New Aged Care Act Draft Rules
Stage 2a: Support at Home Program Funding

Prepared **by**

COTA Australia

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About COTA Australia

COTA Australia is the peak body representing the almost nine million Australians over 50. For over 70 years our systemic advocacy has been improving the diverse lives of older people in policy areas such as health, retirement incomes, and more. Our broad agenda is focussed on tackling ageism, respecting diversity, and the empowerment of older people to live life to the full.

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Introduction

The new Aged Care Act enables the implementation of a Support at Home program that delivers more levels of care and higher funding amounts with specific assistive technology and short-term palliative care support available.

We note our understanding that further rules relating to the Support at Home program based on amendments during the legislative process were not contained in this release. Of particular importance to COTA is Government amendments that provide powers to Government to direct providers to not charge fees to people assessed as in financial hardship are yet to be consulted on.

Older people should receive clear information about hardship provisions and know how to apply for this support.

The Rules need to be flexible to respond to older people in exceptional circumstances or who require additional support. This includes exemptions for individuals who may not have supplied their financial information within the requested timeframes due to their individual circumstances, such as acute mental health episodes. The ability to waive fee requirements, or to grant further time for information to be gathered will be required in some exceptional circumstances. Punitive outcomes such as charging the full individual contribution rate should be avoided within a person-centred framework.

Support at Home information should focus on the 2027 reforms where participants can make choices about who delivers their specific services.

Rules for Support at Home should be given comparable weight as residential care and be based on consistent principles. It is important that the no worse off principle applies equally to support at home as to residential care, and that this is described in a clear, easy to understand manner. We note that Rules regarding how grandfathered participants, before 12 September 2024, will have their individual contribution rate calculated, has not been included and we encourage this portion of the rules to be included in the updated release with Residential fee rules in January.

Choice and self-determination should be a major objective of the Support at Home program and reflected in funding rules including ensuring that self-management is a genuine option. Unfortunately, such options are not yet transparent in this stage of the rules.

Definitions

Nursing assistant

As stated in our Aged Care Act Rules Release 1 Service List submission, COTA Australia recommends that nursing assistant should be abolished in the Rules and the Act and included as part of an expanded definition of a Personal Care Worker in the Act. There

should be no differential in pricing between a 'nursing assistant' or a 'personal care worker' delivered activity.

Aged care participants should receive quality care from qualified staff. The role of nursing assistant has been removed from the relevant award by the Fair Work Commission. A nursing assistant must be under the supervision of a registered nurse and a personal care worker can be supervised by anyone else. COTA Australia is concerned that following the removal of AIN as a class of worker in the Award, the Aged Care Act continues to make an arbitrary distinction between two classes of workers, potentially at a differential price point that older people will contribute towards, while the service delivered would be the same.

COTA Australia has proposed that the Act define a Personal Care Worker with a Nursing Assistant included within that definition.

No hardship definition

We note the absence of a hardship definition. It is our understanding that current hardship provisions are defined as income at 15 percent of the basic pension after paying essential expenses and current hardship asset levels are 1.5 times the full pension at $44,000.

Currently, an individual must already reach the asset level in order to apply for hardship. Given the timeframe for review and approval of applications, and the monthly withdrawal of fees - the ability to apply in advance before reaching the minimum asset level point must be introduced in the future approach to hardship.

We are concerned that a clear, simple and consistent message is required across fees and charges. In this regard, consider the following example:

- *If*
    - *after paying your essential expenses (including your aged care fees) you are left with less than 15% of the basic age pension in income, or*
    - *paying your fees would reduce your assets to less than 2.25 the annual basic pension, then*
- *you may be eligible for hardship. Apply here with Services Australia*
- *If you are found to be eligible for hardship, the Government can direct your provider to reduce your aged care fees, or cease charging them all together, including:*
    - *Your individual contributions in the Commonwealth Home Support Program*
    - *Your co-contributions charged in the CHSP program*
    - *Your residential aged care fees, including all fees such as*
        - *Higher Everyday Living Fees (formerly Additional or Extra Services)*
        - *Accommodation Payments/Contributions (RAD/RAC or DAP/DAC)*
        - *Non-Clinical Care Contributions*
        - *Hotelling Supplement*
        - *Basic Daily Fee*

- *The outcome of a hardship approval will be based on the individual circumstances of the approved applicant.*

The current distinction between the Act's definition of Assets and the hardship policy definition of Assets makes this a much more complex message where one asset level is used for some things, and another for other things. A clear consistent simple message must be designed in the system.

