ACCPA
Aged & Community Care Providers Association

6 December 2024

Department of Health and Aged Care

To whom it may concern,

New Aged Care Act Rules consultation – Release 2a – funding related to Support at Home

The Aged & Community Care Providers Association (ACCPA) appreciates the opportunity to provide feedback on the funding as contained within the second tranche of the new Aged Care Act rules released for consultation.

ACCPA is the national organisation representing providers of aged care to older Australians, delivering retirement living, seniors housing, residential care, home care, community care and related services.

We welcome the opportunity to have visibility of, and provide feedback on, the new Aged Care Act rules prior to their implementation, supporting a well-designed legislative framework. Our feedback is provided in the context of the information available at present and we are yet to see all rules relevant to Support at Home, including those in Chapter 2 of the Aged Care Bill 2024. We are therefore unable to provide comprehensive feedback on the interdependencies and cohesiveness of the suite of legislation as a whole.

ACCPA's key messages and recommendations are provided below, with specific comments on the draft Rules contained in the attached appendices.

1. Home care funding components

R1 Account cessation timeframes should increase from 60 days to 90 days after consumers exit services, enabling finalisation of home modification accounts and contributions, among other matters.

R2 Care Management should be calculated based on the approved budget classification level rather than an interim budget. In addition, funding mechanisms should be established to support individuals with significant long-term vulnerabilities or where care management needs of the cohort the organisation supports exceed the pool of care management funding.

R3 The Rural and Remote supplement needs to be expanded to include MM 2 through to MM 7 regions. A costing study needs to be undertaken to consider weightings and premiums required for these regions to fund specialist services, as well as technologies and freight costs.

R4 Providers should be permitted to charge 110% on goods and services supplied by directly sourced individual providers, including when the invoice exceeds the National Efficient Unit Price, or charge the Nationally Efficient Unit Price regardless of the associated provider charges.

R5 Address the feedback as provided in Appendix 1.

We have reviewed the draft funding Rules 2a with the expectation that the unit and supplement prices will be sufficient to fund all business costs (except care management,

for which we have made recommendations in this submission and in Appendix 1), and that the pricing framework will enable provider sustainability and service delivery in all regions of Australia.

We are concerned that some components of the rules, as currently written, do not provide the practical financial flexibility needed to support the delivery of aged care services. We are similarly concerned about the financial safeguards for providers and consumers that support fund recovery on services and goods delivered.

Extending account cessation timeframes from 60 days to 90 days after consumers exit services will create the necessary flexibility for providers to finalise the budget including settling outstanding home modification accounts and consumer reimbursements. While the current program allows 70 days to finalise accounts and make claims, a minimum of a 90-day timeframe is required under the new in-home care program due to the additional financial process complexities.

Additional Care Management funding mechanisms to support individuals with significant vulnerabilities, or in cases where care management needs surpass available resources, need to be developed. These mechanisms could include assessments for higher-level care management subsidies when care management consistently exceeds 10% of a consumer's budget, as well as supplementary funding options such as grants or block funding to address situations where the organisations care management resources have been fully utilised.

Providers should have the option to determine if they account for the care management 'pool' of funding at the organisational or service level. This option will enable providers to have increased flexibility in provision of care management in areas of greater need.

We strongly recommend that the Care Management contribution to the provider pool is calculated on the approved budget classification level, to ensure consumers receive sufficient support to organise services and address needs identified in their assessments. Consumers may be assessed by the My Aged Care assessment team as having complex care requirements, but allocated an interim budget that does not align with their assessed needs. In these cases, they will likely require additional care management support to ensure they receive adequate support to minimise the consumers' clinical risk. This approach is critical for protecting vulnerable adults by bridging the gap between their needs and available funding.

Expanding the Rural and Remote Supplement to include Modified Monash (MM) regions 2 through 7 is essential to address the additional costs for delivering services in these areas. A costing study should be undertaken to determine appropriate weightings for these regions, ensuring that premiums adequately fund specialist services, advanced technologies, and freight costs. This approach will help to ensure equitable access of services for older Australians living in regional and remote areas.

The component of the rules relating to recovery of costs for services individually directly sourced (section 273B) needs to be reconsidered so that providers are permitted to either:

- charge up to 110% on goods and services supplied by directly sourced individual providers, including when invoices exceed the National Efficient Unit Price, or
- charge the National Efficient Unit Price for the service regardless of the associated providers charges.

This adjustment is critical to enabling providers to recover administrative quality assurance costs associated with managing these arrangements. The decision relating to this element of the rules will have a direct impact on a provider's capacity to enable consumer choice and flexibility in care.

Estimates from members, that have calculated the financial implications of section 273B (b) of the rules, indicate significant revenue losses that will impact on their sustainability. These risks are particularly acute during the transitional period from 2025 to 2027,

before consumers are able to directly engage multiple providers. This confirms the need to revisit this component of the rules to balance consumer choice with the financial viability of providers. If home and community care providers cannot maintain viability, a significant portion of the sector will fail, ultimately reducing the availability of aged care across Australian communities.

Additional recommendations need to be incorporated into section 205C, when this section is being drafted:

1) that it is not mandatory to itemise Care Management spending on a consumer budget/statement. The itemisation of care management spending can have unintended consequences of limiting the flexibility of the care management pool, which could be particularly notable in the Rural townships.
2) the individual should be able to receive multiple care management supplements simultaneously. This will ensure recognition of increased need for people living with multiple complexities.

Finally, there is a need to further integrating rights-based principles throughout the rules. For example, strengthening consumer choice including through mechanisms for self-management.

For further and more detailed feedback, please see **Appendix 1.**

2. Market stability through transition

R6 That the Government fund a 20% care management cap for Support at Home, for a minimum of 12 months, supporting ongoing care management during transition.

R7 That the Government request IHACPA include transition costs in its pricing framework for Support at Home providers in the first two years and undertake a study to ensure an equitable method of delivering this funding to the market.

R8 That the Government request IHACPA conducts a mid-cycle pricing review within 6 months of Support at Home program's commencement, in consultation with the sector, to understand necessary pricing adjustments to ensure sustainability of all service types and fund business costs including regulation requirements.

R9 Given the extremely short lead times for price setting prior to 1 July 2025 commencement of Support at Home, Government should support sector sustainability through service list prices, aiming to maintain 2024-25 funding levels at a minimum.

This consultation comes at a critical and sensitive time for the home care sector. The scale of Support at Home reform is unprecedented and impacts both the existing sector and new entrants. By 2035, it will provide access to services for 1.4 million older people. In doing so, aged care providers will be fundamental in meeting community expectations of the Royal Commission into Aged Care Quality and Safety as well as the first principle of the Aged Care Taskforce, 'to support older people to live at home for as long as they wish and can do so safely'.

Our home and community care members have advised the scale of change and pressure is problematic, particularly within the timeframes and funding mechanisms planned. There is a high risk of providers exiting the market or reducing their capacity, at a time when sector stability is required to respond to long waiting lists for home care packages and increasing numbers of older Australians expected to access the program in coming years.

