(d) to the extent that the audit relates to services delivered in a particular approved residential care home:
  (i) the name of the approved residential care home; and
  (ii) the date of completion of the home assessment conducted in accordance with subsection 110-26(2); and
  (iii) a summary of the outcome of the home assessment, including the grade assigned (as outlined in the audit methodology) for conformance with any of the Aged Care Quality Standards assessed at the approved residential care home.

Note: Home assessment outcomes about an approved residential care home in which funded aged care services are delivered by a registered provider may be published before the completion of the final audit report (see section 546-10).

Section 555-5

# Chapter 14—Miscellaneous

## Part 1—Introduction

### 555-5 Simplified outline of this Chapter

[To be drafted.]

# Part 2—Reconsideration and review of decisions

### 556-5 Decisions by the Commissioner

The following table prescribes decisions and entities for the purposes of table item 31 in subsection 556(1) of the Act.

| **Decisions by the Commissioner** | | |
|---|---|---|
| **Item** | **Column 1**<br>**Decision** | **Column 2**<br>**Entity** |
| 1 | A decision under subsection 507-20(3) of this instrument to not make a requested correction to information that is included in the register of banning orders in relation to an entity | The entity |
| 2 | A decision under subsection 507-25(5) of this instrument not to make a proposed correction, or to make a different correction, to information that is included in the register of banning orders in relation to an entity | The entity |

### 557-5 Decisions by the System Governor

The following table prescribes decisions and entities for the purposes of table item 44 in section 557 of the Act.

| **Decisions by the System Governor** | | |
|---|---|---|
| **Item** | **Column 1**<br>**Decision** | **Column 2**<br>**Entity** |
| 1 | A decision under subsection 175-25(1) of this instrument to refuse to grant an exemption from subsection 175(1) of the Act to a registered provider in relation to a residential care home | The registered provider |
| 2 | A decision under subsection 175-50(1) of this instrument to revoke a registered provider's exemption from subsection 175(1) of the Act in relation to a residential care home | The registered provider |
| 3 | A decision under subsection 211-10(6) of this instrument to determine a longer account period for an individual for the classification type short-term for the service group assistive technology | Each of the following:<br>(a) the individual;<br>(b) the registered provider |
| 4 | A decision under subsection 211-20(5) of this instrument to determine an amount for an individual who has the classification level AT High for the classification type short-term for the service group assistive technology | Each of the following:<br>(a) the individual;<br>(b) the registered provider |
| 5 | A decision under subsection 220-5(5) of this instrument to determine a longer account period for an individual for the classification type short-term for the service group home modifications | Each of the following:<br>(a) the individual; |

Section 557-5

**Decisions by the System Governor**

| Item | Column 1<br>Decision | Column 2<br>Entity |
|---|---|---|
| | | (b) the registered provider |
| 6 | A decision under paragraph 197-5(1)(b) of this instrument that subsection 197-5(2) (circumstances in which the fee reduction supplement will apply to an individual for the service groups home support, assistive technology and home modifications) does not apply to an individual | Each of the following:<br>(a) the individual;<br>(b) the registered provider |
| 7 | A decision under section [to be drafted] of this instrument to revoke a determination for a fee reduction supplement for an individual for the service groups home support, assistive technology and home modifications | Each of the following:<br>(a) the individual;<br>(b) the registered provider |
| 8 | A decision to refuse to make a determination under subsection 230-30(1) of this instrument that an approved residential care home is a significantly refurbished home | The registered provider |
| 9 | A decision to refuse to make a determination under subsection 230-35(1) of this instrument that an approved residential care is a significantly refurbished home | The registered provider |
| 10 | A decision under paragraph 230-35(5)(a) of this instrument that the System Governor is not satisfied, as referred to in paragraph 230-35(1)(b), that an approved residential care home meets the requirements in paragraphs 230-35(3)(a) to (h) | The registered provider |
| 11 | A decision under paragraph 231-15(1)(b) of this instrument that subsection 231-15(2) (circumstances in which the fee reduction supplement will apply to an individual for the service group residential care) does not apply to an individual | Each of the following:<br>(a) the individual;<br>(b) the registered provider |
| 12 | A decision under section [to be drafted] of this instrument to revoke a determination for a fee reduction supplement for an individual for the service group residential care | Each of the following:<br>(a) the individual;<br>(b) the registered provider |
| 13 | A decision under subsection 246A-5(2) of this instrument to determine that a judgment or settlement is to be treated as having taken into account the future costs of delivering funded aged care services to an individual, and the part of the compensation under the judgment or settlement that is to be treated as relating to those future costs | The individual |
| 14 | A decision under subsection 246A-5(3) of this instrument to determine the part of the compensation that is to be treated as relating to the future costs of delivering funded aged care services to an individual | The individual |