Recommendation 1: Hardship measures define assets at 2.25 times the annual basic pension (currently around $61,000) to enable a consistent hardship measure with asset values defined under the Act – namely the 'asset free area' (used for the means tested fee calculation), and 'minimum permissible assets value' (used for the purpose of amount that a RAD can charge).

Cost

It is our understanding that any charge based on cost has no price cap or maximum margin that can be applied. This will require further consideration.

Final efficient price

The final national efficient price is defined as being made up of the base efficient price and any loading amount for a loading type relevant to that service. How this information is published will require some consideration as to how individual providers are also required to represent their prices. If base plus loading dollars or percentage is the way that they are published, obligations on providers to be comparable will be necessary. Creating a long list of every combination of base plus loadings to develop a final efficient price may not be the preferred approach. But, without comparability between the official source of national efficient prices and the actual way an individual's monthly statement represents the provider's price - older people will have additional challenges in being able to clearly understand the prices charged and whether they are less than the national efficient price.

Price charged

The references to "hour of service" should be followed by "(or part thereof)" to make it explicit that parts of hours can be an acceptable price unit. For example, a personal care worker may only take 30 minutes to shower someone under the independent/everyday living category. Participants will not want to pay for the full hour when the activity only takes 30 minutes.

Recommendation 2: The definition of the price charged should enable increments of an hour of service to ensure that participants are not charged for time when the service is not being undertaken.

Service List – showering should be broken out as a service type

COTA notes the considerable feedback received during the Parliamentary processes reviewing the Aged Care Act regarding concerns that showering would form part of the Independence price category. While acknowledging the Government has not chosen to include showering within the Clinical Care price category, we strongly urge the Government to amend the service list to identify 'showering' as a distinct service type, thus enabling targeting monitoring of the take up of this specific service.

Recommendation 3: Amend the Service List to separate 'showering' as a distinct service from other types of personal care services.

Commonwealth contributions

Person-centred subsidy

Available ongoing home support account balance

Circumstances for no credit

While appreciative that an individual's budget will remain for up to a year, we also acknowledge that in a period of strained resources this may lead to others waiting longer. While supportive of this clause, we would ask the Department to consider what earlier contact will be triggered by the system to alert both the individual and the primary provider that an account has not been reported to be on hold and continues to be available. This will enable the individual to advise if they no longer need the account and wish to relinquish it. Assuming there is a systematic "account on hold" status, we would suggest this occur at the 90-day mark. A longer period may be required given periods of rehabilitation or other longer term medical treatment requirements.

Recommendation 4: Ensure that, in circumstances where accounts are not being regularly credited, that both individuals and primary providers are contacted after 90 days to enable decisions on the future of the account.

193C sub-clause (b) states that "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".

The 60-day mark is too short and should be extended to 90 days. We are concerned that a provider may seek to activate a package at the point of onboarding to be paid their care management, while waiting for services to commence. For example, we have received several reports that, in some geographical locations, for lower-level packages utilised for domestic assistance only, some service types commence longer than 60 days after onboarding.

Clear policy documents about dates are required to be published so that a clear and a consistent approach is understood.

Recommendation 5: The 60-day minimum start notification period for activating accounts should be extended to 90 days.

Base individual amounts

Classification type ongoing

In the table provided, we note that the Full Budget individual (column 2) amount appears to be 90% of the funds of the classification amount - which would be the funds available for service (noting 10% is being allocated to the provider's branch account for care management).