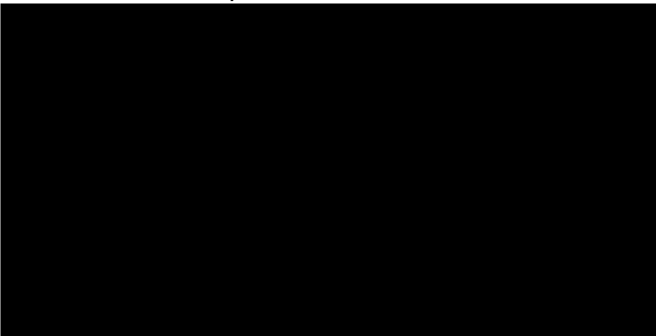
The Department and the Government need to incorporate feedback from home care providers and learnings from the NDIS Review in relation to pricing, and managing risks related to market stability, growth, and meeting increased demand.

In order to maintain and increase confidence in aged care services in the community, the Department and the Government need to immediately enact a communication strategy about program changes and funding design including consumer contributions.

Finally, the Government, the Department, and IHACPA have an important role to play in mitigating risks related to the limited time between the full release of pricing advice and commencement of Support at Home. Central to this includes activities related to transition pricing, aimed at both accounting for the costs involved in implementing reforms and reducing the risk of untested pricing on sector viability and quality.

Thank you again for the opportunity to contribute to the consultation on the new Aged Care Act rules – funding. Please contact [redacted], Head of Policy, at [redacted] if you have any questions or would like to discuss this submission.

Yours sincerely



Attachments

- APPENDIX 1: Feedback on Aged Care Rules 2a release – funding related to Support at Home.

CONSULTATION DRAFT

Aged Care Rules 2024

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

Dated 2024

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

APPENDIX 1: Feedback on Aged Care Rules 2a release – funding related to Support at Home

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Chapter 1—Introduction

Part 1—Preliminary

1 Name

This instrument is the *Aged Care Rules 2024*.

2 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 Authority

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

4 Simplified outline of this instrument

[To be drafted.]

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Part 2—Definitions

5 Definitions

Note: The following expressions used in this instrument are defined in the Act:

(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.

Commented [A1]: Require definition for Service delivery branch. Aged Care Bill states the meaning is prescribed by the rules.

In this instrument:

Act means the *Aged Care Act 2024*.

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

(a) the Repatriation Commission has accepted liability to pay a pension under the Veterans' Entitlements Act; or
(b) the Military Rehabilitation and Compensation Commission has accepted liability to pay compensation under the *Military Rehabilitation and Compensation Act 2004* or the *Safety, Rehabilitation and Compensation Act 1988*.

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

AT-HM List means the Assistive Technology and Home Modifications List published by the Department, as existing on [date of commencement of this instrument].

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

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

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

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

(a) full-pensioner;
(b) part pensioner;
(c) seniors health card holder;
(d) self-funded retiree.

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MM category means a category for an area provided for by the Modified Monash Model and known as MM 1, MM 2, MM 3, MM 4, MM 5, MM 6 or MM 7.

Modified Monash Model means the model known as the Modified Monash Model (MMM) 2019 developed by the Department to categorise areas according to geographical remoteness and population size, as the model existed on 1 October 2022.

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

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

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

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

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

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

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

veteran means a person:

(a) who is taken to have rendered eligible war service under section 7 of the Veterans' Entitlements Act; or

(b) in respect of whom a pension is payable under subsection 13(6) of that Act; or

(c) who is:

  (i) a member of the Forces within the meaning of subsection 68(1) of that Act; or

  (ii) a member of a Peacekeeping Force within the meaning of that subsection; or

(d) who is:

  (i) a member within the meaning of the *Military Rehabilitation and Compensation Act 2004*; or

  (ii) a former member within the meaning of that Act; or

(e) who is an employee within the meaning of the *Safety, Rehabilitation and Compensation Act 1988*.

Note: The Acts mentioned in paragraphs (d) and (e) provide that, in some cases:

(a) a member of the Forces, or a member of a Peacekeeping Force, includes a person who is no longer serving; and

(b) an employee includes a person who has ceased to be an employee.

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

11 Cost

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

17 Entry day

(1) This section is made for the purposes of the definition of ***entry day*** in section 7 of the Act.

Classification type ongoing

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

Classification type short-term for the service groups home support, assistive technology and home modifications

Commented [A2]: Expand for consistency: Add 'end of life pathway' and 'restorative care pathway' if assistive technology and home modifications are referenced.

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

Classification type short-term for the service group residential care

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

Classification type hospital transition

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

18 Final efficient price

(1) This section is made for the purposes of the definition of ***final efficient price*** in section 7 of the Act.

Commented [A3]: Definition required in rules: 'final efficient price', as stated in the Aged Care Bill.

Services for which subsidy basis is efficient price

(2) The final efficient price for the delivery of a funded aged care service for which the subsidy basis is efficient price to an individual on a day is the sum of:

(a) the base efficient price for an hour of the service on the day; and

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(b) the loading amount for each loading type that applies to the service on the day.

Services for which subsidy basis is unit price

(3) The final efficient price for the delivery of a funded aged care service for which the subsidy basis is unit price to an individual on a day is the sum of:

(a) the base unit price for a unit of the service on the day; and

(b) the loading amount for each loading type that applies to the service on the day.

20 Lifetime cap

For the purposes of the definition of ***lifetime cap*** in section 7 of the Act, the amount is $130,000.

21 Price charged

For the purposes of the definition of ***price charged*** in section 7 of the Act, the price charged for the delivery by a registered provider of a funded aged care service for which the subsidy basis is efficient price or unit price means the amount charged by the provider for an hour or unit of the service (whichever is applicable).

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Chapter 7—Funding of aged care services—Commonwealth contributions

Part 1—Introduction

190 Simplified outline of this Chapter

[to be drafted]

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Part 2—Subsidy for home support

Division 1—Person-centred subsidy

Subdivision A—Eligibility

191 Excluded classification levels

For the purposes of subparagraph 191(2)(d)(ii) of the Act, the following classification levels are prescribed:

(a) CHSP class 1;

(b) CHSP class 2;

(c) CHSP class 3;

(d) CHSP class 4.

Commented [A4]: Recommend: CHSP classes should not include a financial value before 2027. A financial value would reduce flexibility for providers and consumers, achieved through grant funding.

Subdivision B—Available ongoing home support account balance

193A Quarterly rollover credit

For the purposes of subsection 193(5) of the Act, the amount for a quarter is the higher of the following amounts:

(a) $1,000;

(b) the amount that is 10% of the sum of the following for the day on which the amount is credited, multiplied by the number of days in the quarter:

(i) the base individual amount for the individual for the classification type for the service group;

(ii) the sum of any primary person-centred supplements for the classification type for the service group that apply to the individual;

(iii) for an individual covered by subsection 203(3) of the Act—the base provider amount for a registered provider in relation to the individual.

Commented [A5]: Requires further definition and consistency with Chapter 4, Part 2, Division 1, Section 203 Available service delivery branch account balance

193B Order of debits

For the purposes of subsection 193(8) of the Act, the order is the order in which the claims are made.

Commented [A6]: Recommend: Require financial safeguards for providers to ensure fund recovery on services and goods delivered, as well as dispute resolution rules, need to be defined.

