EXPLANATORY STATEMENT

Aged Care Act 1997
Aged Care (Transitional Provisions) Act 1997

Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2024

The *Aged Care Act 1997* (the Aged Care Act), the *Aged Care (Transitional Provisions) Act 1997* (the Transitional Provisions Act) and the *Aged Care Quality and Safety Commission Act 2018* (the ACQSC Act) provide for the funding and regulation of aged care services.

Providers who are approved under the ACQSC Act to provide aged care (approved providers) may be eligible to receive subsidy payments in respect of the care they provide to a person who has been approved under the Aged Care Act as recipients of aged care (approved care recipients). The Aged Care Act and the Transitional Provisions Act provide that, for each type of aged care, the Minister may determine the amount of subsidy payable to an approved provider for the provision of that type of aged care.

The Aged Care Act and Transitional Provisions Act also provides that approved providers have responsibilities in relation to the aged care they provide through their aged care services. These responsibilities relate to matters that include the quality of care, fees and payments, and accountability for the care that is provided and for the suitability of key personnel. Sanctions may be imposed under Part 7B of the ACQSC Act on approved providers who do not meet their responsibilities.

Purpose and operation
The *Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2024* (Amending Instrument) amends aged care subordinate legislation to provide for changes to:

- how the responsibility of approved providers of residential care to provide a staff average amount of direct care ('care minutes') each quarter is calculated, and to how that responsibility may be met
- the amount of residential care hotelling supplement
- the amount and the method of calculating the amount of residential care basic subsidy
- the amount and method of calculating the amount of registered nurse supplement, and
- residential care accommodation payments arrangements.

The hotelling supplement, basic subsidy and the RN supplement are all applicable in the calculation of residential care subsidy in respect of residential care provided to care recipients (who are subject to the *Aged Care Act 1997* and its legislative instruments) and continuing residential care recipients (who are subject to the *Aged Care (Transitional Provisions) Act 1997* and its legislative instruments). The care minutes responsibility is also applicable to the provision of care to both residential care recipients and continuing residential care recipients.

To support residential care accommodation payment arrangements, the amendments will require an approved provider give to the Secretary a copy of the notice from the Independent Health and Aged Care Pricing Authority (IHACPA) approving the provider to charge an accommodation payment higher than the maximum amount. This is to facilitate the accurate publication of accommodation payment amounts that exceed the maximum accommodation payment amount determined by the Minister (currently $550,000).

The Amending Instrument amends the following subordinate legislation:

- *Fees and Payments Principles 2014 (No.2)* (Fees and Payments Principles)
- *Quality of Care Principles 2014* (Quality of Care Principles)
- *Subsidy Principles 2014* (Subsidy Principles)
- *Aged Care (Subsidy, Fees and Payments) Determination 2014* (Subsidy Determination)
- *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014* (Transitional Provisions Determination).

Background

Staff average amount of direct care ('care minutes')
Schedule 1 of the Amending Principles amends the Quality of Care Principles from 15 September 2024 to change the method for calculating the responsibilities to provide a combined staff average amount of direct care per care recipient per day and a registered nurse average amount of direct care per care recipient per day in respect of a residential care service for a quarter of a financial year for the approved provider of the service.

Recommendation 86 of the Final Report of the Royal Commission into Aged Care Quality and Safety (Final Report) recommended, amongst other matters, that, from 1 July 2024, the Government should require approved providers of residential care to meet a minimum staff time quality and safety standard, including that the minimum staff time standard should require approved providers to engage RNs, ENs, and personal care workers for at least 215 minutes per care recipient per day for the average care recipient, with at least 44 minutes of that time provided by a RN. The Government subsequently accepted Recommendation 86, with an implementation date of 1 October 2024 for the 215 care minutes requirement.

Recommendation 86 of the Final Report also recommended that the minimum staff time standard should be linked to what is now known as the *classification amount* element of *basic subsidy* for residential care, so that approved providers with a higher-than-average proportion of high needs care recipients be required to engage additional staff, and vice versa. Accordingly, the method to calculate the care minutes responsibility places relative weights (through varying direct care per care recipient per day 'amounts') on care recipients' classification levels under Part 2.4A of the Aged Care Act.

Schedule 1 legislates part of the Government's response to Recommendation 86 of the Final Report, both to realise the recommended average 215 care minutes requirement (including an average 44 minutes of RN care) across the residential care sector as a whole from the October-December 2024 quarter onward, and to align calculated

care minutes responsibilities at specific residential care services with amended classification amounts of basic subsidy (see Schedule 3 to the Amending Instrument).

Schedule 4 of the Amending Principles amends the Quality of Care Principles from 1 October 2024 to permit up to a capped number of minutes of direct care delivered by direct care staff members who are ENs to be counted toward meeting an approved provider's responsibility to deliver RN care minutes in a quarter of a financial year at a residential care service. This change will provide flexibility for approved providers of residential care to use all their nurse workforce more efficiently, recognising the important role ENs play amid ongoing shortages of RNs in residential care.

Hotelling supplement
Schedule 2 of the Amending Instrument amends the Subsidy Determination and the Transitional Provisions Determination from 20 September 2024 to change the amount of the hotelling supplement for routine indexation and to take account of anticipated decisions in Stage 3 of the Fair Work Commission's Work Value Case that will apply to non-care workers in the residential care sector. Government policy is to index the amount of the hotelling supplement each 20 March and 20 September, to take account of general movements in costs and, as needed, to adjust the amount for other changes in costs relevant to hotelling services.

The amount of the hotelling supplement, together with other funding sources, is intended to sufficiently cover approved providers' costs of providing to care recipients the *hotel services* in Part 1 of Schedule 1 of the *Quality of Care Principles 2014* (Quality of Care Principles). The hotelling supplement also assists with the costs of employing non-care staff for such services, which include catering, cleaning and gardening.

Basic subsidy
Schedule 3 of the Amending Instrument amends the Subsidy Determination and the Transitional Provisions Determination from 1 October 2024 to change the following elements of residential care basic subsidy:

- the amount of the national efficient price (NEP)
- the amount of national weighted activity units (NWAUs) associated with classification amounts
- the structure of service amounts.

Residential care *basic subsidy* consists of a *classification amount*, linked to a care recipient's classification level under Part 2.4A of the Aged Care Act, and a *service amount*, linked to specified characteristics of the residential care service of where a care recipient receives care. The dollar value of a given classification amount and a given service amount is calculated by reference to how many NWAUs are associated with the amount and the NEP (with the NEP being the dollar value of one NWAU).

Government policy is to change basic subsidy each year on 1 October, taking into account aged care costing and pricing advice from IHACPA.

Change to the NEP reflects IHACPA's advice that the overall cost of providing residential care has increased since the NEP was last legislated, and also for modelled increases during 2024-25 due to:

- changes to the responsibility of approved providers of residential care to deliver, on average, increased care minutes (legislated through Schedule 1 of the Amending Instrument)
- anticipated decisions in Stage 3 of the Fair Work Commission's Work Value Case that will apply to clinical care workers in the residential care sector.