**Decisions by the System Governor**

| Item | Column 1<br>Decision | Column 2<br>Entity |
|---|---|---|
| 15 | A decision under paragraph 263-10(2)(b) of this instrument not to approve the proposed transfer of a service delivery branch of a registered provider to another registered provider | Each registered provider |

Australian Government
Department of Health and Aged Care

# Appendix 2

# Meal obligation for in-home aged care and community respite

## Explainer document for Release 4b of the Rules of the new *Aged Care Act* 2024

This document provides an overview of the proposed meal obligation outlined under the Rules of the new *Aged Care Act 2024* (new Act) (^148-20). Consultation on this provision is occurring as part of Stage 4b consultation on the Rules of the new Act.

## Overview

A meal obligation has been developed to regulate Commonwealth funded meals and refreshments delivered to an older person's home and provided during community respite under the new Act. The obligation aims to ensure meals and refreshments are nutritious, appetising and have regard to older people's abilities and preferences. Providers are required to have meals and refreshments assessed by an Accredited Practising Dietitian (APD) and drive continuous improvement through implementation of a quality assurance framework that considers older people's satisfaction with meals and refreshments.

The obligation was developed considering the differences between the residential care and home and community care settings including:

- meals in the community may not provide 100% of nutrition for older people as older people commonly supplement funded meals with other food and drinks.
- older people use meal services differently, some have three meals a day, while others occasionally receive delivered meals.

As such, the obligation ensures meals and refreshments delivered meet the nutritional needs of the cohort of people over the aged of 65 years[1]. While the obligation does not require providers to address each older person's individual needs and preferences, the quality assurance framework requirement ensures older people's feedback on meals including their personal preferences is considered by providers when developing meals and menus.

To support dignity of risk and choice for older people the obligation will not monitor or seek to influence older people's decisions regarding the meals they select.

The meal obligation would apply to registered providers who deliver meal services under provider registration category[1] – Home and community services and category 4 – Personal and care support in the home and community delivering community, centre-based and

**Commented [A1]:** It needs to be made clear whether "refreshments" means drinks and/or the provision of food other than meals. Recommend terminology is used which is consistent with the strengthened Aged Care Quality Standards which uses 'meals, drinks and snacks'.

**Commented [A2]:** To aid readability, recommend don't abbreviate to APD as it is not a commonly known abbreviation.

**Commented [A3]:** Guidance is required on how registered providers can implement such a framework.

**Commented [A4]:** For clarity, recommend change to 'the intention of the obligation is that meals, snacks, and drinks (including for specialised diets) are tailored to meet the nutritional needs of people aged 65 years or older as a cohort'.

[1] 50 years and over for Aboriginal and Torres Strait Islander peoples

cottage respite. Under the new Act, registered providers are responsible for meeting all regulatory requirements even when a subcontracted company or associated provider may be used to deliver services.

## Interpretation

### Meals and refreshments are appropriate for older people

The intention of the meal obligation is to ensure that meals and refreshments delivered are appropriate for the needs of older people aged 65 years and older. For example, meals and refreshments would be designed considering the needs of older people as a cohort such as higher protein and calcium requirements. Meals and refreshments designed for specialised diets such as vegetarian, low sodium, diabetic or texture modified will consider the needs of older people requiring these diets.

**Commented [A5]:** For clarity, recommend delete both sentences and replace with "For example, meals, snacks and drinks including adequate protein and calcium requirements."