193C Circumstances for no credits

For the purposes of subsection 193(10) of the Act, each of the following are circumstances in which a credit to an individual's notional ongoing home support account, which would otherwise be required under subsection 193(4) or (5) of the Act, is not to be made:

(a) more than 393 days have passed since an ongoing funded aged care service was delivered to the individual through the service group home support;

(b) more than 60 days have passed since the day a registered provider provided a start notification to the System Governor and the Commissioner about starting the delivery of funded aged care services to the individual through the service group residential care.

193D Circumstances for ceasing of account

For the purposes of subsection 193(11) of the Act, the circumstances in which an individual's notional ongoing home support account ceases are that:

(a) more than 60 days have passed since the individual died; and

(b) any longer period determined by the System Governor under paragraph 251(3)(c) of the Act for a claim for person -centred subsidy that is payable to a registered provider under section 250 of the Act for the delivery of a funded aged care service to the individual has ended.

Commented [A7]: Recommend: Account cessation timeframes should increase from 60 days to 90 days after consumers exit services enabling matters such as finalising home modification accounts, and contributions. Currently providers have 70 days to finalise accounts and make claims, in a program with greater uniformity in financial processes.

Subdivision C—Base individual amounts

194A Classification type ongoing

For the purposes of section 194 of the Act, the following table sets out the base individual amounts for individuals for the classification type ongoing for the service group home support.

[These amounts are approximate and subject to change]

Base individual amounts for the classification type ongoing

Item	Column 1 For an individual that has the classification level …	Column 2 if the individual is a full budget individual, the amount is … ($)	Column 3 if the individual is an interim budget individual, the amount is… ($)
1	SAH level 1	27.13	16.24
2	SAH level 2	39.46	23.67
3	SAH level 3	54.24	32.54
4	SAH level 4	73.97	44.38
5	SAH level 5	98.63	59.17
6	SAH level 6	118.36	71.02
7	SAH level 7	143.01	85.81
8	SAH level 8	192.33	115.4

Commented [A8]: Recommend: Care Management needs to be calculated on the approved budget classification level not the interim budget that is assigned. This will ensure consumers receive the support required to organise services when their service needs, as assessed by the Single Assessment Service, extend above funding available, . This will help ensure the safety of vulnerable adults.

Action: Increase the amounts in column 3 to include the 10% care management allocation included in the full budget.

194B Classification type short-term

For the purposes of section 194 of the Act, the following table sets out the base individual amounts for individuals for the classification type short-term for the service group home support.

[These amounts are approximate and subject to change]

Base individual amounts for the classification type short-term

Item	Column 1 For an individual that has the classification level …	Column 2 the amount is … ($)
1	SAH restorative care pathway	71.43
2	SAH end-of-life	297.62

Subdivision D—Available short-term home support account balance

195A Order of debits

For the purposes of subsection 195(5) of the Act, the order is the order in which the claims are made.

195B Circumstances for ceasing of account

For the purposes of subsection 195(7) of the Act, the circumstances in which an individual's notional short-term home support account ceases are that:

(a) the individual's classification level for the classification type short-term for the service group home support was SAH end-of-life; and

(b) 60 days have passed since the end of the maximum period of effect for that classification level; and

(c) any longer period determined by the System Governor under paragraph 251(3)(c) of the Act for a claim for person-centred subsidy that is payable to a registered provider under section 250 of the Act for the delivery of a funded aged care service to the individual has ended.

Commented [A9]: Recommend: Account cessation timeframes should increase from 60 days to 90 days after consumers exit services enabling matters such as finalising home modification accounts, and contributions. Currently providers have 70 days to finalise accounts and make claims, in a program with greater uniformity in financial processes.

Subdivision E—Primary person-centred supplements

196A Supplements, circumstances and amounts

For the purposes of section 196 of the Act:

(a) the following table sets out the primary person-centred supplements for an individual for a day for a classification type for the service group home support, and the amount of the supplements; and

(b) this Subdivision sets out the circumstances in which the supplements will apply to individuals.

Commented [A10]: Recommend: Dementia Supplement should be considered as a 'Primary person-centred supplement' if a consumers needs extend beyond the approved classification due to their cognition.

[These amounts are approximate and subject to change]

Supplements and amounts

Item	Column 1 Supplement	Column 2 Amount
1	Oxygen supplement	$14.11
2	Enteral feeding supplement	(a) for bolus feeding—$22.36 (b) for non-bolus feeding—$25.11
3	Veterans' supplement	the amount that is 11.5% of the base individual amount for the individual's classification level for the classification type for the service group for the day, rounded up to the nearest cent

196B Oxygen supplement—applicability

Oxygen supplement applies to an individual for a day if:

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(a) on the day, the care and services plan for the individual covers the delivery of a funded aged care service in the service type nursing care to the individual; and

(b) under the plan, the service includes providing oxygen to the individual:

(i) other than because of an emergency; and

(ii) other than on a short-term or episodic basis; and

(iii) using materials and equipment hired, temporarily obtained or owned by the provider; and

(c) a medical practitioner or a nurse practitioner has certified, in writing, that the individual has a continual need for the provision of oxygen.

Commented [A11]: Amend: Improve clarity of wording e.g. nursing care must be included in the service and care plan to deliver oxygen supplement.

196C Enteral feeding supplement—applicability

Enteral feeding supplement applies to an individual for a day if:

(a) on the day, the care and services plan for the individual covers the delivery of the funded aged care service nutrition supports to the individual; and

(b) under the plan, the service includes supplying enteral supplementary dietary products to the individual, other than for intermittent or supplementary enteral feeding given in addition to oral feeding; and

(c) a medical practitioner has certified, in writing, that the individual has a medical need for enteral feeding.

196D Veterans' supplement—applicability

Veterans' supplement applies to an individual for a day if:

(a) the individual is a veteran with an accepted mental health condition; and

(b) the individual has, before, on or after that day, authorised either or both of the following to disclose to a registered provider that the individual is a veteran with an accepted mental health condition:

(i) the Secretary of the Department administered by the Minister administering the Veterans' Entitlements Act;

(ii) the Secretary of the Department administered by the Minister administering the *Human Services (Centrelink) Act 1997*.

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Division 2—Provider -based subsidy

Subdivision A—Eligibility

201 Eligible funded aged care services

For the purposes of paragraph 201(b) of the Act, the funded aged care service home support care management is prescribed.

Subdivision B—Available service delivery branch account balance

203A Day by which registered provider must give start notification

For the purposes of paragraph 203(3)(a) of the Act, the day in the previous quarter is the last day in the previous quarter.

203B Amount to be credited

For the purposes of subsection 203(4) of the Act, the amount to be credited to the account in relation to an individual for a day is the sum of the following for the day, multiplied by the number of days in the quarter:

(a) the base provider amount for the registered provider in relation to the individual;

(b) any provider-based supplements that apply to the service delivery branch of the registered provider in relation to the individual.

203C Day for periodic rollover re-set and amount to be credited

(1) This section is made for the purposes of subsection 203(6) of the Act.

(2) The day is 1 July in each year.

(3) For an account that was established between 1 January and 30 June in a year, the amount is:

(a) for 1 July in that year—the amount that was in the account immediately before the account was debited to zero; and

(b) for 1 July in a later year—the amount under subsection (4).