Change to the NWAUs associated with classification amounts and the structure of service amounts reflect IHACPA's advice that the relative costs of providing residential care between care recipients with different residential care classification levels and between different types of residential care services have changed since the methods for calculating classification amounts and service amounts were last legislated.

Change to the structure of service amounts will have the effect of better recognising the significant differences in the average 'fixed' costs of delivering care on a day to care recipients in metropolitan areas, regional centres and large rural towns, medium and small rural towns, and remote and very remote communities.

RN supplement

Schedule 4 of the Amending Instrument amends the Subsidy Principles, the Subsidy Determination and the Transitional Provisions Determination from 1 October 2024 to change the following elements of the RN supplement:

- definition of a group A qualifying facility
- structure of facility amounts for group A and group B qualifying facilities
- dollar value of each facility amount.

The RN supplement provides additional subsidy to eligible approved providers of residential care for RNs providing, or directing the provision of, care to residential care recipients to meet an approved provider responsibility under subsection 54-1A(2) of the Aged Care Act. The responsibility is to ensure, at all times on and after 1 July 2023, there is at least one registered nurse (within the meaning of the *Health Insurance Act 1973*) on site, and on duty, at each residential facility through which the approved provider provides residential care (the 24/7 RN responsibility).

The RN supplement recognises that meeting the 24/7 RN responsibility may be more difficult for an approved provider who is operating a residential facility that, on average, has few care recipients. These residential facilities receive smaller amounts of basic subsidy that can be used to employ sufficient RNs to meet the 24/7 RN responsibility. Working out the amount of RN supplement payable includes working out whether a residential facility is either a *group A qualifying facility* or *group B qualifying facility*. T he appropriate *facility amount* is calculated depending on whether it is a group A or group B qualifying facility.

The definition of a group A qualifying facility will change from 1 October 2024 so that for a facility to qualify—assuming other criteria are met—the total number of days of eligible residential care provided in respect of care recipients at the facility during the period, divided by the number of days in the period reduces to 50 days (from 60 days).

The change to the definition of a group A qualifying facility complements changes in Schedule 1 and Schedule 3 of the Amending Instrument that, from 1 October 2024, will increase the RN staff average amount of direct care that approved providers must provide, and also correspondingly increase basic subsidy to meet extra costs, so that the 24/7 RN responsibility should be able to be met at more residential facilities without the need for additional funding through the RN supplement.

The structure of the RN supplement will also change from 1 October 2024, to include different amounts for qualifying facilities in metropolitan areas, regional centres and large rural towns, medium and small rural towns, and remote and very remote communities. This aligns with changes to the structure of the service amount component of basic subsidy that will commence from 1 October 2024 through Schedule 3 of the Amending Instrument, consistent with the RN supplement acting as a complement to basic subsidy.

The facility amounts at qualifying facilities, within the new regionally-based structure of facility amounts, will be set from 1 October 2024 so that, between basic subsidy and the new facility amounts of RN supplement, approved providers operating residential facilities with relatively few care recipients are sufficiently funded to meet the 24/7 RN responsibility.

Accommodation payments

Schedule 5 of the Amending Instrument will amend the Fees and Payments Principles from 1 October 2024 to require an approved provider give to the Secretary a copy of the notice from IHACPA to enable accurate publication of accommodation payment amounts that exceed the maximum accommodation payment amount determined by the Minister (currently $550,000).

Residential aged care providers must publish information about the accommodation payments they propose to charge for a room or a part of a room in their service. Where an approved provider wants to charge an accommodation payment amount higher than the maximum amount determined by the Minister (currently $550,000) approval is required from IHACPA. By requiring providers to give copies of these approvals to the Secretary, this will ensure only accommodation payment amounts with a valid approval are published by the Secretary. The notice itself will not be made publicly available by the Secretary but is intended to provide assurance that the provider has an approval from IHACPA prior to the room being published by the Secretary.

Authority

Staff average amount of direct care ('care minutes')

With respect to **Schedules 1** and **4**, under section 96-1 of the Aged Care Act, the Minister may, by legislative instrument, make Principles providing for matters required or permitted by Part 4.1 of the Act, or necessary or convenient, in order to carry out or give effect to Part 4.1. Relevantly, section 96-1 provides for the making of the Quality of Care Principles.

Paragraph 54-1(1)(h) of the Aged Care Act provides that the responsibilities of an approved provider in relation to the quality of the aged care that the approved provider provides include such other responsibilities as are specified in the Quality

of Care Principles. The responsibility of residential care approved providers to provide a staff average amount of direct care is established through the Quality of Care Principles.

Hotelling supplement, basic subsidy and RN supplement
With respect to **Schedules 2, 3** and **4**, the Aged Care Act and the Transitional Provisions Act provide that, for each type of aged care, the Minister may determine the amounts of components of aged care subsidy, including the amounts of basic subsidy and of supplements payable to an approved provider for the provision of that type of aged care. Specifically, the authority provisions in the Aged Care Act for making changes to basic subsidy, the hotelling supplement and the registered nurse supplement through the Amending Instrument are set out in the following table:

Type of care and type of payment	**Section of the Aged Care Act**
Residential care	
Hotelling supplement	subsection 44-27(3)
National Efficient Price, classification amount and service amount	subsection 44-3(2)
Registered nurse supplement	subsection 44-27(3)

The authority provisions in the Transitional Provisions Act for making changes to basic subsidy, the hotelling supplement and the registered nurse supplement are set out in the following table:

Type of Care and type of payment	**Section of the Transitional Provisions Act**
Residential Care	
Hotelling supplement	subsection 44-27(3)
National Efficient Price, classification amount and service amount	subsection 44-3(2)
Registered nurse supplement	subsection 44-27(3)

Accommodation payments
With respect to **Schedule 5**, Section 52G-2 of the Aged Care Act provides that an approved provider must comply with rules about charging accommodation payments, including rules specified in the *Fees and Payments Principles 2014 (No. 2)*. Section 19 of the *Fees and Payments Principles 2014 (No. 2).*

Reliance on subsection 33(3) of the *Acts Interpretation Act 1901*
Under subsection 33(3) of the *Acts Interpretation Act 1901*, where an Act confers a power to make, grant or issue any instrument of a legislative or administrative character (including rules, regulations or by-laws), the power shall be construed as including a power exercisable in the like manner and subject to the like conditions (if any) to repeal, rescind, revoke, amend, or vary any such instrument.

Commencement
The Schedules to the Amending Instrument commence as follows:

- Schedule 1 – 15 September 2024
- Schedule 2 – 20 September 2024
- Schedules 3 to 5 – 1 October 2024.