However, neither the legislation, nor the Rules appear to explain the purpose or role of an "interim" budget in Column 3. Greater explanation about the purpose of these amounts (including the legislative basis for their introduction in the Rules) is required before an assessment can be made about the appropriateness of assigning a lower funding amount to a person who is receiving an 'interim' budget.

If, however, an interim package means a package that has been assigned in an emergency while a full assessment is completed, we note concerns that lower amounts would be attributed. This point also applies to Clause 204 of these Rules.

Recommendation 6: Provide detail about the purpose and legislative basis of interim budgets and provide further opportunity to comment on the appropriateness of assigning lower levels to an individual.

Available short-term home support account balance

Order of debits

Regarding subsection 195 (5) of the Act, claims should be ordered in the time and date they were lodged with Services Australia. However, the language "in which claims are made" is imprecise as to whether a claim lodged and claim made is the same thing, or if system failures for processing a claim will result in a provider not being in their original position in the queue. Clarity about what "are made" means should be considered either by rewording, or a clearer note. This point also applies to 203D, 211E of these Rules.

Recommendation 7: Provide clearer language in the Rules regarding order of debits regarding claims lodged and claims made and the impact of claims processing system failures on the claims queue.

Circumstances for ceasing of account

We are concerned that this clause appears to mean a person on a short-term transition care program cannot also be assessed for an end-of-life classification. Noting that we anticipate intergovernmental agreements are likely to result in TCP funding to address the issues of long-term stays, this pathway may become critical for terminal patients at moments where end of life packages are not available. Older people should not be required to be reassessed purely because of this rule preventing them from being assessed once and accessing the transition care while waiting for an end-of-life care package to become available.

Recommendation 8: Provide information about access and assessment for end-of-life classification for individuals in a short-term transition care program.

Provider-based subsidy

Order of debits

See comments above under person-centred subsidy.

Circumstances for ceasing of account

We note that a registered provider may be removed from operating in the system by the ACQSC. In such a scenario, we note it may not be appropriate that reliance on ceasing an account solely rests with the provider. We anticipate this matter would be addressed when rules relating to s166 of the Act are available for review.

Base provider amount

Classification type ongoing

See comments above under person-centred subsidy.

Care management supplement—applicability

While supportive of the inclusion of Care Finders, which is currently designed to focus on clients with complex needs, we note that there is a gap in the navigation and information needs of people without complex needs. The inclusion of all care finder program referrals indicate that the Care Finder program reinforces the perception that Care Finders will continue to not service people without complex needs, continuing this gap. A distinct program of support for navigation and information support is therefore required.

Recommendation 9: Establish a clear navigation and information support program for people with a diverse range of needs including those who required time limited and tailored assistance.

Care management supplement—clearer information on the individual's access to care management

We note our understanding that 10% of an individual's funds are siphoned into a pooled service outlet account for the use towards care management for all clients of that service outlet. Accordingly, there is a severing between the package allocation to the individual and choice and control over how that portion of their funds are directed and used. Instead for that 10% of funds, the provider will determine the quantum of services that any single individual will receive. In some cases, this will mean an individual will receive less than their 10% funding would provide, and in other cases an individual will receive more than their 10% could fund.

We know today the cost an individual contributes towards care management, compared to the visible services the individual perceives they receive is a source of significant tension. Paying 20% of their package towards care management today and receiving one monthly phone call about care management presents a cognitive dissonance for individuals about the value of the services they receive. While recognising that today 20% belongs to the individual and in the future the 10% care management will not, clear messages to explain this is required. Even when well understood, COTA anticipates that individuals will still seek to understand if they are receiving value for money for their care package amounts, despite the technical severing of this 10% of their package allocation from their sphere of choice and control.

Clearer information explicitly outlining this over/under individual outcome and pooled approach is required in the Rules, expanded in the future Support at Home Manual and

Handbook, supplemented with consumer facing information. Greater communication and policy work is needed to ensure that older people are informed of the quantum of care management their aged care needs assessment has identified, and the payment required. This provides the participant with an independent-from-their-provider source of information.