(4) For any other account, the amount is the lesser of the following:

(a) the amount that was in the account immediately before the account was debited to zero;

(b) the amount most recently credited to the account under subsection 203(5) of the Act.

203D Order of debits

For the purposes of subsection 203(7) of the Act, the order is the order in which the claims are made.

Commented [A12]: Recommend: Additional Care Management funding mechanisms required for individuals with significant vulnerabilities. Mechanisms may include assessment for higher level care management subsidy when their care management support consistently exceeds 10% of their consumer budget.

Commented [A13]: Recommend: Additional Care Management funding mechanisms included for situations where organisations have utilised all care management. Mechanisms may include additional supplements or grant based block funding.

Commented [A14]: Recommend: Providers should have the option to determine if they account for the care management 'pool' of funding at the organisational or service level. This option will enable providers to have increased flexibility in provision of care management in areas of greater need.

Commented [A15]: Further definition required for 203C. Unclear on rule purpose and instruction.

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203E Circumstances for ceasing of account

For the purposes of subsection 203(9) of the Act, the circumstance in which a notional service delivery account for a registered provider in relation to a service delivery branch of the provider ceases is that the registered provider has reported to the System Governor, under subsection 166(1) of the Act, that the service delivery branch has closed.

Subdivision C—Base provider amount

204 Classification type ongoing

For the purposes of section 204 of the Act, the following table sets out the base provider amount for a registered provider in relation to an individual covered by subsection 203(3) of the Act for individuals for the classification type ongoing for the service group home support.

Commented [A16]: Add: 'Daily' provider amount

[These amounts are approximate and subject to change]

Base provider amounts for the classification type ongoing

Item	Column 1 For an individual that has the classification level ...	Column 2 if the individual is a full budget individual, the amount is ... ($)	Column 3 if the individual is an interim budget individual, the amount is... ($)
1	SAH level 1	3.01	1.81
2	SAH level 2	4.38	2.63
3	SAH level 3	6.03	3.62
4	SAH level 4	8.22	4.93
5	SAH level 5	10.96	6.57
6	SAH level 6	13.15	7.89
7	SAH level 7	15.89	9.53
8	SAH level 8	21.37	12.82

Subdivision D—Provider-based supplements

205A Care management supplement

For the purposes of subsection 205(1) of the Act, the supplement care management supplement is prescribed.

205B Care management supplement—applicability

For the purposes of paragraph 205(2)(a) of the Act, the circumstances in which care management supplement will apply to a service delivery branch of a registered provider in relation to an individual on a day are that:

(a) the individual is an Aboriginal or Torres Strait Islander person; or
(b) the individual is homeless or at risk of homelessness; or

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(c) the individual is a care leaver, that is, an individual who has spent time in institutional care or out of home care (such as orphanages and foster care), and includes an individual who is a Forgotten Australian, a former child migrant or a member of the Stolen Generations; or

(d) the individual is referred to the provider by the care finder program funded by the Department; or

(e) veterans' supplement applies to the individual under section 196D of this instrument.

205C Care management supplement—amount

For the purposes of paragraph 205(2)(b) of the Act, the amount of care management supplement in relation to an individual is [to be drafted].

Commented [A17]: Recommend: Consider during drafting 205C:

1)Consideration needs to be given to administrative burden of itemising Care Management spending to a consumer budget/statement.
2)A individual should be able to receive multiple supplements which is a recognition of increased complexities.

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Part 3—Subsidy for assistive technology

Division 1—Eligibility

209 Excluded classification levels

For the purposes of subparagraph 209(2)(d)(ii) of the Act, the classification level AT CHSP is prescribed.

Commented [A18]: Further definition required: Confirm if Part 3, Division 1, 209 is stating that the SaH AT-HM program can not be accessed through CHSP referral. If not, add further detail.

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Division 2—Available assistive technology account balance

211A Account period for classification type ongoing

For the purposes of subsection 211(1) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type ongoing for the service group assistive technology, the account period for the account is the period beginning on the entry day and ending at the earlier of the following:

(a) the end of the day the individual dies;

(b) the end of the maximum period of effect for the classification level.

211B Account period for classification type short-term

(1) For the purposes of subsection 211(1) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type short-term for the service group assistive technology, the account period for the account is:

(a) the period of 12 months beginning on the entry day for the individual; or

(b) if subsection (2) applies to the individual:

(i) the period of 24 months beginning on the entry day for the individual; or

(ii) if the System Governor determines a longer period for the individual under subsection (6)—that longer period.

(2) This subsection applies to an individual if a medical practitioner has certified, in writing, that the individual has been diagnosed with any of the following conditions:

(a) cerebral palsy;

(b) epilepsy;

(c) Huntington's disease;

(d) motor neurone disease;

(e) multiple sclerosis;

(f) Parkinson's disease;

(g) polio;

(h) spinal cord injury;

(i) spinal muscular atrophy;

(j) stroke;

(k) other acquired brain injury;

(l) muscular dystrophy or muscular atrophy.

(3) A registered provider may apply to the System Governor for a determination of a longer period for an individual under subsection (6).

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

(a) in an approved form; and

(b) before the end of 24 months beginning on the entry day for the individual.

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(5) The System Governor must consider an application under subsection (3) and decide whether to determine a longer period under subsection (6).

(6) The System Governor may determine a period of more than 24 months but not more than 48 months beginning on the entry day for the individual if the System Governor is satisfied it is necessary to do so to ensure that the individual's care needs are met.

(7) 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.

(8) A notice under subsection (7) must include:

(a) the reasons for the decision; and

(b) how the registered provider may apply for reconsideration of the decision.

211C Day and amount for credit to account for classification type ongoing

For the purposes of subsection 211(4) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type ongoing for the service group assistive technology:

(a) the day is each anniversary of the day the account is established; and

(b) the amount is the tier amount for the individual.

211D Day and amount for credit to account for classification type short-term for classification level AT High

(1) For the purposes of subsection 211(4) of the Act, if an individual's notional assistive technology account is established because an entry day for the individual occurs for the classification type short-term for the service group assistive technology, and the individual has the classification level AT High:

(a) the day is the day a determination of an amount under subsection (5) is made for the individual; and

(b) the amount is the amount determined for the individual.

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

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

(a) in an approved form; and

(b) before the end of 12 months beginning on the entry day for the individual.

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

(5) The System Governor may determine an amount for the individual if:

(a) the registered provider has provided written evidence of:

(i) the individual's need for an item; and

(ii) the cost of the item; and

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(b) the cost of the item exceeds the sum of the amounts credited to the individual's account under subsections 211(3) and (5) of the Act; and

(c) the amount is the amount by which the cost of the item exceeds the sum mentioned in paragraph (b).

(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.

(7) A notice under subsection (6) must include:

(a) the reasons for the decision; and

(b) how the registered provider may apply for reconsideration of the decision.

211E Order of debits

For the purposes of subsection 211(6) of the Act, the order is the order in which the claims are made.

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Division 3—Tier amounts

212A Classification type ongoing

For the purposes of section 212 of the Act, the following table sets out the tier amount for an individual for an account period for the classification type ongoing for the service group assistive technology.