Consultation

Staff average amount of direct care ('care minutes') – 215 average care minutes

Change to the overall average care minutes responsibility implements part of the Government's 2022 election commitment "Fixing the Aged Care Crisis: Putting nurses back into nursing homes, and giving carers more time to care". Planned movement to average 215 overall / 44 RN care minutes responsibilities was also announced in May 2024 updates to the *Care minutes and 24/7 registered nurse responsibility guide*, published on the Department of Health and Aged Care website.

Detail of the changes to how care minutes responsibilities are to be calculated were discussed with the residential care sector in September 2024 through a meeting of the Residential Aged Care Funding Reform Working Group and a webinar, with attendees able to ask questions.

Staff average amount of direct care ('care minutes') – how approved providers can meet the RN care minutes component of the care minutes responsibility

With respect to the role of ENs in providing care minutes, since 2023 the Minister for Aged Care and the department have received feedback from a range of stakeholders on the, which informed options that have led to changes in the Amending Instrument.

In early 2023, following publicity that some providers planned to make their EN workforce redundant, the department consulted with the Residential Aged Care Funding Reform Working Group on a range of options to ensure ENs are retained in the residential aged care sector.

- Some approved providers and their representative bodies expressed that approved providers should be able to meet their care minutes responsibilities flexibly, including through staffing models that do not include ENs. Others expressed concerns that ENs were a vital part of the workforce.

Approved providers provided feedback in response to outreach on the care minute responsibility through the department's state and territory network. This engagement involved contacting around 250 services in September and October 2023:

- Key concerns included issues around attracting enough RNs to meet care minutes responsibilities, the need to use agency staff at high cost, and impacts on the continuity of care for residents of agency RN usage.
- Many providers also reported they are either not employing ENs or reducing EN hours.

In late 2023, sector stakeholders provided feedback to the University of Wollongong as part of a project, commissioned by the department, looking at clinically appropriate alternative arrangements to 24/7 RN coverage where workforce shortages mean they are not available. The final report noted:

- 'Stakeholders consistently spoke of the important role that ENs have in the workforce.'
- 'The important role played by ENs has emerged as an important theme throughout this project.'
- 'Despite this widely expressed view that ENs are an invaluable component of the Australian residential aged care workforce, their employment across the sector varies considerably, including in rural and remote locations. In some cases, providers are reducing the size of their EN workforce. This appears

largely to reflect a perspective that the additional cost associated with ENs relative to PCWs, combined with their reduced scope of practice relative to RNs, is not justified.'

- 'It is important to recognise that there is a genuine shortage of ENs available to work in aged care in many locations. However, as noted in the analysis … the availability of ENs relative to RNs is higher in regional and remote areas than in metropolitan areas.'

In early 2024 the department, through the Chief Nursing and Midwifery Officer, consulted with the Australian Nursing and Midwifery Federation (ANMF) on the specific proposal to allow up to a set percentage of a residential care service's target RN care minutes for a quarter to be met by ENs. While the ANMF strongly supported action being taken to ensure the ongoing roles of ENs in the sector, it did not support the proposal, proposing that EN-specific care minutes targets should be introduced.
Subsequently, in May 2024 the department announced through updates to the *Care minutes and 24/7 registered nurse responsibility guide*, published on the department's website, the Government's intention to legislate from 1 October 2024 that an amount of EN time can count toward meeting the RN care minutes responsibility.

Following the announcement, in May 2024 aged care providers provided generally positive feedback about the announcement, including at National Aged Care Advisory Council and Residential Aged Care Funding Reform Working Group meetings, while expressing a preference for a higher cap on the amount of EN time that can contribute toward to meeting RN care minutes responsibilities.

Stakeholders have also written approximately 75 letters to members of parliament, including letters from aged care workers, workers representatives, residents and their family members, approved providers, state governments and the TAFE sector. More representations have been made directly to the department.

- Approved providers and their representative bodies have argued that RN shortages mean that providers will not be able to meet higher RN care minute responsibilities, which should be relaxed.
- Workers (particularly ENs) have called for the Government to amend care minutes responsibilities to reflect the important role of ENs in residential aged care, and to prevent EN hours reduced or ENs being made redundant.
- Worker representatives (and some academics and commentators) have called for the introduction of EN-specific care minute responsibilities.
- TAFE representatives have noted increasing difficulties in obtaining placements for students studying enrolled nursing in residential aged care.

Detail of the changes to how to an amount of ENs time can contribute to meeting the RN care minutes responsibility were discussed with the residential care sector in September 2024 through a meeting of the Residential Aged Care Funding Reform Working Group and a webinar, with attendees able to ask questions.

Hotelling supplement
Routine indexation of the hotelling supplements in this instrument is calculated using a well-established formula based on the CPI as a measure of the movements in the non-labour costs of providers. Accordingly, no specific consultation has been undertaken with respect to application of routine indexation.

The increase to the hotelling supplement will also deliver on the Government's 2022 election commitment to fund the outcome of the Fair Work Commission's Aged Care Work Value Case, which has been welcomed by residential care sector representatives.

Detail of the changes to the amount of the hotelling supplement were discussed with the residential care sector in September 2024 through a meeting of the Residential Aged Care Funding Reform Working Group and a webinar, with attendees able to ask questions.

Basic subsidy
Changes to basic subsidy, including to the NEP, the classification amounts and the service amounts, reflect the Government's acceptance of advice from IHACPA. Since August 2022, IHACPA has had the function of providing advice to Government (through relevant Commonwealth ministers) on aged care costing and pricing matters (see section 131A of the *National Health Reform Act 2011*).

After IHACPA gained its aged care costing and pricing advice function it released the *Towards an Aged Care Pricing Framework Consultation Paper* (August 2022), with responses informing its subsequent *Pricing Framework for Australian Residential Aged Care Services 2023–24* (*Pricing Framework*) (May 2023).

IHACPA's advice to Government about basic subsidy arrangements from 1 October 2024 reflects implementation of the *Pricing Framework* throughout 2023 and 2024, including collection and analysis of data from 111 residential aged care facilities that participated in the 2023 *Residential Aged Care Costing Study* (summarised in a Final Report, January 2024) and analysis of data in approved provider Aged Care Financial Reports (submitted annually under sections 31 to 41 of the *Accountability Principles 2014*).

Independently of IHACPA's consultation processes, since 2022 regional and rural approved providers of residential care have also recommended to Government amendments to the structure of service amounts to provide differentiated funding to services that are in the MM 1, MM 2 and 3, and MM 4 and 5 regions.

Increases to basic subsidy also deliver on the Government's 2022 election commitment to fund the outcome of the Fair Work Commission's Aged Care Work Value Case, which has been welcomed by residential care sector representatives.

Detail of the changes to basic subsidy was discussed with the residential care sector in September 2024 through a meeting of the Residential Aged Care Funding Reform Working Group department and a webinar, with attendees able to ask questions.

RN supplement
Since October 2022, officers of the Department of Health and Aged Care (department) have consulted on the policy for the registered nurse supplement with residential care provider, workforce and care recipient representatives through the Residential Aged Care Funding Reform Working Group, and have engaged on technical design issues with vendors of residential aged care subsidy reconciliation software.