Recommendation 10 Increase understanding of over/under pooled approach to care management amongst providers and individuals.

Subsidy for assistive technology

Account period for classification type short-term

Clarity is required via the Home Support Manual the rationale for providing a short-term allocation of funds of 24 months for the prescribed conditions, but 12 months for other situations.

We note there is no equivalent section in Assistive Technology that appears under Home Modifications 221(2)(b) of the Rules. Accordingly, there does not appear to be an explicit rule indicating that once an individual receives one classification assessment for AT that individual cannot receive another classification reading when the account period concludes. This means the current reading of the Rules for AT would suggest at the end of the account period a person may seek a new assessment and be allocated with additional funds in a new account, including for amounts above the AT limits. Accordingly, some might argue that some of the prescribed conditions requiring greater technology as part of reablement early on, should not be subject to a longer wait period.

The intended purpose of a 12-month period under 211B(1)(a) of the Rules requires greater explanation.

Recommendation 11: Provide more detailed information in the Home Support Manual on the rationale for providing differing time periods for short term allocation of funds for different conditions and situations.

Order of debits

See comments above under person-centred subsidy.

Subsidy for home modifications

Available home modifications account balance

Account period for classification type short-term

We note concern that the "entry day" for AT-HM appears to occur once a place allocation is made and a provider accepts the client. At this point a prescription for their specific Home Modification (usually by an OT) will occur, then tradesmen will be booked and complete the work. COTA is hearing of up to a 12 month wait for an OT assessment alone. Accordingly, we are concerned by the 12-month period potentially being too short.

Given that providers may have a single client with both an AT-HM classification and a Support at Home classification, greater clarity on implementation about the 'entry day for the individual' will be required. For example, is it envisaged that this would be the day the provider's care manager begins the work on the Home Modifications element, or would it be the day that a provider has finalised an OT prescription of what is needed.

If the former, which we would expect may occur as a provider is seeking funds for the care management of the AT-HM, which is not a service under Support at Home Care Management - a clear monitoring of the time from onboarding to OT assessments completed and then work commenced is needed in the new system to ensure the 12-month period is appropriate.

While particularly an issue for Home Modifications in this clause, AT requiring a prescription may also face this same problem and the 211B(1)(a) 12-month timeframe it relates to.

Recommendation 12: Provide clearer information on the 'entry day for the individual' for individuals with both a AT-HM classification and a Support at Home classification.

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

Fee reduction supplement—circumstances (financial hardship)

While noting that this tranche of the Rules relates to Home Support, we note that in s199A of these Rules that references relating to residential care have been made.

We note our understanding that this provision on financial hardship should be expanded to include s231(2)(a) so that the hardship provisions apply consistently to Residential Care, as they would to Home Care.

It is vital in the new system that a clear message is provided to support older people understanding and accessing financial hardship. Potential wording could be:

If after paying your essential expenses (including age care fees) you are left with less than 15% the basic pension, or after paying your fees your assets are below 2.25 the basic pension - you may be eligible for financial hardship support. If your hardship application is approved, the Government can direct your provider to stop charging or reduce the amount your provider is charging you.

Such provisions are particularly important to older people concerned that vital services such as showering will be avoided due to an inability to pay their co-contribution. Clear consistent and robust messaging is vital to assure older people that safety net provisions are built into the system.

Accordingly, COTA objects to s197A(1)(b) as defined. This defines asset levels at 1.5 the full pension ($44,631.60).

The Aged Care Act 2024 defines both the 'minimum permissible value' and the 'asset free area' as 2.25 the basic age pension amount ($61,255.35). The minimum permissible asset value is used to ensure that a provider does not charge a RAD at a rate that would leave a person with assets less than this amount.

We strongly object to this inconsistent position between fees in hardship and fees in what a provider may charge.

We seek alterations of this section to match the *minimum permissible asset value*.

We also note that the income amount left after essential expenses are paid is not listed in the Rules and should be. We understand this to be 15% of the basic pension.