[These amounts are approximate and subject to change]

Tier amounts for the classification type ongoing		
Item	**Column 1** **For an individual that has the classification level ...**	**Column 2** **the amount is ... ($)**
1	Continence products	1,000
2	Assistance dogs	2,000
3	Continence products and assistance dogs	3,000

212B Classification type short-term

For the purposes of section 212 of the Act, the following table sets out the tier amount for an individual for an account period for the classification type short-term for the service group assistive technology.

[These amounts are approximate and subject to change]

Tier amounts for the classification type short-term		
Item	**Column 1** **For an individual that has the classification level ...**	**Column 2** **the amount is ... ($)**
1	AT Low	500
2	AT Medium	2,000
3	AT High	15,000

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Division 4—Primary person-centred supplements

213 Rural and remote supplement

For the purposes of section 213 of the Act, for an individual for a day for a classification type for the service group assistive technology:

(a) the supplement rural and remote supplement is prescribed; and

(b) the circumstances in which rural and remote supplement will apply to the individual are that the individual resides at a street address, or in a suburb or locality, that is in the MM category known as MM 6 or 7; and

(c) the amount of rural and remote supplement is the amount that is 50% of the tier amount for the individual for the account period for the classification type for the service group assistive technology, rounded to the nearest cent [These amounts are approximate and subject to change].

Commented [A19]: Recommend: Rural and Remote supplement needs to be expanded to be inclusive of MM 2 through to MM 7 regions. Recommend undertaking costing study to consider premiums to fund specialist services, and technologies and freight costs in these areas and review the precedence of AN-ACC in RACF's.

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Part 4—Subsidy for home modifications

Division 1—Eligibility

218 Excluded classification levels

For the purposes of subparagraph 218(2)(d)(ii) of the Act, the classification level HM CHSP is prescribed.

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Division 2—Available home modifications account balance

220A Account period for classification type short-term

(1) For the purposes of subsection 220(1) of the Act, if an individual's notional home modifications account is established because an entry day for the individual occurs for the classification type short-term for the service group home modifications, the account period for the account is:

(a) the period of 12 months beginning on the entry day for the individual; or

(b) if the individual has the classification level HM High for that service type, and the System Governor determines a longer period for the individual under subsection (5)—that longer period.

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

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

(a) in an approved form; and

(b) at least 60 days before the end of 12 months beginning on the entry day for the individual.

(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 12 months but not more than 24 months beginning on the entry day for the 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 end of 12 months beginning on the entry day for the individual.

(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.

(7) A notice under subsection (6) must include:

(a) the reasons for the decision; and

(b) how the registered provider may apply for reconsideration of the decision.

220B Order of debits

For the purposes of subsection 220(5) of the Act, the order is the order in which the claims are made.

Commented [A20]: Review: Accounting practices required if the funds are credited on the 'established day', and this is before the 'entry day'. Consider the possible implications on the creation of additional program which accumulates unspent funds and the providers responsibilities to account for these funds.

Commented [A21]: Add into rules: Provisions for adjustments of late or incorrect payments to protect the integrity of the payment for services rendered.

Commented [A22]: Recommend: establishing provisions to reduce impact on consumers if their budget funds are depleted and insufficient for reimbursement, when invoices are submitted.

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Division 3—Tier amounts

221 Classification type short-term

(1) For the purposes of section 221 of the Act, the following table sets out the tier amount for an individual for an account period for the classification type short-term for the service group home modifications.

[These amounts are approximate and subject to change]

Tier amounts for the classification type short-term		
Item	**Column 1** **For an individual that has the classification level ...**	**Column 2** **the amount is ...**
1	HM Low	$1,000
2	HM Medium	$2,000
3	HM High	the amount under subsection (2)

(2) For the purposes of column 2 of item 3 of the table, the amount for an individual with the classification level HM High is:

(a) if it is the first occasion that a notional home modifications account is established for the individual with that classification level—$15,000; and

(b) if it is not the first occasion that a notional home modifications account is established for the individual with that classification level—$15,000 reduced by the total of any amounts debited to the individual's previous notional home modifications accounts when the individual had that classification level.

Commented [A23]: Recommend: conduct an impact assessment on the implications of the $15,000 lifetime cap on the ability to undertake bathroom modifications to prevent incidents and increase independence.

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Division 4—Primary person-centred supplements

222 Rural and remote supplement

For the purposes of section 222 of the Act, for an individual for a day for a classification type for the service group home modifications:

(a) the supplement rural and remote supplement is prescribed; and

(b) the circumstances in which rural and remote supplement will apply to the individual are that the individual resides at a street address, or in a suburb or locality, that is in the MM category known as MM 6 or 7; and

(c) the amount of rural and remote supplement is the amount that is 50% of the tier amount for the individual for the account period for the classification type for the service group home modifications, rounded to the nearest cent [These amounts are approximate and subject to change].

Commented [A24]: Recommend: Rural and Remote supplement needs to be expanded to be inclusive of MM 2 through to MM 7 regions. Recommend undertaking costing study to consider premiums to fund specialist services, and technologies and freight costs in these areas and review the precedence of AN-ACC in RACF's.

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Part 5—Secondary person-centred supplements for home support, assistive technology and home modifications

197A Fee reduction supplement—circumstances (financial hardship) [also 214 and 223]

(1) For the purposes of paragraphs 197(2)(a), 214(2)(a) and 223(2)(a) of the Act, the circumstances in which fee reduction supplement will apply to an individual are that the System Governor is satisfied that:

(a) subsection 314AB(6) of this instrument does not apply to the individual; and

(b) the value of the individual's assets, worked out in accordance with Division 1 of Part 3.12 of the Social Security Act and reduced by the amounts mentioned in subsection (2), is not more than 1.5 times the sum of the annual amount of the following:

(i) the maximum basic rate under point 1064-B1 of Module B of Pension Rate Calculator A that applies to a person who is not a member of a couple;

(ii) the pension supplement amount under point 1064-BA3 of Module BA of Pension Rate Calculator A that applies to a person who is not a member of a couple;

(iii) the energy supplement amount under point 1064-C3 of Module C of Pension Rate Calculator A that applies to a person who is not a member of a couple; and

(c) the individual has not gifted more than $10,000 in the previous 12 months; and

(d) the individual has not gifted more than $30,000 in the previous 5 years.

(2) For the purposes of paragraph (1)(b), the amounts are the following:

(a) the amounts mentioned in section 314CA of this instrument;

(b) the value of the individual's principal home;

(c) the value of any unrealisable assets.

197B Fee reduction supplement—amount [also 214 and 223]

For the purposes of paragraph 197(2)(b), 214(2)(b) and 223(2)(b) of the Act, the amount of the fee reduction supplement is [calculation to be drafted (to involve matters similar to the matters mentioned in subsection 95(4) of the *Subsidy Principles 2014*)].