Since the commencement of the RN supplement, information about the Government's intention to change eligibility for the registered nurse supplement from 1 October 2024 through amendments to the definition of qualifying facilities was published in the *Care minutes and 24/7 registered nurse responsibility guide* and in other information published on the department's website, with opportunity for stakeholders to submit queries. Stakeholders were also reminded of this opportunity through a newsletter article in May 2024. After these announcements, the department did not receive questions from stakeholders about the Government's intention to change eligibility for the registered nurse supplement.

In July 2024, the Aged and Community Care Providers Association independently wrote to the department recommending changes to the structure of RN supplement amounts to pay differentiated regional rates that are similar to the new structure in the Amending Instrument.

Detail of the changes to RN supplement was discussed with the residential care sector in September 2024 through a meeting of the Residential Aged Care Funding Reform Working Group department and a webinar, with attendees able to ask questions.

Accommodation payments
Officers of the department consulted with IHACPA (which has responsibility for approval of accommodation prices under 52G-4 of the Aged Care Act).

Impact Analysis
Staff average amount of direct care ('care minutes') – 215 average care minutes
In May 2021, consistent with the former Office of Best Practice Regulation (now known as the Office of Impact Analysis) requirements at the time, the department certified that an independent review undertook a process analysis for the staff average amount of direct care responsibility which was equivalent to a regulatory impact statement (now known as an impact analysis).

In July 2022 the department also completed a supplementary impact analysis that dealt with increasing the staff average amount of direct care responsibility from 1 October 2024 to reach an average of 215 minutes per resident per day for the average resident, with at least 44 minutes of that time provided by a RN.

The certification, details of the review, and the supplementary impact analysis are available in the Explanatory Memoranda to the *Aged Care (Implementing Care Reform Act) 2022* and on the Office of Impact Analysis website.

Staff average amount of direct care ('care minutes') – how approved providers can meet the RN care minutes component of the care minutes responsibility
The Office of Impact Analysis has advised that a detailed impact analysis is not required for the changes to how approved providers can meet the RN care minutes component of the care minutes responsibility from 1 October 2024 (OIA24-06468).

Hotelling supplement, basic subsidy and RN supplement
The Office of Impact Analysis has advised that a detailed impact analysis is not required for the the changes to the hotelling supplement (OIA24-07917), basic subsidy (OIA24-07857) and RN supplement (OIA24-07971).

Accommodation payments
The Office of Impact Analysis has advised that a detailed impact analysis is not required for the changes related to accommodation payments (OIA23-05846).

General
The Amending Principles are a legislative instrument for the purposes of the *Legislation Act 2003*.

Details of the Amending Principles are set out in **Attachment A**.

The Amending Principles are compatible with the human rights and freedoms recognised or declared under section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*. A full statement of compatibility is set out in **Attachment B**.

ATTACHMENT A

Details of the *Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2024*

Section 1 provides that the name of the instrument is the *Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2024* (Amending Instrument).

Section 2 states that the Amending Instrument commence as follows:

- Schedule 1 – 15 September 2024
- Schedule 2 – 20 September 2024
- Schedules 3 to 5 – 1 October 2024.

Section 3 provides the authority for making the Amending Instrument is the *Aged Care Act 1997* (Aged Care Act) and the *Aged Care (Transitional Provisions) Act 1997* (Transitional Provisions Act).

Section 4 provides that each instrument that is specified in a Schedule to the Amending Instrument is amended or repealed as set out in the applicable items in the relevant Schedule and other items in the Schedules have effect according to its terms.

SCHEDULE 1—Required amounts of direct care

Quality of Care Principles 2014

Item 1 – Subsection 9(1)
This item amends subsection 9(1) to clarify that the required combined staff average amount of direct care per care recipient per day in respect of a residential care service for a quarter of a financial year for the approved provider of the service is worked out *on the calculation day for the quarter*.

Calculation day, for a quarter, means the 15th day of the calendar month before the calendar month in which the quarter begins (see section 4 of the *Quality of Care Principles 2014* (Quality of Care Principles)).

Item 2 – Paragraph 9(1)(a)
This item amends paragraph 9(1)(a) to clarify the first step in working out the required combined staff amount of direct care starts with the sum of the combined staff daily amounts, *as in force on the calculation day*, for all of the days of recognised residential care provided in respect of care recipients through the residential care service during the reference period for the quarter.

Calculation day, for a quarter, means the 15th day of the calendar month before the calendar month in which the quarter begins (see section 4 of the Quality of Care Principles).

Item 3 – Subsection 9(2)
This item amends subsection 9(2) to clarify that the required registered nurse average amount of direct care per care recipient per day in respect of a residential care service

for a quarter of a financial year for the approved provider of the service is worked out *on the calculation day for the quarter*.

Calculation day, for a quarter, means the 15th day of the calendar month before the calendar month in which the quarter begins (see section 4 of the Quality of Care Principles).

Item 4 – Paragraph 9(2)(a)
This item amends paragraph 9(2)(a) to clarify the first step in working out the required registered nurse amount of direct care starts with the sum of the combined staff daily amounts, *as in force on the calculation day*, for all of the days of recognised residential care provided in respect of care recipients through the residential care service during the reference period for the quarter.

Calculation day, for a quarter, means the 15th day of the calendar month before the calendar month in which the quarter begins (see section 4 of the Quality of Care Principles).

Item 5 – Subsection 9(3) (table)
This item repeals and substitutes the table in subsection 9(3), which provides identification of the relevant daily amount used in working out the required combined staff average amount of direct care (see subsection 9(1) of the Quality of Care Principles as amended) and the required registered nurse staff average amount of direct care (see subsection of the Quality of Care Principles 9(2) as amended).

The substituted daily amounts (with effect from 15 September 2024) are as follows:

Daily amounts			
	Column 1	**Column 2**	**Column 3**
Item	**For a care recipient classified as …**	**the combined staff daily amount is … (minutes)**	**and the registered nurse daily amount is … (minutes)**
1	Class 1	281	53
2	Class 2	122	25
3	Class 3	169	35
4	Class 4	138	29
5	Class 5	185	41
6	Class 6	177	37
7	Class 7	215	45
8	Class 8	239	50
9	Class 9	209	42
10	Class 10	254	50
11	Class 11	244	47
12	Class 12	243	46
13	Class 13	281	53
14	Respite Class 1	163	33
15	Respite Class 2	196	42
16	Respite Class 3	252	49

The combined staff daily amount and registered nurse daily amount for a day in the reference period for a care recipient are identified by reference to the classification level under Part 2.4A of the Aged Care Act of the care recipient on that day.

Schedule 2—Hotelling supplement

Aged Care (Subsidy, Fees and Payments) Determination 2014

Item 1 – Section 64ZT
This item amends section 64ZT to provide that the amount of the hotelling supplement for a day for a care recipient is increased from $11.24 to $12.55 (with effect from 20 September 2024).

Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014

This item amends section 91R to provide that the amount of the hotelling supplement for a day for a continuing residential care recipient is $12.55 (with effect from 20 September 2024).

Continuing residential care recipient means a person who:

- entered a residential care service before 1 July 2014, and
- has not:
  - ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

Schedule 3—Basic subsidy amount

Aged Care (Subsidy, Fees and Payments) Determination 2014

Item 1 – Section 64H (definition of *national efficient price*)
This item amends section 64H to provide that the national efficient price for residential care activity is increased from $253.82 to $280.01 (with effect from 1 October 2024).

Item 2 – Section 64K (table)
This item amends section 64K to repeal and substitute the table, with the effect of defining the non-respite classification amount for each class as the amount worked out by multiplying the national efficient price ($280.01 from 1 October 2024, see Item 1 of Schedule 3 of the Amending Instrument) by the specified NWAU attributable to each non-respite class as set out in the following table:

Non-respite class	NWAU
Class 1	0.80
Class 2	0.19
Class 3	0.37
Class 4	0.25
Class 5	0.44
Class 6	0.40
Class 7	0.55
Class 8	0.64
Class 9	0.52
Class 10	0.70
Class 11	0.66
Class 12	0.66
Class 13	0.80

NWAU (short for National Weighted Activity Unit) means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set (see section 64H of the *Aged Care (Subsidy, Fees and Payments) Determination 2014* (Subsidy Determination)).

Item 3 – Section 64L (table)

This item amends section 64L to repeal and substitute the table, not including the note, with the effect of defining the respite classification amount for each class as the amount worked out by multiplying the national efficient price ($280.01 from 1 October 2024, see Item 1 of Schedule 3 of the Amending Instrument) by the specified NWAU attributable to each respite class as set out in the following table:

Respite Class	NWAU
Respite Class 1	0.365
Respite Class 2	0.479
Respite Class 3	0.691

NWAU (short for National Weighted Activity Unit) means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set (see section 64H of the Subsidy Determination).

Item 4 – Subsection 64M(1) (table)

This item amends subsection 64M(1) to repeal and substitute the table, to provide that the service amount for a care recipient for a day is the amount worked out in accordance with what is specified in column 2 of the relevant item in the substituted table, provided that:

- the care recipient is provided with residential care on a day through a residential care service, and
- on the day, the service also meets the requirements set out in column 1 of an item of the substituted table.

The effect is that, if eligibility criteria for payment of basic subsidy are met, different service amounts are payable based on relevant factors at the residential care service where a care recipient receives care, including whether the service has specialised Aboriginal and Torres Strait Islander status or specialised homeless status, the number of operational places at the service, and whether the street address at the service is in a metropolitan area, regional centre or large rural town, medium or small rural town, or remote or very remote community.

Operational places are defined in subsection 64(2) of the Subsidy Determination.

Specialised Aboriginal and Torres Strait Islander status and specialised homeless status are defined in Part 2 of Chapter 2A of the Subsidy Determination.

Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014

Item 5 – Section 81 (definition of *national efficient price*)
This item amends section 81 to provide that the *national efficient price* for residential care activity is increased from $253.82 to $280.01 (with effect from 1 October 2024).

Item 6 – Section 83 (table)
This item amends section 83 to repeal and substitute the table, with the effect of defining the non-respite classification amount for each class as the amount worked out by multiplying the national efficient price ($280.01 from 1 October 2024, see Item 1 of Schedule 3 of the Amending Instrument) by the specified NWAU attributable to each non-respite class as set out in the following table:

Non-respite class	NWAU
Class 1	0.80
Class 2	0.19
Class 3	0.37
Class 4	0.25
Class 5	0.44
Class 6	0.40
Class 7	0.55
Class 8	0.64
Class 9	0.52
Class 10	0.70
Class 11	0.66
Class 12	0.66
Class 13	0.80

NWAU (short for National Weighted Activity Unit) means a measure of residential care activity, expressed as a common unit, against which the national efficient price is set (see section 81 of the *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014* (Transitional Provisions Determination)).

Item 7 – Subsection 84(1) (table)
This item amends subsection 84(1) to repeal and substitute the table, to provide that the service amount for a continuing residential care recipient for a day is the amount worked out in accordance with what is specified in column 2 of the relevant item in the substituted table, provided that:

- the continuing residential care recipient is provided with residential care on a day through a residential care service, and
- on the day, the service also meets the requirements set out in column 1 of an item of the substituted table.

The effect is that, if eligibility criteria for payment of basic subsidy are met, different service amounts are payable based on relevant factors at the residential care service where a continuing care recipient receives care, including whether the service has specialised Aboriginal and Torres Strait Islander status or specialised homeless status, the number of operational places at the service, and whether the street address at the service is in a metropolitan area, regional centre or large rural town, medium or small rural town, or remote or very remote community.

Operational places are defined in subsection 84(2) of the Transitional Provisions Determination.

Specialised Aboriginal and Torres Strait Islander status and specialised homeless status are defined in Part 2 of Chapter 2A of the Subsidy Determination.

Continuing residential care recipient means a person who:

- entered a residential care service before 1 July 2014, and
- has not:
  - ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles 2014, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

Schedule 4—Direct care responsibility and registered nurse supplement

Quality of Care Principles 2014

Item 1 – Section 4
This item inserts a new definition that ***enrolled nurse staff member*** means a staff member of an approved provider who is an enrolled nurse.

Enrolled nurse means a person who is registered under the National Law in the nursing profession as an enrolled nurse (see section 4 of the Quality of Care Principles).

National Law has the same meaning as in the *Health Insurance Act 1973* (see section 4 of the Quality of Care Principles).

Item 2 – Subsection 10(2), Item 3 – Subsection 10(3) and Item 4 – After Subsection 10(3)
Item 2 amends subsection 10(2) to clarify that the responsibility to provide direct care provided by direct care staff members applies to approved providers.

Item 3 amends subsection 10(3) to provide that the approved provider must ensure that the average amount of direct care provided through the service by registered nurse staff members of the provider per counted care recipient per day is at least 90% of the required registered nurse average amount of direct care per care recipient per day calculated under subsection 9(2) in respect of the service for the quarter.

Item 4 inserts a new subsection 10(3A) after subsection 10(3) that provides that the approved provider must ensure that the average amount of direct care provided through the service by registered nurse staff members and enrolled nurse staff members of the provider per counted care recipient per day is at least the required registered nurse average amount of direct care per care recipient per day calculated under subsection 9(2) in respect of the service for the quarter.

Subsection 9(2), as amended by Schedule 1 of the Amending Instrument, provides for the method to work the required registered nurse average amount of direct care per care recipient per day in respect of a residential care service for a quarter.

The combined effect of items 2, 3 and 4 is that, from 1 October 2024, up to 10% of the calculated required registered nurse average amount of direct care per care recipient per day for a residential care service for a quarter can be provided by enrolled nurse staff members, to provide flexibility for approved providers of residential care to use all their nurse workforce more efficiently, recognising the important role enrolled nurses play amid ongoing shortages of registered nurses in residential care.