Recommendation 13: Amend Section 197A(1)(b) to match the minimum permissible asset value of 2.25 times the basic age pension amount, providing a consistent approach to hardship and provider fees.

Recommendation 14: List the income amount left after essential expenses are paid in the Rules.

Individual fees and contributions

Fees and contributions payable in a home or community setting

Working out individual contributions—circumstances and amounts

In the table, in item 2, column 2, it states that "the amount that is 66.6% of the cost of the service." This would appear to mean that the individual contribution rate for people living in

rural or remote areas (MM 6 or 7) is applied to only 66% of the Home Modification cost to deliver the service.

Our understanding is that, for example, if a person's contribution rate is 10%, the service cost was $10,000, the person would pay $666, and the Government would pay $9444. This being 66.6% of $10,000 = $6666 and 10% individual contribution rate equates to $666. Whereas a person living in other geographical areas would contribute $1000 as the amount of the cost to which the service is calculated would not be discounted.

A clear understanding of why a ⅓ discount is being provided should be made available with the accompanying explanatory materials to the Rules.

Recommendation 15: Provide clear details in the Rules outlining the rationale for and explanation of home modification discounts.

Requirements for prices charged

The proposed Rules state under 273B(b) that "if the individual directly sourced the delivery of the service at a particular price from an associated provider of the registered provider – the price charged by the registered provider must not exceed 110% of that particular price."

In our submission on the Aged Care Bill, we stated that an efficient price should be set assuming the home support model in 2027 considering a range of different models including subcontracted model, direct employment models, digital platforms and sole traders operating as a registered provider for single services.

The efficient price will need to be neutral about the business model providers choose to operate under as the registered provider remains responsible for all services it provides, whether that it directly and indirectly.

The older person will be able to work with their care manager (who will get 10% of the package to manage their services) and choose one or multiple providers to deliver their services and directly charge those services to the Government.

From 2025, due to the Government's decision to delay the implementation of multiple providers, the cost of managing requests from older people to use a particular provider will be forced upon the registered provider (whereas from 2027 the consumer could simply direct them to receive funds directly from Government). This is a legitimate additional cost above the ongoing efficient price that must be considered for the transition between the 2025 model of Support at Home and the 2027 model.

A loading beyond the base national efficiency price may be required during the two-year transition period while direct charging to the Government cannot occur with the multiple provider model from 2027.

To not separate out this cost will either:

- send inappropriate and inflated price signals in the ongoing efficient price, or
- force registered providers to not offer this option to clients, effectively shutting down the self-management pathway within aged care's home support system.

Subclause (b) will enable older people to access a service provider of their choosing, who must become an associated provider of their registered provider. This will enable older people to self-manage their package, while also providing the registered provider with a maximum of 10% on top of the charge of that service provider.

We remain deeply concerned by the approach outlined in subclause (a) section as it will distort the price market in aged care for the next two years until the introduction of multiple providers being able to charge prices directly to the Government.

For example, IHACPA will set a national efficient price for physiotherapy, but if that person is engaged by the older person directly, they will only be able to charge 90% of the national efficient price, as the registered provider will demand they receive their 10% cut.

Similar provider-led subcontracting arrangements to their chosen associated providers will also likely see similar outcomes where providers will not pay an amount more than 90% of the national efficient price, to take their clip of the ticket.

A preferred approach, to maintain integrity in the new pricing system, and not distort the market in the favour of traditional provider models over the next two years, is to provide a temporary loading beyond the base national efficient price during the two-year transition period while direct charging to the Government cannot occur with the multiple provider model from 2027.

Recommendation 16: Implement a temporary loading beyond the base national efficient price for the 2025-2027 transition period.

Means testing

Means testing in a home or community setting

Determination of individual contribution rate

Method for determining individual contribution rate

The method for determining the individual contribution rate has no reference to individuals captured under the 'no worse off principle'. While this may be addressed via the transition rules, or in another part of these Rules, a legislative note should be inserted to reference that section to ensure clarity and understanding.

Recommendation 17: Insert a legislative note to rules regarding means testing to reference information about individuals captured under the 'no worse off principle'.