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Part 6—Subsidy for residential care [to be drafted]

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Part 7—Reduction amounts—compensation payment reduction

199A Circumstances in which compensation information known [also 216, 225 and 233]

(1) For the purposes of subsections 199(1), 216(1), 225(1) and 233(1) of the Act, circumstances in which a compensation payment reduction for person-centred subsidy applies to an individual for a day are that:

(a) the individual is entitled to compensation under a judgment, settlement or reimbursement arrangement; and

(b) the compensation takes into account the future costs of delivering funded aged care services to the individual on that day; and

(c) the application of compensation payment reductions to the individual for preceding days has not resulted in reductions in subsidy that, in total, exceed or equal the part of the compensation that relates, or is to be treated under subsection (2) or (3) as relating, to future costs of delivering funded aged care services to the individual.

Determinations relating to future costs of delivering funded aged care services

(2) If an individual is entitled to compensation under a judgment or settlement that does not take into account the future costs of delivering funded aged care services to the individual, the System Governor may, in accordance with subsection (4), determine, by notice in writing given to the individual:

(a) that, for the purposes of this section, the judgment or settlement is to be treated as having taken into account those future costs; and

(b) the part of the compensation that, for the purposes of this section, is to be treated as relating to those future costs.

(3) If:

(a) an individual is entitled to compensation under a settlement; and

(b) the settlement takes into account the future costs of delivering funded aged care services to the individual; and

(c) the System Governor is satisfied that the settlement does not adequately take into account those future costs;

the System Governor may, in accordance with subsection (4), determine, by notice in writing given to the individual, the part of the compensation that, for the purposes of this section, is to be treated as relating to those future costs.

(4) In making a determination under subsection (2) or (3):

(a) the System Governor must take into account the following matters:

(i) the amount of the judgment or settlement;

(ii) for a judgment—the components stated in the judgment and the amount stated for each component;

(iii) the proportion of liability apportioned to the individual;

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(iv) the amounts spent on delivering funded aged care services to the individual at the time of the judgment or settlement; and

(b) the System Governor may take into account any other matters the System Governor considers relevant, including the following:

(i) the amounts that are likely to be paid to, or withheld by, other government agencies because of the judgment or settlement;

(ii) the amounts spent on care (other than funded aged care services) at the time of the judgment or settlement;

(iii) the likely future costs of delivering funded aged care services to the individual;

(iv) other costs of care for which the individual is likely to be liable;

(v) other reasonable amounts, not related to care, that the individual has spent at the time of the judgment or settlement, or is likely to be liable for.

Note: For subparagraph (4)(a)(ii), examples of the components of a judgment include the following:

(a) loss of income;

(b) costs of future care.

199B Amount for circumstances in which compensation information known [also 216, 225 and 233]

(1) This section is made for the purposes of subsections 199(2), 216(2), 225(2) and 233(2) of the Act.

If liability not apportioned between the individual and the compensation payer

(2) Unless subsection (3) applies, the amount of the compensation payment reduction for person-centred subsidy for an individual for a day is equal to the sum of:

(a) the amount of person-centred subsidy for which a registered provider would be eligible for funded aged care services delivered to the individual on the day, assuming that no fee reduction supplement applies to the individual for the day; and

(b) the sum of any primary person-centred supplements for the classification type for the service group that apply to the individual on the day; and

(c) the sum of individual contributions that the registered provider would be able to charge the individual for delivering those services on the day.

If liability apportioned between the individual and the compensation payer

(3) If:

(a) the compensation payment reduction arises from a judgment or settlement that fixes the amount of compensation on the basis that liability should be apportioned between the individual and the compensation payer; and

(b) as a result, the amount of compensation is less than it would have been if liability had not been so apportioned; and

(c) the compensation is not paid in a lump sum;

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the amount of the compensation payment reduction for person-centred subsidy for the individual for a day is equal to the sum of the following, reduced by the proportion corresponding to the proportion of liability that is apportioned to the individual by the judgment or settlement:

(d) the amount of person-centred subsidy for which a registered provider would be eligible for funded aged care services delivered to the individual on the day, assuming that no fee reduction supplement applies to the individual for the day;

(e) the sum of any primary person-centred supplements for the classification type for the service group that apply to the individual on the day.

199C Circumstances in which compensation information not known [also 216, 225 and 233]

For the purposes of subsections 199(1), 216(1), 225(1) and 233(1) of the Act, circumstances in which a compensation payment reduction for person-centred subsidy applies to an individual for a day are that section 234 of the Act applies in relation to section 199, 216, 225 or 233 of the Act (as applicable).

234 Requirements for determining compensation payment reductions for circumstances in which compensation information not known

For the purposes of subsection 234(5) of the Act, in making a determination under subsection 234(4) of the Act in relation to section 199, 216, 225 or 233 of the Act:

(a) the System Governor must take into account the matter mentioned in subparagraph 199A(4)(a)(iv) of this instrument; and

(b) the System Governor may take into account any other matters the System Governor considers relevant, including the following (to the extent that the matters are known to the System Governor):

(i) the matters mentioned in subparagraphs 199A(4)(a)(i) to (iii) of this instrument;

(ii) the matters mentioned in paragraph 199A(4)(b) of this instrument.

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Part 8—Subsidy for certain specialist aged care programs [to be drafted]

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Part 9—Subsidy claims and payment [to be drafted]

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Part 10—Grants [to be drafted]

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Chapter 8—Funding of aged care services—individual fees and contributions

Part 1—Introduction

272AA Simplified outline of this Chapter

[to be drafted]

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Part 2—Individual fees and contributions

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

273A Working out individual contributions—circumstances and amounts

For the purposes of paragraph (b) of Step 3 of the method statement in subsection 273(2) of the Act (for working out the individual contribution for the delivery of a funded aged care service to an individual on a day), the following table sets out circumstances and amounts for those circumstances.

Amounts used to work out individual contributions in certain circumstances

Item	Column 1 For the following circumstances ...	Column 2 the amount is ...
1	(a) the funded aged care service is any of the following (which involve the sourcing and supply to the individual of products listed in the AT-HM List): (i) managing body functions; (ii) self-care products; (iii) mobility products; (iv) domestic life products; (v) communication and information management products; (vi) home modification products; and (b) the individual has an access approval in effect for, and the service is delivered to the individual through, the classification type ongoing or short-term for the service group assistive technology or home modifications	the amount of the cost of the products listed in the AT-HM List that are supplied to the individual
2	(a) a classification decision establishing the classification level HM High in a classification type for the service group home modifications is in effect for the individual; and (b) the service is delivered to the individual through that classification type for the service group; and (c) the individual resides at a street address, or in a suburb or locality, that is in the MM category known as MM 6 or 7	the amount that is 66.6% of the cost of the service [This amount is approximate and subject to change]

273B Requirements for prices charged

For the purposes of subsection 273(4) of the Act, the requirements for the price charged by a registered provider to an individual for the delivery of a funded aged care service are that:

(a) if the subsidy basis for the service is efficient price or unit price—the price charged by the registered provider must not exceed the final efficient price for the service; and

(b) if the individual directly sourced the delivery of the service at a particular price from an associated provider of the registered provider—the price

Commented [A25]: Add: Definition of 'individual directly sourced'. Include in definition the requirements to meet the criteria of individually directly sourced e.g. does the consumer need to identify the provider, organise the compliance checks or schedule the services?

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charged by the registered provider must not exceed 110% of that particular price.