Subsidy Principles 2014

Item 5 – Paragraph 70AM(1A)(c)
This item amends paragraph 70AM(1A)(c) with the effect that, from 1 October 2024, one of the criteria for a residential facility to be a *group A facility* for a payment period is that the total number of days of eligible residential care provided in respect of care recipients at the facility during the period, divided by the number of days in the period, is no more than 50.

Whether a residential facility is a group A facility affects what facility amount is payable under section 64ZU of Subsidy Determination (see Items 6 to 8 of Schedule 4 of the Amending Instrument) and under section 91S of the Transitional Provisions Determination (see Items 9 to 11 of Schedule 4 of the Amending Instrument).

Aged Care (Subsidy, Fees and Payments) Determination 2014

Item 6 – Subsection 64ZU(3)
This item amends subsection 64ZU(3) to provide that, subject to subsection 64ZU(4), the service supplement amount for a payment period for a residential care service

is the sum of the facility amounts, determined under subsections 64ZU(5) to (6C) (as amended by Item 7 of Schedule 4 of the Amending Instrument), for each qualifying facility for the period during which days of eligible residential care are provided in respect of care recipients during the period through that service.

Item 7 – Subsections 64ZU(5) to (6B)
This item repeals subsections 64ZU(5) to (6B) and substitutes new subsections 64ZU(5) to (6C).

New subsection 64ZU(5) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 1. The facility amount is set out in the table in subsection 64ZU(5), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(5) provides that the facility amount for group A qualifying facilities in MM category 1 (that is, group A qualifying facilities in metropolitan areas), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is $27,055 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is $24,124 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is $13,167 for the payment period.
- where the average daily care count is more than 30 but less than or equal to 35, the facility amount is $10,687 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40, the facility amount is $8,207 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45, the facility amount is $5,727 for the payment period.
- Where the average daily care count is more than 45 but less than or equal to 50, the facility amount is $3,247 for the payment period.

New subsection 64ZU(5A) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 2 or 3. The facility amount is set out in the table in subsection 64ZU(5A), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(5A) provides that the facility amount for group A qualifying facilities in MM 2 and 3 (that is, group A qualifying facilities in regional centres and large rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is $29,715 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is $26,496 for the payment period.

- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is $14,461 for the payment period.
- where the average daily care count is more than 30 but less than or equal to 35, the facility amount is $11,738 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40, the facility amount is $9,014 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45, the facility amount is $6,290 for the payment period.
- Where the average daily care count is more than 45 but less than or equal to 50, the facility amount is $3,566 for the payment period.

New subsection 64ZU(5B) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 4 or 5. The facility amount is set out in the table in subsection 64ZU(5B), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(5B) provides that the facility amount for the period for group A qualifying facilities in MM 4 and 5 (that is, group A qualifying facilities in medium and small rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is $70,883 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is $60,143 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is $49,403 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is $38,663 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is $27,162 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is $14,825 for the payment period.
- Where the average daily care count is more than 30 but less than or equal to 35 the facility amount is $12,032 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40 the facility amount is $9,240 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45 the facility amount is $6,448 for the payment period.
- where the average daily care count is more than 45 but less than or equal to 50 the facility amount is $3,655 for the payment period.

New subsection 64ZU(5C) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 6 or 7. The facility amount is set out in the table in subsection 64ZU(5C), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(5C) provides that the facility amount for the period for group A qualifying facilities in MM 6 and 7 (that is, group A qualifying facilities in remote and very remote communities), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is $84,057 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is $71,321 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is $58,585 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is $45,849 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is $32,210 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is $17,580 for the payment period.
- Where the average daily care count is more than 30 but less than or equal to 35 the facility amount is $14,269 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40 the facility amount is $10,958 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45 the facility amount is $7,646 for the payment period.
- where the average daily care count is more than 45 but less than or equal to 50 the facility amount is $4,335 for the payment period.

New subsection 64ZU(6) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 1. The facility amount is set out in the table in subsection 64ZU(6), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(6) provides that the facility amount for group B qualifying facilities in MM 1 (that is, group B qualifying facilities in metropolitan areas), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is $13,528 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is $12,062 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is $6,584 for the payment period.

New subsection 64ZU(6A) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM2 or 3. The facility amount is set out in the table in subsection 64ZU(6A), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(6A) provides that the facility amount for group B qualifying facilities in MM 2 and 3 (that is, group B qualifying facilities in regional centres and large rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is $14,858 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is $13,248 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is $7,231 for the payment period.

New subsection 64ZU(6B) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 4 or 5. The facility amount is set out in the table in subsection 64ZU(6B), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(6B) provides that the facility amount for the period for group B qualifying facilities in MM 4 and 5 (that is, group B qualifying facilities in medium and small rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is $35,442 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is $30,072 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is $24,702 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is $19,332 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is $13,581 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is $7,413 for the payment period.

New subsection 64ZU(6C) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 6 or 7. The facility amount is set out in the table in subsection 64ZU(6C), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 64ZU(6C) provides that the facility amount for the period for group B qualifying facilities in MM 6 and 7 (that is, group B qualifying facilities in remote and very remote communities), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is $42,029 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is $35,661 for the payment period.

- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is $29,293 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is $22,925 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is $16,105 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is $8,790 for the payment period.

'Modified Monash Model' and 'MM category' have the same meanings as in section 64H of the Subsidy Determination. Modified Monash Model means the 2019 model developed by the Department to categorise areas according to geographical remoteness and population size, as the model existed on 1 October 2022. 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.

The average daily care count is worked out in accordance with subsections 64ZU(7) and (8).

Item 8 – Subsection 64ZU(7)
This item amends subsection 64ZU(7) so that it applies for the purposes of subsections 64ZU(5) to (6C) (as amended by Item 7 of Schedule 4 of the Amending Principles).

Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014

Item 9 – Subsection 91S(3)
This item amends subsection 91S(3) to provide that, subject to subsection 91S(4), the service supplement amount for a payment period for a residential care service is the sum of the facility amounts, determined under subsections 91S(5) to (6C) (as amended by Item 10 of Schedule 4 of the Amending Instrument), for each qualifying facility for the period during which days of eligible residential care are provided in respect of continuing care recipients during the period through that service.

Continuing residential care recipient means a person who:
- entered a residential care service before 1 July 2014, and
- has not:
  - ceased to be provided with residential care by a residential care service for a continuous period of more than 28 days (other than because the person is on leave), or
  - before moving to another residential care service, made a written choice, in accordance with the Fees and Payments Principles 2014, covered by Chapters 3 and 3A of the Aged Care Act in relation to the other service (see Schedule 1 of the Aged Care Act).

Item 10 – Subsections 91S(5) to (6B)
This item repeals subsections 91S(5) to (6B) and substitutes new subsections 91S(5) to (6C).