Providers must have regard for the abilities and preferences of older people when delivering meals and refreshments. Providers would be expected to make available meals and refreshments in line with the needs of each older person's identified specialised diet needs such as gluten free meals.

### APD assessment

To ensure meals and refreshments offered by a registered provider are nutritious and appetising, APDs must assess meals and refreshments at least annually including menus for specialised diets. APDs would consider the most appropriate contemporary and evidence-based practice to make their assessment of meals and refreshments to determine if they are appetising and nutritious. It would be expected that where new or modified menu items are added following APD review, the provider has considered advice from the APD on how to develop meals that are appropriate for the intended audience of the meals and refreshments. Where access to APDs is limited such as in geographically challenged areas, APD assessment can be conducted remotely however should include assessment of photos and videos to assess appeal. Additional guidance will be provided to assist APDs and providers to understand what meal and refreshment assessment should consider.

**Commented [A6]:** Providers will need to be funded appropriately for this new requirement.

### Quality assurance framework

The quality assurance framework seeks to ensure meals and refreshments are continuously improved. The obligation ensures feedback from older people is considered as part of the quality assurance framework. Feedback could be sourced from a range of activities that fit the needs of providers and older people such as surveys with older people, telephone calls or discussions when meals are delivered to an older person's home. This feedback must include older people's satisfaction with aspects of the meals and refreshments such as taste, size and variety. To continuously improve meals, providers must also consider the APD assessment of meals and refreshments.

**Commented [A7]:** This is an unrealistic requirement. They should be reviewed and any appropriate changes made to ensure they continue to be nutritious and appetising.

**Commented [A8]:** Standardised survey questions and question prompts from the Department or the Commission are recommended.

In what format will providers need to collate and share the results with the Commission, when audited?

Australian Government
Department of Health and Aged Care
Aged Care Quality and Safety Commission

# Process for managing complaints

**The below information refers to actions the Complaints Commissioner (supported by Commission staff) would take under the proposed rules for complaints management as required by the *Aged Care Act 2024*.**

## Step 1

### Collect and Triage

**The Commission will:**

- gather information from you and assess any risks
- ensure they understand your complaint and the outcome you want
- take immediate action if an older person is at serious risk of harm
- provide you with details about aged care advocacy services.

**Timeline: Within 3 business days**

## Step 2

### Assess

**The Commission will:**

- clarify issues with you and explain the steps in the complaints process
- contact the provider about your concerns and start gathering information
- let you know if it is going to take longer to assess your complaint.

**Timeline: Within 10 business days**

## Step 3

### Resolve

**The Commission will:**

- talk to you about what they will do to resolve your complaint, such as open disclosure or conciliation
- advise you of all actions they will require~~s~~ your provider to take
- provide you with fortnightly progress updates (unless agreed otherwise)
- let you know if resolving your complaint will take longer, once they have all the information.

## Step 4

### Finalise

**The Commission will:**

- try to get the outcome you want
- ensure any risks to you, and any other older people, are managed
- ensure your provider is meeting their legislated obligations
- talk through the outcome of your complaint with you, before it is closed
- advise of possible next steps, if you are unhappy with the outcome
- send you a letter explaining the outcome of your complaint.

**Timeline: Within 90 days from receiving complaint**

**Appendix 3**

You can make a complaint about **any aspect of your care** from aged care services, including **your rights**.
For more information about complaints policy and processes, visit **agedcarequality.gov.au** or by phone on **1800 951 822**.



**Commented [A1]:** Does there need to be a distinction or caveat somewhere which states that a lot of these steps (in terms of the communication with the complainant throughout the process) won't happen if a complaint is made anonymously?

**Commented [A2]:** The information in this document assumes that a complaint will have basis. Some complaints will not, and should not, proceed if they are frivolous or vexatious (for example). Resources like this for individuals should be tempered accordingly to manage expectations.

**Commented [A5]:** This statement is leading. The commission is not an advocate but an assessor of compliance.

**Commented [A3]:** Per earlier comment, this assumes that a resolution process will be undertaken, which will not necessarily be the case.

**Commented [A4]:** Providers may not be required to take action. This should be qualified with wording such as 'where applicable', or by replacing the word 'all' with 'any'.