Commented [A26]: Recommend: Providers should be permitted to charge 110% on goods and services supplied by directly sourced individual providers, including when the invoice exceeds the National Efficient Unit Price. This will enable providers to recover administrative costs and enhance their ability to support consumer choice.

Commented [A27]: Confirmation required that the 'price' is GST inclusive.

Commented [A28]: Define: Price.

Recommend: Price should be defined as National Efficient Price (not invoiced price) to enable providers to use the price that has been determined as Efficient and includes expenses associated with administering the service. During the transition period, if there is no National Efficient Price cap, the provider should be able to continue to charge the unit price for that service as per their pricing list.

Program requirements will determine if a provider 'must' use a associated provider if it is the consumers choice, therefore impacting the businesses financial position.

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Division 2—Fees and contributions payable in an approved residential care home [to be drafted]

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Division 3 Fees and contributions for specialist aged care programs [to be drafted]

Division 3—Fees and contributions for specialist aged care programs [to be drafted]

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Chapter 9—Funding of aged care services—accommodation payments and accommodation contributions [to be drafted]

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Chapter 10—Funding of aged care services—means testing

Part 1—Introduction

314A Simplified outline of this Chapter

[to be drafted]

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Part 2—Means testing

Division 1—Means testing in a home or community setting

Subdivision A—Determination of individual contribution rate

314AA Method for determining individual contribution rate

(1) For the purposes of paragraph 314(1)(a) of the Act, the method for determining the individual contribution rate for an individual for a means testing category is as follows:

Method statement

Step 1. Work out the individual's means testing class in accordance with Subdivision B.

Step 2. Work out the percentage for the category and the class using the table in subsection (2).

(2) The following table sets out percentages for individual contribution rates for individuals for means testing classes and categories.

Percentages

Item	Column 1 For an individual in the following means testing class …	Column 2 the percentage for the means testing category clinical supports is …	Column 3 and the percentage for the means testing category independence is …	Column 4 and the percentage for the means testing category everyday living is …
1	Full-pensioner	0%	5%	17.5%
2	Part-pensioner	0%	the amount of the percentage calculated in accordance with section 314DA	the amount of the percentage calculated in accordance with section 314DA
3	Seniors health card holder	0%	the amount of the percentage calculated in accordance with section 314DA	the amount of the percentage calculated in accordance with section 314DA
4	Self-funded retiree	0%	50%	80%

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314AB Period for determining individual contribution rate

Purpose

(1) For the purposes of paragraph 314(1)(b) of the Act, this section sets out the period for determining the individual contribution rate for an individual for each means testing category.

Application

(2) This section applies to an individual if a registered provider provides a start notification on a day (the ***start notification day***) to the System Governor and the Commissioner about the delivery of funded aged care services to the individual.

If System Governor has sufficient information

(3) If, on the start notification day, the System Governor has sufficient information to work out the individual's means testing class in accordance with Subdivision B, the period is 28 days from the start notification day.

If individual provides sufficient information without request from System Governor

(4) If:

(a) on the start notification day, the System Governor does not have sufficient information to work out the individual's means testing class in accordance with Subdivision B; and

(b) within 3 days from the start notification day, the individual provides information to the System Governor that is sufficient to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B;

the period is 28 days from the day the individual provided the information.

If individual provides sufficient information on request from System Governor

(5) If:

(a) on the start notification day, the System Governor does not have sufficient information to work out the individual's means testing class in accordance with Subdivision B; and

(b) within 3 days from the start notification day, either:

(i) the individual does not provide information to the System Governor that is sufficient to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B; or

(ii) the individual provides information to the System Governor, but that information is not sufficient to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B; and

(c) the System Governor requests information or documents from the individual under subsection 343(1) of the Act to enable the System

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Governor to work out the individual's means testing class in accordance with Subdivision B; and

(d) within 28 days from the day the System Governor requested information or documents, the individual provides information or documents that are sufficient to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B;

the period is 28 days from the day the individual provided the information or documents as mentioned in paragraph (d).

If individual does not provide sufficient information or elects not to give information

(6) If:

(a) paragraphs (5)(a) to (c) apply to the individual; and

(b) either:

(i) the individual does not, within the period mentioned in paragraph (5)(d), provide information or documents that are sufficient to enable the System Governor to work out the individual's means testing class in accordance with Subdivision B; or

(ii) the individual gives the System Governor a written notice electing not to give the information or documents to the System Governor;

the period is 3 days from the end of the period mentioned in paragraph (5)(d).

314AC Other matters to be included in notice of determination

For the purposes of paragraph 314(3)(e) of the Act, the other matters that must be included in a notice under subsection 314(2) of the Act in relation to an individual contribution rate determination for an individual are as follows:

(a) the previous individual contribution rate (if any) for the individual for each means testing category;

(b) the date of effect of the determination as worked out in accordance with section 314AD of this instrument.

314AD Method for working out date of effect of determination

For the purposes of subsection 314(4) of the Act, the method for working out the day at the start of which an individual contribution rate determination for an individual takes effect is that the day is:

(a) if, on the day the determination was made, an individual contribution rate determination was not in force for the individual—the day the start notification mentioned in subsection 314AB(2) of this instrument relating to the individual was provided to the System Governor and the Commissioner; or

(b) if the determination is a new determination made in accordance with paragraph 316(2)(c) of the Act, and the new determination results in an increase to the individual contribution rate—the day after the end of the quarter in which the determination was made; or

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(c) if the determination is a new determination made in accordance with paragraph 316(2)(c) of the Act, and the new determination results in a decrease to the individual contribution rate—the day the determination was made; or

(d) in any other case—the day the determination was made.

Subdivision B—Means testing classes

314BA Full-pensioner

Individuals not permanently blind and receiving maximum income support payments

(1) An individual is in the means testing class full-pensioner on a day if:

(a) the individual is not permanently blind; and

(b) the individual is receiving an income support payment; and

(c) the individual's payment rate for the income support payment is the maximum payment rate for that payment for that individual.

Note: For example, the maximum payment rate for age and disability support pensions and carer payment for people who are not blind is the rate worked out at Step 4 of the method statement in Module A of Pension Rate Calculator A.

Individuals permanently blind or not receiving income support payments

(2) An individual is in the means testing class full-pensioner on a day if:

(a) either:

(i) the individual is permanently blind; or

(ii) the individual is not receiving an income support payment; and

(b) if the individual were receiving age pension calculated in accordance with Pension Rate Calculator A, the individual's payment rate would be the maximum payment rate for age pension under that calculator for that individual if the value of the individual's assets were worked out in accordance with Division 1 of Part 3.12 of the Social Security Act, reduced by the amounts mentioned in section 314CA of this instrument.

314BB Part-pensioner

Individuals not permanently blind and receiving income support payments at less than maximum payment rates

(1) An individual is in the means testing class part-pensioner on a day if:

(a) the individual is not permanently blind; and

(b) the individual is receiving an income support payment; and

(c) the individual's payment rate for the income support payment is less than the maximum payment rate for that payment for that individual.

Note: For example, the maximum payment rate for age and disability support pensions and carer payment for people who are not blind is the rate worked out at Step 4 of the method statement in Module A of Pension Rate Calculator A.