New subsection 91S(5) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 1. The facility amount is set out in the table in subsection 91S(5), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(5) provides that the facility amount for group A qualifying facilities in MM 1 (that is, qualifying facilities in metropolitan areas), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is $27,055 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is $24,124 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is $13,167 for the payment period.
- where the average daily care count is more than 30 but less than or equal to 35, the facility amount is $10,687 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40, the facility amount is $8,207 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45, the facility amount is $5,727 for the payment period.
- Where the average daily care count is more than 45 but less than or equal to 50, the facility amount is $3,247 for the payment period.

New subsection 91S(5A) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 2 or 3. The facility amount is set out in the table in subsection 91S(5A), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(5A) provides that the facility amount for group A qualifying facilities in MM 2 and 3 (that is, qualifying facilities in regional centres and large rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is $29,715 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is $26,496 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is $14,461 for the payment period.
- where the average daily care count is more than 30 but less than or equal to 35, the facility amount is $11,738 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40, the facility amount is $9,014 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45, the facility amount is $6,290 for the payment period.
- Where the average daily care count is more than 45 but less than or equal to 50, the facility amount is $3,566 for the payment period.

New subsection 91S(5B) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 4 or 5. The facility amount is set out in the table in subsection 91S(5B), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(5B) provides that the facility amount for the period for group A qualifying facilities in MM 4 and 5 (that is, facilities in medium and small rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is $70,883 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is $60,143 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is $49,403 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is $38,663 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is $27,162 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is $14,825 for the payment period.
- Where the average daily care count is more than 30 but less than or equal to 35 the facility amount is $12,032 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40 the facility amount is $9,240 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45 the facility amount is $6,448 for the payment period.
- where the average daily care count is more than 45 but less than or equal to 50 the facility amount is $3,655 for the payment period.

New subsection 91S(5C) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 6 or 7. The facility amount is set out in the table in subsection 91S(5C), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(5C) provides that the facility amount for the period for group A qualifying facilities in MM 6 and 7 (that is, facilities in remote and very remote communities), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is $84,057 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is $71,321 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is $58,585 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is $45,849 for the payment period.

- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is $32,210 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is $17,580 for the payment period.
- Where the average daily care count is more than 30 but less than or equal to 35 the facility amount is $14,269 for the payment period.
- where the average daily care count is more than 35 but less than or equal to 40 the facility amount is $10,958 for the payment period.
- where the average daily care count is more than 40 but less than or equal to 45 the facility amount is $7,646 for the payment period.
- where the average daily care count is more than 45 but less than or equal to 50 the facility amount is $4,335 for the payment period.

New subsection 91S(6) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 1. The facility amount is set out in the table in subsection 91S(6), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(6) provides that the facility amount for group B qualifying facilities in MM 1 (that is, group B qualifying facilities in metropolitan areas), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is $13,528 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is $12,062 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is $6,584 for the payment period.

New subsection 91S(6A) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 2 or 3. The facility amount is set out in the table in subsection 91S(6A), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(6A) provides that the facility amount for group B qualifying facilities in MM 2 and 3 (that is, group B qualifying facilities in regional centres and large rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 20, the facility amount is $14,858 for the payment period.
- where the average daily care count is more than 20 but less than or equal to 25, the facility amount is $13,248 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30, the facility amount is $7,231 for the payment period.

New subsection 91S(6B) provides the facility amount for a payment period for a group B qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 4 or 5. The facility amount is set out in the table in subsection 91S(6B), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(6B) provides that the facility amount for the period for group B qualifying facilities in MM 4 and 5 (that is, group B qualifying facilities in medium and small rural towns), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is $35,442 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is $30,072 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is $24,702 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is $19,332 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is $13,581 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is $7,413 for the payment period.

New subsection 91S(6C) provides the facility amount for a payment period for a group A qualifying facility for a payment period with a street address in the Modified Monash Model MM category known as MM 6 or 7. The facility amount is set out in the table in subsection 91S(6C), with different amounts depending on the average daily care count for the facility for the period.

The table in subsection 91S(6C) provides that the facility amount for the period for group B qualifying facilities in MM 6 and 7 (that is, group B qualifying facilities in remote and very remote communities), and the amount, depending on the average daily care count, is as follows:

- where the average daily care count is less than or equal to 5 the facility amount is $42,029 for the payment period.
- where the average daily care count is more than 5 but less than or equal to 10 the facility amount is $35,661 for the payment period.
- where the average daily care count is more than 10 but less than or equal to 15 the facility amount is $29,293 for the payment period.
- where the average daily care count is more than 15 but less than or equal to 20 the facility amount is $22,925 for the payment period.
- Where the average daily care count is more than 20 but less than or equal to 25 the facility amount is $16,105 for the payment period.
- where the average daily care count is more than 25 but less than or equal to 30 the facility amount is $8,790 for the payment period.

'Modified Monash Model' and 'MM category' have the same meanings as in section 81 of the Transitional Provisions Determination. Modified Monash Model means the 2019 model developed by the Department to categorise areas according to geographical remoteness and population size, as the model existed on 1 October 2022. 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.

The average daily care count is worked out in accordance with subsections 91S(7) and (8).

Item 11 – Subsection 91S(7)
This item amends subsection 91S(7) so that it applies for the purposes of subsections 91S(5) to (6C) (as amended by Item 10 of Schedule 4 of the Amending Principles).

Schedule 5—Accommodation payments

Fees and Payments Principles 2014 (No. 2)

Item 1 – Paragraph 19(3)(b)
This item omits the wording 'for publication by the Secretary' from this paragraph, so that it now provides an approved provider must give the information required under subsection 19(1) to the Secretary. This is to clarify that the Secretary is not required to publish the information provided under subsection 19(1), but rather has the discretion to publish this information under section 86-9 of the Aged Care Act.

Item 2 – at the end of Section 19
This item inserts an additional provision that requires approved providers who propose to charge an accommodation amount higher than the maximum amount determined by the Minister (currently $550,000) to give the Secretary a copy of the notice from IHACPA that approves the provider to charge the higher amount. A note is included to clarify that the Secretary may make information about accommodation payments connected with an aged care service publicly available in accordance with paragraph 86-9(1)(e) of the Aged Care Act.

Residential aged care providers must publish information about the accommodation payments they propose to charge for a room or part of a room in their service and provide this information to the Secretary. This amendment will ensure that where a provider gives information to the Secretary proposing to charge an amount higher than the maximum accommodation amount, the Secretary can identify whether the porviedr has approval from IHACPA to charge the higher amount. This will ensure only accommodation payments with a valid approval from IHACPA are published by the Secretary. It is not intended for the notice from IHACPA to be published by the Secretary.

Where a provider gives information to the Secretary proposing to charge an amount higher than the maximum accommodation payment amount but does not provide the Secretary with a notice from IHACPA which approves the higher amount the Secretary will not publish this information.

ATTACHMENT B

Statement of Compatibility with Human Rights

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

Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2024

This instrument is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny Act) Act 2011*.