Recognise that CSHC are also Self-Funded Retirees

Commonwealth Seniors Health Card holders are self-funded retirees. We suggest that labels be updated to reflect this in the means testing categorisation table. Item 3 could be changed to Self-funded retirees (CSHC holders). Item 4 could be changed to Self-funded retirees – Full. These labels should be used in other sections of the rules where Commonwealth Seniors Health Care Card holders and self-funded retirees are referred to.

Other matters to be included in notice of determination

As noted above in relation to individuals covered by the 'no worse off' principle - the fact the client was eligible for the no-worse off principle must be a matter that is included in the notice under this section.

Means testing classes

Full pensioner

We note that the rules refer to a means testing full pensioner "on a day". How will this work when a pensioner may declare work income in a particular fortnight, or has their pension reduced for a particular year due to receipt of income above a particular amount, but then in a future year their income ceases, and they return to full pension.

Clear guidance about how to request a reassessment of their individual contribution rate when their circumstances change is required.

Recommendation 18: Provide clear guidance about how older people can request a reassessment of their individual contribution rate when their circumstances change.

Senior health card holder

Section 314BC (2)(c) refers to a seniors health card holder being defined by the relevant sections of the Social Security Act related to the value of the individual's assets. COTA seeks further understanding of this paragraph's legal meaning.

We understand and support the policy intent to extrapolate an CSHC equivalent asset point as well as the existing CSHC income point and a person with assets or income below this amount, who is not receiving an age pension would be deemed to be a CSHC holder. However, our understanding is that section 1071 (CSHC Income) has no impact by assets

and accordingly are concerned the language “if the value of the individual’s assets” may have no meaning when interpreted in context. Our interpretation concern is that the result would be that this clause would therefore rely solely on income for defining a CSHC holder, and not their asset levels.

Recommendation 19: Review 314BC (2)(c) to ensure the modelled assets point for CHSC holders is accurately included.

Valuing an individual’s assets

Amounts to be disregarded

COTA supports the inclusion of these amounts to be disregarded when determining assets and seeks the further inclusion of any compensation amount paid under Chapter 3, Part 5, Division 3 of the Aged Care Act 2024 (Compensation Pathway).

Requirement to notify event or change in circumstances

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

COTA notes that individuals deal with Services Australia on a regular basis for their Aged Pension matters, which include obligations on reporting for these matters.

COTA seeks an understanding that if Centrelink is provided with notifications by the individual, relevant to these matters, that such notifications to Centrelink, will be sufficient for meeting these obligations to notify the System Governor.

Having the same entity “Services Australia” conduct business for both Centrelink and on behalf of the System Governor presents potential confusion for the individual who may not be aware they have to tell the same organisation twice the same information each to different parts of the Services Australia.

Period for notification of event or change in circumstances

COTA notes that many periods under the Aged Care Act are 28 days. While we accept that 14 days align with the Social Security Act requirements for notification, we would prefer that a consistent period of notifications by older people is applied for aged care to avoid confusion. We therefore submit this should be changed to 28 days.

Recommendation 20: Change the period for notification of event or change in circumstances to 28 days.

Manner for notification of event or change in circumstances

Older people with a diverse range of needs can find administrative processes in related to aged care challenging. Legislation must make sure that digital and verbal solutions are captured by the definition of the "approved form."

We seek clarification that an approved form may be via telephone verbally advising the agent on the line.

Varying or revoking individual contribution rate determination

Other amounts to be included in notice of determination

As noted above in relation to individuals covered by the 'no worse off' principle - the fact the client was eligible for the no-worse off principle must be a matter that is included in the notice under this section.

Introduce clear communications about means testing for older people by January 2025.

We remain concerned about the confusion and lack of understanding about how means testing will work amongst older people, six months out before the new system starts. An urgent focus on communications for older people is needed that includes:

- Clearer communications about who is included in no worse off / grandfathering
- Top line and detailed information on how means testing will be calculated
- Clearer information about Hardship – both policy details and application processes