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Individuals permanently blind or not receiving income support payments

(2) An individual is in the means testing class part-pensioner on a day if:
  (a) either:
    (i) the individual is permanently blind; or
    (ii) the individual is not receiving an income support payment; and
  (b) if the individual were receiving age pension calculated in accordance with Pension Rate Calculator A, the individual's payment rate would be less than the maximum payment rate for age pension under that calculator for that individual, but not nil, if the value of the individual's assets were worked out in accordance with Division 1 of Part 3.12 of the Social Security Act, reduced by the amounts mentioned in section 314CA of this instrument.

314BC Seniors health card holder

Holders of seniors health cards

(1) An individual is in the means testing class seniors health card holder on a day if:
  (a) the individual is not receiving age pension; and
  (b) the individual holds a seniors health card.

Individuals who are not holders of seniors health cards

(2) An individual is in the means testing class seniors health card holder on a day if:
  (a) the individual is not receiving age pension; and
  (b) the individual does not hold a seniors health card; and
  (c) the individual would satisfy the seniors health card income test in section 1071 of the Social Security Act if the value of the individual's assets were worked out in accordance with Division 1 of Part 3.12 of that Act, reduced by the amounts mentioned in section 314CA of this instrument.

314BD Self-funded retiree

An individual is in the means testing class self-funded retiree on a day if:
  (a) the individual is not in the means testing class full-pensioner, part-pensioner or seniors card holder; or
  (b) subsection 314AB(6) of this instrument applies to the individual.

Subdivision C—Valuing an individual's assets

314CA Amounts to be disregarded

For the purposes of paragraph 314BA(2)(b), 314BB(2)(b) and 314BC(2)(c), and Step 1 of the method statement in section 314DC, the amounts are the following:
  (a) any compensation payments received by the individual under the following:

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(i) the *Compensation (Japanese Internment) Act 2001*;

(ii) the *Veterans' Entitlements (Compensation—Japanese Internment) Regulations 2001*;

(iii) Part 2 of the *Veterans' Entitlements (Clarke Review) Act 2004*;

(iv) Schedule 5 to the *Social Security and Veterans' Affairs Legislation Amendment (One-off Payments and Other 2007 Budget Measures) Act 2007*;

(b) any redress payment paid to the individual, or to an administrator for the individual, under section 48 of the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018*.

Subdivision D—Calculating amounts of percentages for the means testing categories independence and everyday living

314DA Calculation method

For the purposes of columns 3 and 4 of items 2 and 3 in the table in subsection 314AA(2), the method for calculating the amounts of the percentages is as follows:

Step 1.	Work out the income reduction amount under section 314DB.
Step 2.	Work out the assets reduction amount under section 314DC.
Step 3.	Work out the maximum reduction amount under section 314DD.
Step 4.	Work out the input contribution rate under section 314DE.
Step 5.	Work out the amount of the percentage: (a) for the means testing category independence—under section 314DF; and (b) for the means testing category everyday living—under section 314DG.

314DB Working out the income reduction amount

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

Step 1.	Work out the amount that would be worked out as the individual's ordinary income for the purpose of applying Module E of Pension Rate Calculator A.
Step 2.	Work out the amount that would be worked out as the individual's ordinary income free area under point 1064-E4 of that Module.
Step 3.	Subtract the amount under Step 2 from the amount under Step 1.

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

The result is the income reduction amount.

314DC Working out the assets reduction amount

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

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

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

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

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

The result is the assets reduction amount.

314DD Working out the maximum reduction amount

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

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

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

Step 3. Multiply the amount under Step 2 by 0.5 and round to the nearest dollar.

The result is the maximum reduction amount.

314DE Working out the input contribution rate

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

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

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Step 2. Multiply the Step 1 amount by 100.

The result is the input contribution rate.

314DF Working out the amount of the percentage for the means testing category independence

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

Step 1. Multiply the input contribution rate by 0.45.

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

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

314DG Working out the amount of the percentage for the means testing category everyday living

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

Step 1. Multiply the input contribution rate by 0.625.

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

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

Subdivision E—Requirement to notify event or change in circumstances

315A Circumstances in which notification of event or change in circumstances is required

Commented [A29]: Recommend: During the consumer contribution assessment process, the Government Department must instruct consumers to inform the System Governor of the changes in circumstance, and, and related legal and Security of Tenure implications if this does not occur.

For the purposes of subsection 315(1) of the Act, the circumstances in which an individual for whom an individual contribution rate determination is in force must notify the System Governor of the occurrence of an event or a change in the individual's circumstances are as follows:

(a) a decision under the social security law (within the meaning of the Social Security Act) relating to the individual has been made;
(b) the individual's income changes;
(c) the individual's partner's income changes;
(d) the value of the individual's assets changes;
(e) the value of the individual's partner's assets changes;
(f) the individual starts or stops being a member of a couple;

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(g) the individual is a member of a couple that stops or starts being an illness separated couple (within the meaning of the Social Security Act);
(h) the individual is a member of a couple that stops or starts being a respite care couple (within the meaning of the Social Security Act);
(i) the individual leaves Australia permanently.

315B Period for notification of event or change in circumstances

For the purposes of paragraph 315(2)(a) of the Act, the period within which an individual must notify the System Governor of the occurrence of an event or a change in the individual's circumstances is 14 days from the day the event or change of circumstances occurs.

315C Manner for notification of event or change in circumstances

For the purposes of paragraph 315(2)(b) of the Act, the manner in which an individual must notify the System Governor of the occurrence of an event or a change in the individual's circumstances is the approved form.

Subdivision F—Varying or revoking individual contribution rate determination

316 Other matters to be included in notice of determination

For the purposes of paragraph 316(4)(f) of the Act, the other matter that must be included in a notice under subsection 316(3) of the Act in relation to a varied individual contribution rate determination for an individual is the individual contribution rate for the individual for each means testing category specified in the notice given under subsection 314(2) of the Act in relation to the old determination for the individual.

317 Period for deciding if individual contribution rate determination is no longer correct following certain social security decisions

For the purposes of subsection 317(2) of the Act, the period is 28 days from the day the System Governor is satisfied as mentioned in paragraph 317(1)(b) of the Act.

318A Period for deciding whether to vary or revoke individual contribution rate determination following event or change in circumstances

For the purposes of subsection 318(2) of the Act, the period is 28 days from the day the System Governor is:
(a) notified as mentioned in subparagraph 318(1)(b)(i) of the Act; or
(b) satisfied as mentioned in subparagraph 318(1)(b)(ii) of the Act;
(as applicable).

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318B Variation or new determination following event or change in circumstances to take effect on specified day in specified circumstances

For the purposes of subsection 318(6) of the Act, in the circumstances that:

(a) a variation or new determination for an individual is made following the System Governor being notified, as mentioned in subparagraph 318(1)(b)(i) of the Act, of the occurrence of an event or change after the end of the period prescribed by section 315B of this instrument; and

(b) the variation or new determination results in an increase to the individual contribution rate for the individual for a means testing category;

the variation or new determination takes effect on the day the System Governor was notified as mentioned in subparagraph 318(1)(b)(i) of the Act of the event or change.

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Division 2—Means testing in approved residential care home [to be drafted]

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