Overview of the instrument

The *Aged Care Legislation Amendment (Subsidy and Other Measures) Instrument 2024* (Amending Instrument) amends aged care subordinate legislation to provide for changes to:

- how the responsibility of approved providers of residential care to provide a staff average amount of direct care ('care minutes') each quarter is calculated, and to how that responsibility may be met
- the amount of residential care hotelling supplement
- the amount and the method of calculating the amount of residential care basic subsidy
- the amount and method of calculating the amount of registered nurse supplement, and
- residential care accommodation payments arrangements.

The hotelling supplement, basic subsidy and the registered nurse (RN) supplement are all applicable in the calculation of residential care subsidy in respect of residential care provided to care recipients (who are subject to the *Aged Care Act 1997* and its legislative instruments) and continuing residential care recipients (who are subject to the *Aged Care (Transitional Provisions) Act 1997* and its legislative instruments). The care minutes responsibility is also applicable to the provision of care to both residential care recipients and continuing residential care recipients.

To support residential care accommodation payment arrangements, the amendments will require an approved provider give to the Secretary a copy of the notice from the Independent Health and Aged Care Pricing Authority (IHACPA) approving the provider to charge an accommodation payment higher than the maximum amount. This is to enable accurate publication of accommodation payment amounts that exceed the maximum accommodation payment amount determined by the Minister (currently $550,000).

The Amending Instrument amends the following subordinate legislation:

- *Fees and Payments Principles 2014 (No. 2)* (Fees and Payments Principles)
- *Quality of Care Principles 2014* (Quality of Care Principles)
- *Subsidy Principles 2014* (Subsidy Principles)
- *Aged Care (Subsidy, Fees and Payments) Determination 2014* (Subsidy Determination)

- *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014* (Transitional Provisions Determination).

Human rights implications

Right to health

Schedules 1, 3 and 4 of the Amending Instrument, through amending the direct care responsibility, arrangements for basic subsidy and the RN supplement, engage the human rights to health in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and article 25 of the Convention on the Rights of Persons with Disabilities (CRPD). These articles refer to the right of individuals, including persons with disability, to the highest attainable standard of physical and mental health.

Schedules 1 and 4 – staff average amount of direct care responsibility

Schedules 1 and 4 engage the right to health by providing for amendments to the responsibility of approved providers of residential care to provide at each residential care service each quarter of a financial year at least an average amount of direct care per care recipient per day. This includes at least an average amount of direct care per care recipient per day that must be delivered by registered nurses. The amendments in Schedule 1 specifically provide for an increase to the average amount of direct care per care recipient per day that is required, taking the sector average to 215 minutes, including an average of 44 minutes of RN care.

Schedules 1 and 4 therefore promote the right to health as the amendments seek to ensure care recipients in a residential care service receive a minimum average amount of direct care each day. The right to health is further promoted by Schedules 1 and 4 as a portion of the direct care to be provided each day must be provided by a registered nurse, with up to 10% of the required registered nurse average amount allowed to be provided by an enrolled nurse. This will specifically assist to ensure that care recipients' clinical care needs are being met each day.

Schedule 3 – basic subsidy

Schedule 3 of the Amending Instrument promotes the right to health by providing for the subsidised provision of aged care accommodation and services on the basis of need. The subsidisation of aged care services will ensure consumers are able to access health facilities and goods, including essential medications and services and other health services.

Schedule 3 amendments to arrangements for calculating residential care basic subsidy will better match the amount of basic subsidy paid for provision of residential care to the real costs of meeting the care recipient's needs in their residential care setting. This is because the calculation method will reflect both the individual characteristics of the care recipient and the characteristics of the service where the care is delivered.

As such, the amended arrangements for calculation of residential care basic subsidy will better facilitate access to health services to promote the enjoyment of the highest attainable standard of physical and mental health by care recipients.

Schedule 4 – RN supplement

The RN supplement, as amended by Schedule 4, promotes the right to health by subsidising the provision of care delivered by RNs to residential care recipients. The amendments seek to ensure eligible approved providers receive subsidy to cover the costs of meeting the 24/7 RN responsibility, which aims to ensure all residential care recipients have their clinical care needs met each day.

Right to an adequate standard of living

Schedules 2, 3 and 5 of the Amending Instrument, through amending the hotelling supplement and arrangements for basic subsidy and accommodation payments engage the human rights to an adequate standard of living in article 11(1) of the ICESCR and the adequate standard of living and social protection in article 28 of the CRPD.

The right to an adequate standard of living, including adequate food, water and housing, and to the continuous improvement of living conditions is contained in article 11(1) of ICESCR. Article 28 of the CRPD also require countries to take appropriate measures to safeguard the right of persons with disabilities to an adequate standard of living.

Schedule 2 – hotelling supplement

Schedule 2 promotes the right of those receiving care to an adequate standard of living by providing for the subsidised provision of aged care accommodation and services on the basis of care needs. This includes ensuring subsidies are paid in respect of the costs of providing hotel services to residential care recipients, which includes accommodation, bedding, cleaning and laundry services and meals and refreshments.

Schedule 3 – basic subsidy

Schedule 3 amendments to arrangements for calculating residential care basic subsidy will better match the amount of basic subsidy paid for provision of residential care to the real costs of meeting the care recipient's needs in their residential care setting. This is because the calculation method will better reflect both the individual characteristics of the care recipient and the characteristics of the service where the care is delivered. As such, the amended arrangements for calculation of residential care basic subsidy promotes the rights of those care recipients to an adequate standard of living.

Right to social security and social protection

The right to social security including social insurance is contained in article 9 of the ICESCR. Article 28 of the CRPD also recognises the right of persons with disabilities to social protection, including measures to ensure access to appropriate and affordable services and public housing programs.

Schedule 3 – basic subsidy

Schedule 3 promotes the right of those receiving care to social security/social protection, by providing for the subsidised provision of aged care accommodation and services on the basis of need.

The amended arrangements for calculation of residential care basic subsidy will better match the amount of basic subsidy paid for provision of residential aged care to the real costs of meeting the care recipient's needs in their residential aged care setting. This is because the calculation method will better reflect both the individual characteristics of the care recipient and the characteristics of the service where the care is delivered.

As such, the amended arrangements for calculation of residential care basic subsidy aim to maintain the right to social security by providing a minimum essential level of benefits to all older persons, to enable them to acquire at least essential health care, basic shelter and housing, water and sanitation and foodstuffs.

Schedule 5 – accommodation payments

Schedule 5 amendments to arrangements for the charging of accommodation payments promotes the social protections of people entering residential care by ensuring that, where required, before the Secretary publishes accommodation payment amounts there is a valid approval from the IHACPA.

Conclusion

The Amending Principles are compatible with human rights as it promotes the rights of care recipients to an adequate standard of living, the right to social security and social protection and the right to health.

The Hon Anika Wells MP
Minister for Aged Care